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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Table of Contents

Executive Summary 2
Reporting Requirements 3
Barriers to Accessing Behavioral Health Services 4
Access Differs Between Populations 4
Behavioral Health Integration 5
Data Results 7
Follow-Up After Emergency Department Visit 7
Receipt of Mental Health Service 9
Behavioral Health Organization Services 9
Children's Mental Health Providers 10
Provider Availability 10
Provider Spoken Languages 10
Providers Accepting New Patients 10
Eating Disorders 11
Children and Youth With Eating Disorder Diagnoses 11
Care Settings for Eating Disorder Treatment 11
Contracted Providers Specializing in Eating Disorder Treatment 11
Conclusion 12
Appendix A: Follow-Up After Emergency Department Visit, Calendar Year (CY) 2017 15
Appendix B: Receipt of Mental Health Service, Calendar Year (CY) 2017 19
Appendix C: Services by Behavioral Health Organizations, April 2016–March 2017 20
Appendix D: Services by Behavioral Health Organizations, Calendar Year (CY) 2017 25
Appendix E: MCO-Contracted Mental Health Providers Serving Children by MCO and County, Calendar Year (CY) 2017 30
Appendix F: Language Access Through Interpreter Services for Medicaid Clients 38
Appendix G: Children and Youth Enrolled in Medicaid or CHIP With Eating Disorder Diagnoses, Calendar Year (CY) 2017 39
Appendix H: MCO-Contracted Providers Serving Children and Youth With Eating Disorder Diagnoses by County, Calendar Year (CY) 2017 42

Executive Summary

Washington Apple Health (Medicaid) plays a critical role for many children with behavioral health needs. In Washington State, Apple Health eligible children may access behavioral health treatment through different programs depending on their eligibility and location. These programs include fee-for-service (FFS), managed care organizations (MCOs), Integrated Managed Care (IMC),[1] or Behavioral Health Organizations (BHOs). With the exception of IMC, MCOs typically provide behavioral health services only to children with less acute behavioral health needs. In non-IMC regions, MCOs refer children with higher-acuity behavioral health treatment needs to their local BHO.

Access barriers to children's behavioral health services are common and often disproportionally affect certain populations. To better understand these barriers, we analyzed performance measures linked to access to care for children (0–18 years old). This report addresses the following: [2]

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

Less than one-third of Apple Health covered children received follow-up care within 30 days after emergency department visits for alcohol and other substance use disorders during calendar year (CY) 2017, this rate increased by 5.8 percentage points from the CY 2016 rate of 23.8 percent.

Compared to the substance use disorder follow-up rate, the 30-day follow-up rate after an emergency department visit for mental health disorders is considerably higher at 82.7 percent. This is an increase of 4.6 percentage points from the CY 2016 rate of 78.1 percent. Some racial/ethnic groups, such as Asian/Native Hawaiian or Pacific Islander populations, had lower levels of follow-up (both 7-day and 30-day) for any behavioral health-related emergency department visit. Follow-up rate changes from CY 2016 to CY 2017 are mixed.

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[1] See RCW 74.09.748 "Regional service areas—Certain reimbursements required or allowed upon adoption of fully integrated managed health care system." <http://app.leg.wa.gov/RCW/default.aspx?cite=74.09.748>, accessed on September 7, 2018.
[2] Please note formal measure names may include obsolete terminology not aligned with current Diagnostic and Statistical Manual of Mental Disorders language.
[3] Per the language of the corresponding Healthcare Effectiveness Data and Information Set (HEDIS) measure.

Service rates and other information related to both BHO services and Apple Health mental health providers are similar to what we reported last year.[4] Beginning in 2018, the Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) are required to report data related to eating disorder treatment services for children and youth.

Access to behavioral health is a key state initiative. Strategic, cross-agency efforts are underway. We are expanding integrated managed care in regions throughout the state. We also provide reimbursement for telehealth/telemedicine and are working to improve bi-directional availability of behavioral and physical health services. These initiatives may help improve disparities in access for children needing behavioral health services. Service modality alternatives, such as telemedicine, could improve access to behavioral health services. However, it is critical that these policy efforts consider and address the specific needs of rural communities and minority populations within statewide service delivery improvement efforts.

Reporting Requirements

The Revised Code of Washington (RCW) 74.09.495[5] directs HCA and DSHS to report annually on the status of access to behavioral health services for children birth through age 17. Reporting must include:

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

[4] "Access to Behavioral Health Services for Children (December 1, 2017)." <https://www.hca.wa.gov/assets/ssb-5779-behavioral-health-services-children-12-01-07.pdf >, accessed on September 7, 2018.
[5] RCW 74.09.495, "Behavioral health services—Access by children—Report." <http://app.leg.wa.gov/RCW/default.aspx?cite=74.09.495>, accessed September 7, 2018.

Barriers to Accessing Behavioral Health Services

According to National Health Interview Survey (NHIS) data, children enrolled in Medicaid or 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 5.1 percent, respectively) in 2014.[6] Apple Health plays a critical role for many children with behavioral health needs by providing comprehensive coverage for children and reducing barriers associated with out-of-pocket costs.

To promote access to behavioral health services, federal law mandates that Medicaid and CHIP programs comply with behavioral health parity requirements. Parity requirements help 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. However, other barriers to accessing behavioral health services exist, such as:

- Lack of available treatment providers;
- Transportation challenges; and
- Client experience of stigma.

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. Publications suggest that distrust of physicians can 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.[7] Studies indicate it is difficult to isolate the effect of low English proficiency from cultural values, because all of these factors are interconnected.[8]

Access Differs Between Populations

Gaps between behavioral health treatment need and service access have been the subject of national discussion. 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 attempts[9]. There is also a notable lack of racial and

[6] Medicaid Access in Brief: Children's Use of Behavioral Health Services. June 2016. MACPAC. Advising Congress on Medicaid and CHIP Policy. Issue Brief.
[7] Racial/Ethnic Differences in Physician Distrust in the United States. 2007. Armstrong, et al. Am J Public Health. *97*(7).
[8] Cross-cultural barriers to mental health services in the United States. 2011. Leong FTL, Kalibatseva Z. Cerebrum: Dana Forum Brain Science.
[9] 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.

cultural diversity among mental health providers, even as demographic trends indicate an increase in both minority populations and their requirements for mental health treatment.[10]

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 services.[11]

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.[12]

Behavioral Health Integration

In Washington State, Apple Health eligible children may access behavioral health treatment through fee-for-service (FFS), managed care organizations (MCOs), Integrated Managed Care (IMC), or Behavioral Health Organizations (BHOs). Behavioral health integration began on April 1, 2016, with the creation of BHOs across the state and IMC in southwest Washington. As of CY 2018, BHOs include Great Rivers, Greater Columbia, King County, North Sound, Optum-Pierce, Salish, Spokane County Regional, and Thurston-Mason.

IMC means the state purchases physical and behavioral health services together, instead of purchasing physical health services through Apple Health MCOs and purchasing behavioral health services separately through BHOs. Integrated Managed Care is currently limited to southwest and north central Washington. Entities involved in offering integrated managed care include the five Medicaid managed care plans — Amerigroup, Community Health Plan of Washington, Coordinated Care of Washington, and Molina Healthcare — and Beacon Health options as the behavioral health administrative services organization. By January 2019, five regions will have IMC: Greater Columbia, King, North Sound, Pierce, and Spokane; only three BHOs will remain in the state: Thurston-Mason, Great Rivers, and Salish. (See Figure 1 below.)

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

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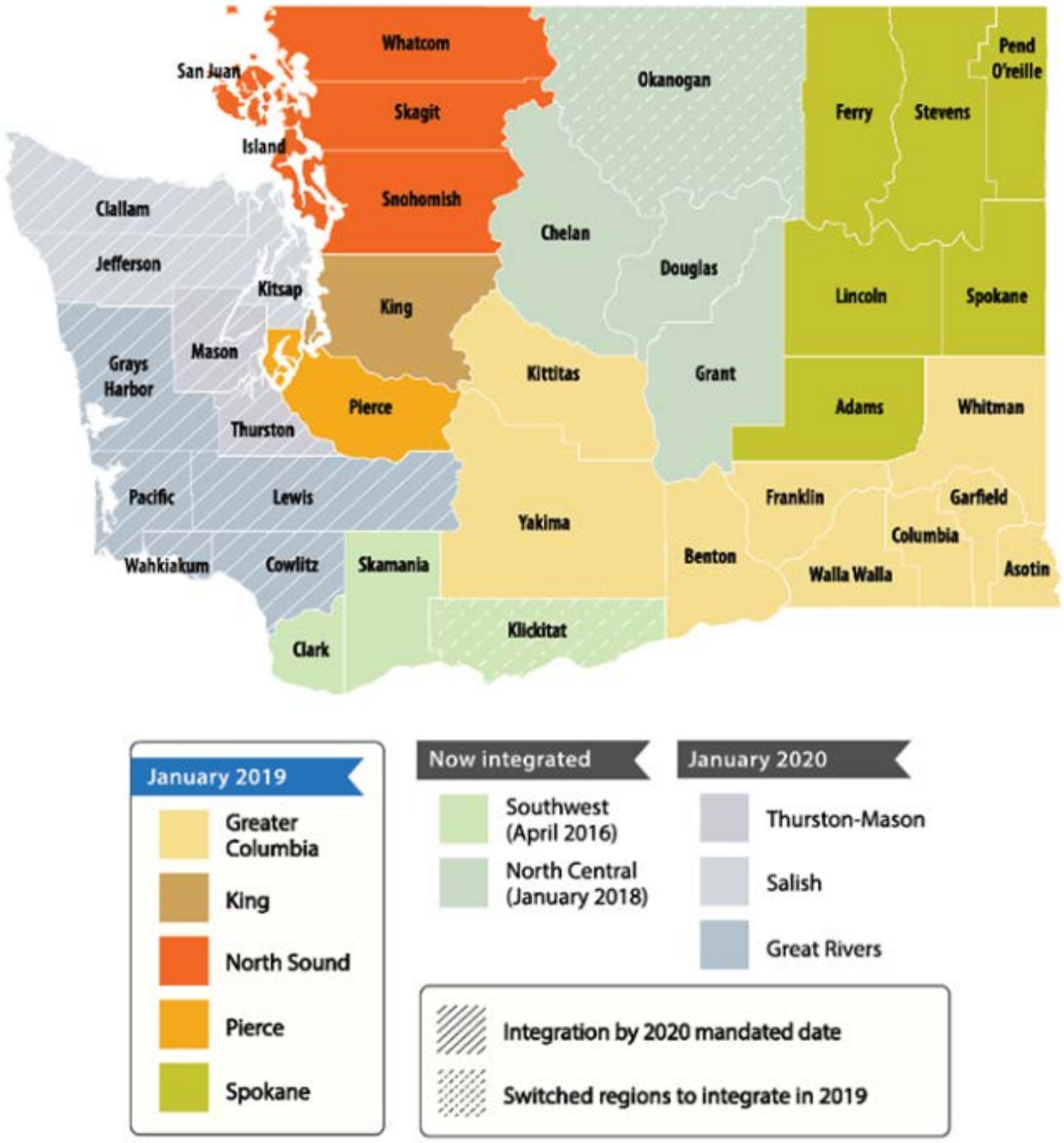
[10] Health Disparities & Mental/Behavioral Health Workforce. American Psychological Association, <http://www.apa.org/about/gr/issues/workforce/disparity.aspx>, accessed August 28, 2018.
[11] Children's Services in Washington State. 2016. DSHS Research and Data Analysis Division, http://www.governor.wa.gov/sites/default/files/documents/BlueRibbonRDA_2016_0510_FINAL_v2.pdf.
[12] Access to Mental Health Services for Children in Rural Areas. 2017. Center for Disease Control. Policy Brief.

Figure 1. Integrated Managed Care Regions



SOURCE: "HCA announces managed care plans offering integrated care starting in 2019 and 2020," <https://www.hca.wa.gov/about-hca/hca-announces-managed-care-plans-offering-integrated-care-starting-2019-and-2020>, accessed on August 23, 2018

Data Results

Follow-Up After Emergency Department Visit

Less than one-third (29.6 percent) of Apple Health covered children received follow-up care within 30 days after emergency department visits for alcohol and other substance use disorders[13] during calendar year CY 2017 (as illustrated in Figure 2 below). This percentage increased by 5.8 percentage points from the CY 2016 rate of 23.8 percent.

The 30-day follow-up after an emergency department visits for mental health disorders remains considerably higher at 82.7 percent (as illustrated in Figure 3 below), which increased by 4.6 percentage points from the CY 2016 rate of 78.1 percent.

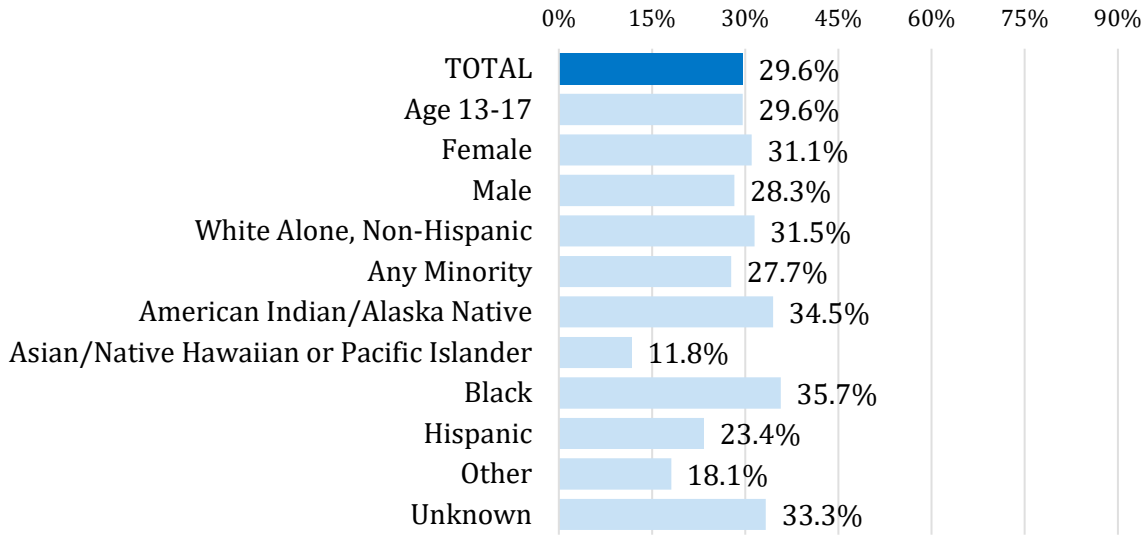
Some racial/ethnic groups, such as Asian/Native Hawaiian or Pacific Islander populations, had lower levels of follow-up (both 7-day and 30-day) for any behavioral health-related emergency department visit. However, changes in follow-up rates between CY 2016 and CY 2017 are mixed. For example:

- The 30-day follow-up rate for alcohol and other substance use disorders for the Asian/Native Hawaiian or Pacific Islander population **decreased** by 4.0 percentage points, from 15.8 percent in CY 2016 to only 11.8 percent in CY 2017.
- The 30-day follow-up rate for mental health disorders for the Asian/Native Hawaiian or Pacific Islander population **increased** substantially by 23.5 percentages points, from 58.1 percent in CY 2016 to 81.6 percent in CY 2017. However, this percentage point increase might be due to small numbers (i.e., only 87 Apple Health clients in the denominator).

Appendix A contains the full datasets for CY 2017 follow-up after an emergency department visit.

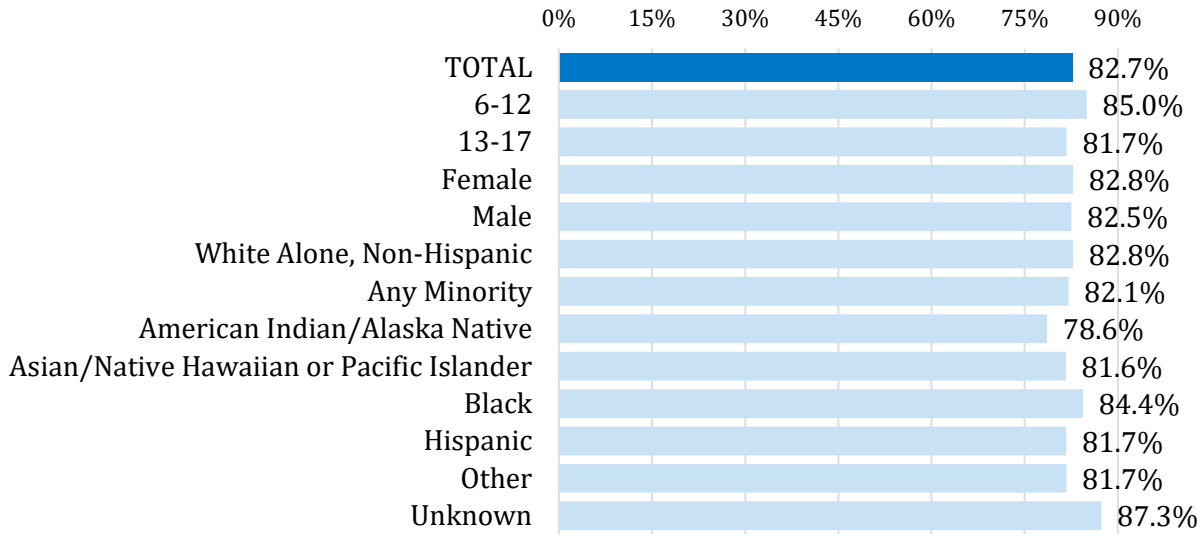
[13] Per the language of the corresponding Healthcare Effectiveness Data and Information Set (HEDIS) measure.

Figure 2. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 30 Days in CY 2017[14]



SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, August 2018.

Figure 3. Follow-Up After Emergency Department Visit for Mental Illness Within 30 Days of Emergency Department Visit in CY 2017[15]



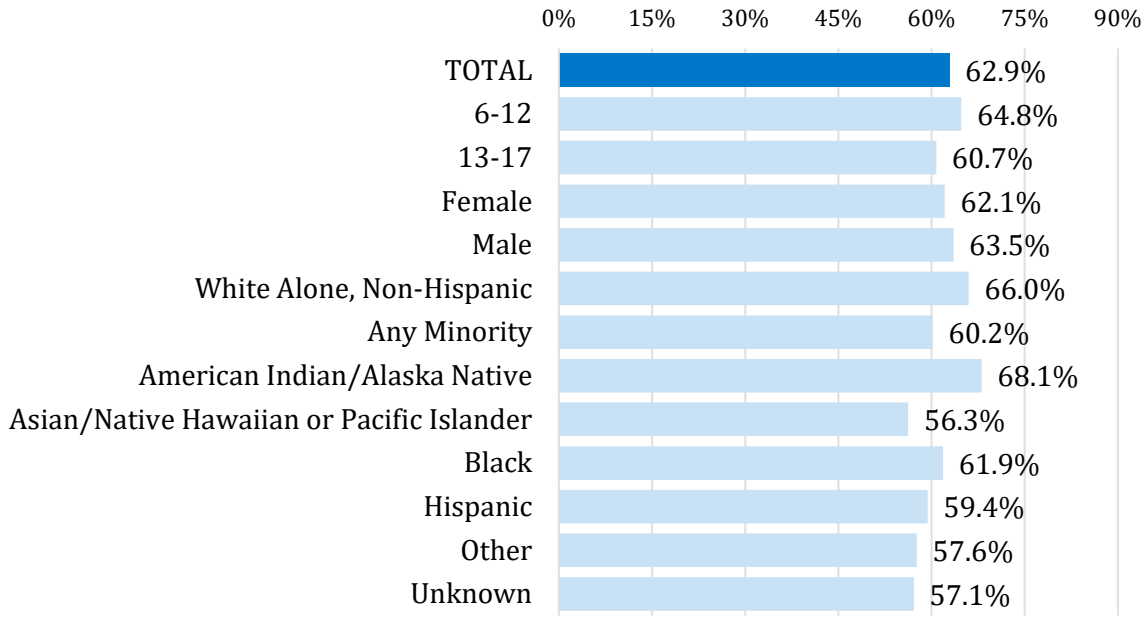
SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, August 2018.

[14] Measure is within the 2018 Statewide Common Measure Set, <https://www.hca.wa.gov/assets/Washington-State-Common-Measure-Set-2018.pdf>, accessed August 28, 2018.
[15] (Ibid.)

Receipt of Mental Health Service

In CY 2017, 62.9 percent of Apple Health children with an identified mental health need received mental health services during the reporting period, unchanged when compared to CY 2016 results (62.7 percent). Some racial/ethnic groups continued to have lower levels of mental health treatment penetration, including Asian/Native Hawaiian or Pacific Islander (56.3 percent) and Hispanic (59.4 percent) populations. Appendix B provides additional demographic information.

Figure 3. Mental Health Treatment Penetration[16] in 2017 — Broadly Defined



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

Behavioral Health Organization Services

During CY 2017, about 6.1 percent (50,985) of Apple Health and CHIP-covered children (841,253) within BHO-covered regions of the state received mental health services through BHOs. This rate remained about the same, compared to the CY 2016 rate of 6.00 percent. Also during CY 2017, 1.2 percent (3,575) of Apple Health and CHIP-covered children ages 11–18 within BHO-covered regions of the state (311,705) received SUD services through BHOs.[17] This rate remained about the same, compared to the CY 2016 rate of 1.2 percent.

[16] Measure is within the 2018 Statewide Common Measure Set, <https://www.hca.wa.gov/assets/Washington-State-Common-Measure-Set-2018.pdf>, accessed August 28, 2018.

[17] The smaller SUD denominator reflects the population of children was limited to ages 11–18, who are within the typical age range for this service type.

Appendices C and D describe the types of services provided and demographic profiles of those receiving this service during CY 2016 and CY 2017, respectively.

Children's Mental Health Providers

Provider Availability

Comprehensive availability data for children's mental health providers in the BHO, FFS, MCO, or IMC networks is not available. The state does not collect provider-level data with sufficient detail or consistency to reliably report on the number of mental health providers available to provide services, languages spoken by providers, and the number of providers accepting new clients. For example, although BHOs know the number of facilities paid to provide children's mental health services each year, many providers may be within each facility.

There are five MCOs offering health care services to Apple Health recipients. With the exception of the IMC regions, MCOs typically provide behavioral health services to children with less acute behavioral health needs. MCOs will refer children with higher-acuity behavioral health treatment needs to their local BHO.

MCOs report information to HCA about their contracted Apple Health providers to enable HCA to monitor provider network adequacy. This requirement provides some information on children's mental health provider availability. Appendix E identifies the number of behavioral health providers reportedly serving children during each quarter of CY 2017 by MCO and county. With the exception of Wahkiakum County, children's mental health providers are available in each county of the state, though availability varies by MCO network.

Provider Spoken Languages

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

Providers Accepting New Patients

Comprehensive data about children's mental health providers in the BHO, FFS, MCO, or IMC networks accepting new patients is not available, because the state does not collect provider-level availability data with sufficient detail or consistency. For example, to comply with reporting requirements in RCW 74.09.337, BHOs maintain lists on their websites that include information about children's mental health providers in their networks. However, those lists are not uniformly structured and do not all clearly identify which mental health providers serve children and youth and are accepting new patients.

MCOs report quarterly to the Health Care Authority regarding the number of enrolled providers and whether the providers are accepting new patients. Appendix E shows the proportion of children's mental health providers accepting new patients, by MCO and county. Based on four

quarterly reports in 2017, every MCO has a majority of children's mental health providers accepting new patients.

We are currently working to refine the *Behavioral Health Provider (BHP) Survey* to provide more data about provider availability and language. The University of Washington administers the *BHP Survey* on behalf of the Division of Behavioral Health and Recovery (DBHR). The University of Washington begins administering the *BHP Survey* to providers in October each year, and results are typically available to DBHR by the following August. Though DBHR recently became part of HCA, we would need more resources to expand this survey.

Eating Disorders

Children and Youth With Eating Disorder Diagnoses

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

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

Appendix G includes data on the number of Apple Health and CHIP-enrolled children with Apple Health claims that contained eating disorder diagnoses during CY 2017. Data are presented by demographic group and county location.

Care Settings for Eating Disorder Treatment

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

Contracted Providers Specializing in Eating Disorder Treatment

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

It is not possible with claims data to determine whether a health service procedure was for an eating disorder. However, to provide some data that approximates the required data related to contracted providers specializing in eating disorder treatment, Appendix H shows, by MCO and county:

- The number of health care providers in MCO networks who provided any health services to children with eating disorders during each quarter of CY 2017; and
- The proportion of those providers who were accepting new clients during each quarter of CY 2017.

The number of health care providers in MCO networks who provided any health services to children with eating disorders during CY 2017 is a limited subset of all children's mental health providers. However, the proportions accepting new clients appear similar.

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. For example:

- In compliance with RCW 74.09.337, MCOs transmit provider network data to HCA quarterly, and BHOs maintain network provider lists on their websites. Future contract amendments with BHOs could require BHOs to transmit provider network data to HCA quarterly, which could enable HCA's analysis of provider availability, access, and spoken language. However, collecting and processing this data would require additional resources.
- The *BHP Survey* could expand to include additional questions related to provider availability, access, and spoken language. This, too, would require additional resources.
- The Legislature could direct the Department of Health to perform a sunrise review about creating an eating disorder specialist certification or licensure for current and future providers. This, too, would require additional resources.

There are still barriers to improving access to children's behavioral health services. In 2016, the Children's Mental Health Work Group[18] 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.

[18] "The Children's Mental Health Work Group: Final Report and Recommendations," <http://leg.wa.gov/JointCommittees/Archive/CMH/Documents/CMH_FinalReport.pdf>, accessed on August 28, 2018.

In addition, studies have recognized that adequate and consistent funding are imperative for maintaining children's behavioral health services access.[19] 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 Line[20] (PAL), a telephone-based child mental health consultation system for primary care providers. The PAL program is financially supported by funds from HCA and staffed by child psychiatrists affiliated with Seattle Children's Hospital and the University of Washington's School of Medicine. 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 other obstacles.

Substitute Senate Bill 6452 (2018) creates a two-year pilot program[21] associated with the PAL program that will include a service that will allow parents and guardians with concerns related to the mental health of their child to receive referrals to children's mental health services and providers that are in-network with the child's health care coverage, accepting new patients, and taking appointments.

Additional efforts, including those specifically aimed at increasing the number of behavioral health providers available for screening and treatment, are necessary 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 with Apple Health.

Targeted interventions should consider the needs of rural communities and minority populations. Approaches such as telemedicine may increase access in rural areas and help address experienced or perceived stigma. Purported benefits of telemedicine 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.[22] As cultural or demographic factors may also influence an individual's decision to access behavioral health care, telemedicine may prove to be a suitable option.

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[19] 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>, accessed August 28, 2018.
[20] Partnership Access Line, <http://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/>, accessed August 28, 2018.
[21] Substitute Senate Bill 6452, Section 2(3)(b), <http://lawfilesext.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/Senate/6452-S.SL.pdf>, accessed on August 28, 2018.
[22] Increasing Access to Behavioral Health Care Through Technology. 2012. U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration.

Though some research has indicated that navigating cultural differences between patient and provider may be more challenging during telemedicine encounters[23], it is a valuable tool when providers are trained and able to deliver culturally and linguistically appropriate services.[24] The HCA will further address this topic in the 2019 legislative report required by RCW 74.09.325(9).

Certain populations may have higher need for behavioral health treatment due to a wide variety of environmental and social factors. Evidence-based prevention programs for children at risk of developing mental health disorders may play a role in helping to offset this disparity. Increased investment in the prevention of mental health and substance use disorders 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. Service modality alternatives, such as telemedicine, could improve access to behavioral health services. However, it is critical that these policy efforts consider and address the specific needs of rural communities and minority populations within statewide service delivery improvement efforts.

[23] Using e-Health to Enable Culturally Appropriate Mental Healthcare in Rural Areas. 2008. Peter Yellowlees, et al. Telemed J E Health.
[24] Telecounseling for the Linguistically Isolated. 2014. Yuri Jang, et al. Gerontologist.

Appendix A: Follow-Up After Emergency Department Visit, Calendar Year (CY) 2017

Table A.1. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 7 Days [HEDIS-FUA[1]], CY 2017

Demographic Category	Numerator	Denominator	Rate
TOTAL	**125**	**622**	**20.1%**
AGE CATEGORY			
13-17	125	622	20.1%
GENDER			
Female	63	293	21.5%
Male	62	329	18.8%
RACE/ETHNICITY			
White Alone, Non-Hispanic	58	270	21.5%
Any Minority	61	328	18.6%
American Indian / Alaska Native	17	87	19.5%
Asian / Native Hawaiian or Pacific Islander	(Suppressed)	(Suppressed)	5.9%
Black	14	56	25.0%
Hispanic	28	171	16.4%
Other	14	105	13.3%
Unknown	(Suppressed)	(Suppressed)	25.0%

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, August 2018.
NOTE: We suppressed both the numerator and denominator if either were less than 10.

1. Healthcare Effectiveness Data and Information Set (HEDIS) measure: Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence within 7 Days (FUA, or Follow-Up: Alcohol). This measure is within the 2018 Statewide Common Measure Set, <https://www.hca.wa.gov/assets/Washington-State-Common-Measure-Set-2018.pdf>, accessed August 27, 2018.

Table A.2. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 30 Days [HEDIS-FUA[1]], CY 2017

Demographic Category	Numerator	Denominator	Rate
TOTAL	**184**	**622**	**29.6%**
AGE CATEGORY			
13-17	184	622	29.6%
GENDER			
Female	91	293	31.1%
Male	93	329	28.3%
RACE/ETHNICITY			
White Alone, Non-Hispanic	85	270	31.5%
Any Minority	91	328	27.7%
American Indian / Alaska Native	30	87	34.5%
Asian / Native Hawaiian or Pacific Islander	(Suppressed)	(Suppressed)	11.8%
Black	20	56	35.7%
Hispanic	40	171	23.4%
Other	19	105	18.1%
Unknown	(Suppressed)	(Suppressed)	33.3%

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, August 2018.
NOTE: We suppressed both the numerator and denominator if either were less than 10.

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

Table A.3. Follow-Up After Emergency Department Visit for Mental Illness Within 7 Days of Emergency Department Visit [HEDIS-FUM[1]], CY 2017

Demographic Category	Numerator	Denominator	Rate
TOTAL	**1,625**	**2,225**	**73.0%**
AGE CATEGORY			
6-12	478	632	75.6%
13-17	1,147	1,593	72.0%
GENDER			
Female	940	1,276	73.7%
Male	685	949	72.2%
RACE/ETHNICITY			
White Alone, Non-Hispanic	903	1,249	72.3%
Any Minority	664	897	74.0%
American Indian / Alaska Native	90	126	71.4%
Asian / Native Hawaiian or Pacific Islander	65	87	74.7%
Black	155	205	75.6%
Hispanic	336	459	73.2%
Other	211	290	72.8%
Unknown	58	79	73.4%

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, August 2018.
NOTE:

1. Healthcare Effectiveness Data and Information Set (HEDIS) measure: Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence within 7 Days (FUM, or Follow-Up: Mental). This measure is within the 2018 Statewide Common Measure Set, <https://www.hca.wa.gov/assets/Washington-State-Common-Measure-Set-2018.pdf>, accessed August 27, 2018.

Table A.4. Follow-Up After Emergency Department Visit for Mental Illness Within 30 Days of Emergency Department Visit [HEDIS-FUM[1]], CY 2017

Demographic Category	Numerator	Denominator	Rate
TOTAL	**1,839**	**2,225**	**82.7%**
AGE CATEGORY			
6-12	537	632	85.0%
13-17	1,302	1,593	81.7%
GENDER			
Female	1,056	1,276	82.8%
Male	783	949	82.5%
RACE/ETHNICITY			
White Alone, Non-Hispanic	1,034	1,249	82.8%
Any Minority	736	897	82.1%
American Indian / Alaska Native	99	126	78.6%
Asian / Native Hawaiian or Pacific Islander	71	87	81.6%
Black	173	205	84.4%
Hispanic	375	459	81.7%
Other	237	290	81.7%
Unknown	69	79	87.3%

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, August 2018.
NOTE:

1. Healthcare Effectiveness Data and Information Set (HEDIS) measure: Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence within 30 Days (FUM, or Follow-Up: Mental). This measure is within the 2018 Statewide Common Measure Set, <https://www.hca.wa.gov/assets/Washington-State-Common-Measure-Set-2018.pdf>, accessed August 27, 2018.

Appendix B: Receipt of Mental Health Service, Calendar Year (CY) 2017

Table B.1. Mental Health Treatment Penetration–Broadly Defined [SUPPL-MH-B[1]], CY 2017

Demographic Category	Numerator	Denominator	Rate
TOTAL	**67,862**	**107,947**	**62.9%**
AGE CATEGORY			
6-12	36,725	56,690	64.8%
13-17	31,137	51,257	60.7%
GENDER			
Female	31,217	50,261	62.1%
Male	36,645	57,686	63.5%
RACE/ETHNICITY			
White Alone, Non-Hispanic	35,108	53,203	66.0%
Any Minority	29,176	48,483	60.2%
American Indian / Alaska Native	3,770	5,539	68.1%
Asian / Native Hawaiian or Pacific Islander	2,385	4,240	56.3%
Black	5,320	8,599	61.9%
Hispanic	16,993	28,624	59.4%
Other	11,085	19,245	57.6%
Unknown	3,578	6,261	57.1%

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, August 2018.
NOTE:

1. Mental Health Service Penetration (Broad Version) is a Department of Social and Health Services measure. Denominator for percentages is number of persons with indications of mental health treatment need in the current or past CY. Numerator is number of persons receiving outpatient mental health services in the current CY. Outpatient mental health services include most modalities of outpatient mental health services delivered through DBHR (excludes, for example, case management), as well as Behavioral Rehabilitation Services from the Children's Administration, and outpatient mental health services delivered through the Health Care Authority or tribal authorities. Note that tabulation of mental health services received in this measure reflects a one-year window, whereas the mental health services component of indication of mental health needs reflects a two-year window. This measure is within the 2018 Statewide Common Measure Set, <https://www.hca.wa.gov/assets/Washington-State-Common-Measure-Set-2018.pdf>, accessed August 27, 2018.

Appendix C: Services by Behavioral Health Organizations, April 2016–March 2017

Table C.1. Medicaid (Title 19) and Children's Health Insurance Program (CHIP) Youth (0–18 Years) Served by the Behavioral Health Organizations (BHOs) in Substance Use Disorder (SUD) Treatment, Withdrawal Management (WM) Services, or Community Mental Health (MH), April 2016–March 2017[25]

BHO[1]	Total Medicaid[2]	Any SUD Treatment / WM or Community MH Service[3]		Any SUD / WM Service[4]		Any Community MH Service[5]	
		#	%	#	%	#	%
Great Rivers	44,867	3,512	7.83%	303	0.68%	3,336	7.44%
Greater Columbia	141,433	8,127	5.75%	612	0.43%	7,750	5.48%
King	184,568	11,391	6.17%	603	0.33%	11,018	5.97%
North Central	21,240	1,265	5.96%	138	0.65%	1,176	5.54%
North Sound	133,487	8,227	6.16%	645	0.48%	7,828	5.86%
Pierce	110,728	7,030	6.35%	387	0.35%	6,804	6.14%
Salish	35,248	2,185	6.20%	212	0.60%	2,072	5.88%
Spokane	119,923	7,909	6.60%	508	0.42%	7,630	6.36%
Thurston Mason	37,680	2,319	6.15%	277	0.74%	2,168	5.75%
Total STATEWIDE	**829,174**	**51,965**	**6.27%**	**3,685**	**0.44%**	**49,782**	**6.00%**

Title 19 & CHIP Youth Living Outside of BHO Service Area: 63,865

NOTES:

1. BHO: BHO associated with the residence county during the first month of the reporting period where the youth (<=18) was Title 19 Medicaid or CHIP eligible (based on CODB tables monthly_age_summary, codb_eligibility, and county_month_array).
2. Total Medicaid: Total number of youth (<=18) who were Title 19 Medicaid or CHIP eligible for at least one month during the reporting period (based on CODB tables monthly_age_summary and codb_eligibility).
3. SUD or MH Served: Subset receiving either a) SUD treatment or WM service or b) Community MH service (excludes SH and CLIP) during a month of Title 19 or CHIP Medicaid eligibility in the reporting period while <=18 yrs of age. (DBHR'sClient Uniqueid was obtained from linking the person_link_id to Pegasus.people. Encounters were extracted directly from BHSS. This was quicker than processing the multiple arrays in CODB derived from BHSS).
4. SUD Served: Subset receiving a SUD treatment or WM service during a month of Title 19 Medicaid or CHIP eligibility during the reporting period while <=18 yrs of age. (DBHR'sClient Uniqueid was

[25] "Chemical Dependency (CD)" treatment has been renamed Substance Use Disorder (SUD) treatment. "Detox Services" have been renamed Withdrawal Management (WM) Services.

obtained from linking the person_link_id to Pegasus.people. Encounters were extracted directly from BHSS. This was quicker than processing the multiple arrays in CODB derived from BHSS).

5. MH Served: Subset receiving a Community MH service (excludes SH and CLIP) during a month of Title 19 Medicaid or CHIP eligibility during the reporting period while <=18 yrs of age. (DBHR's Client Uniqueid was obtained from linking the person_link_id to Pegasus.people. Encounters were extracted directly from BHSS, this was quicker than processing the multiple arrays in CODB derived from BHSS).

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, and Behavioral Health Service Summary Tables, July 30, 2018. CODB2\Buzz\Title 19 Youth Served by BHOs 073018.sas

Table C.2. Number of Medicaid Title 19 or CHIP-Eligible Youths Ages 11-18 Receiving Any SUD Treatment or WM Services, April 2016–March 2017[26]

Category	Number of Clients	Percent of Those Who Received SUD Treatment or Withdrawal Management Services	Percent of Total Medicaid Title 19 or CHIP Eligible Youths in the Demographic Category
AGE			
11-13 yrs	399	10.84%	0.33%
14-18 yrs	3,283	89.16%	1.79%
GENDER			
Female	1,446	39.27%	0.96%
Male	2,236	60.73%	1.44%
RACE/ETHNICITY			
Minority	2,180	59.21%	1.30%
Non-Hispanic White	1,502	40.79%	1.15%
Unknown	0	0.00%	0.00%
RACE/ETHNICITY — MINORITY DETAIL			
African American	554	15.05%	1.65%
American Indian	600	16.30%	2.81%
Asian	145	3.94%	0.63%
Asian/Pacific Islander	15	0.41%	3.25%
Hispanic	1,187	32.24%	1.24%
Native Hawaiian/Pacific Islander	138	3.75%	0.94%
TOTAL SERVED	**3,682**	**100.00%**	**1.21%**

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, and Behavioral Health Service Summary Tables, July 30, 2018. CODB2\Buzz\Title 19 Youth Served by BHOs 073018.sas

[26] "Chemical Dependency (CD)" treatment has been renamed Substance Use Disorder (SUD) treatment. "Detox Services" have been renamed Withdrawal Management (WM) Services.

Table C.3. Number of Medicaid Title 19 or CHIP-Eligible Youths Ages 0-18 Receiving Any Community MH Services, April 2016–March 2017

Category	Number of Clients	Percent of Those Who Received Any Community MH Service	Percent of Total Medicaid Title 19 or CHIP Eligible Youths in the Demographic Category
AGE			
0-4 yrs	2,632	5.29%	1.08%
5-11 yrs	21,333	42.85%	6.59%
12-13 yrs	7,834	15.74%	9.83%
14-18 yrs	17,983	36.12%	9.82%
GENDER			
Female	24,489	49.19%	6.04%
Male	25,293	50.81%	5.97%
RACE/ETHNICITY			
Minority	25,961	52.15%	5.90%
Non-Hispanic White	23,795	47.80%	6.88%
Unknown	26	0.05%	0.06%
RACE/ETHNICITY — MINORITY DETAIL			
African American	7,142	14.35%	7.83%
American Indian	5,372	10.79%	10.37%
Asian	2,480	4.98%	4.48%
Asian/Pacific Islander	129	0.26%	18.02%
Hispanic	14,251	28.63%	5.54%
Native Hawaiian/Pacific Islander	1,787	3.59%	4.40%
TOTAL SERVED	**49,782**	**100.00%**	**6.00%**

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, and Behavioral Health Service Summary Tables, July 30, 2018. CODB2\Buzz\Title 19 Youth Served by BHOs 073018.sas

Table C.4. Types of Services Provided to Children and Youth Through BHOs, April 2016–March 2017

Disorder	Treatment Modality
Substance Use Disorder	Case Management
Substance Use Disorder	Intensive Inpatient Residential Services
Substance Use Disorder	Outpatient Treatment
Substance Use Disorder	Recovery House Residential Services
Substance Use Disorder	Withdrawal Management
Mental Health	Brief Intervention Treatment
Mental Health	Community Hospital
Mental Health	Care Coordination Services
Mental Health	Child And Family Team Meeting
Mental Health	Crisis Services
Mental Health	Day Support
Mental Health	Evaluation & Treatment
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	Involuntary Treatment Investigation MH
Mental Health	Jail Services/Community Transition
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	Special Population Evaluation
Mental Health	Stabilization Services
Mental Health	Supported Employment
Mental Health	Therapeutic Psychoeducation

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, July 2018.

Appendix D: Services by Behavioral Health Organizations, Calendar Year (CY) 2017

Table D.1. Medicaid (Title 19) and Children's Health Insurance Program (CHIP) Youth (0–18 years) Served by the Behavioral Health Organizations (BHOs) in Substance Use Disorder (SUD) Treatment, Withdrawal Management (WM) Services, or Community Mental Health (MH), CY 2017[27]

BHO[1]	Total Medicaid[2]	Any SUD Treatment / WM or Community MH Service[3]		Any SUD / WM Service[4]		Any Community MH Service[5]	
		#	%	#	%	#	%
Great Rivers	45,632	3,967	8.69%	318	0.70%	3,793	8.31%
Greater Columbia	143,379	8,350	5.82%	609	0.42%	7,967	5.56%
King	186,478	11,252	6.03%	577	0.31%	10,880	5.83%
North Central	21,265	1,335	6.28%	159	0.75%	1,231	5.79%
North Sound	135,183	8,145	6.03%	584	0.43%	7,747	5.73%
Pierce	113,177	7,172	6.34%	370	0.33%	6,945	6.14%
Salish	35,663	2,184	6.12%	194	0.54%	2,076	5.82%
Spokane	121,765	8,179	6.72%	480	0.39%	7,901	6.49%
Thurston Mason	38,711	2,597	6.71%	285	0.74%	2,445	6.32%
Total STATEWIDE	**841,253**	**53,181**	**6.32%**	**3,576**	**0.43%**	**50,985**	**6.06%**

Title 19 & CHIP Youth Living Outside of BHO Service Area: 64,746

NOTES:

1. BHO: BHO associated with the residence county during the first month of the reporting period where the youth (<=18) was Title 19 Medicaid or CHIP eligible (based on CODB tables monthly_age_summary, codb_eligibility, and county_month_array).
2. Total Medicaid: Total number of youth (<=18) who were Title 19 Medicaid or CHIP eligible for at least one month during the reporting period (based on CODB tables monthly_age_summary and codb_eligibility).
3. SUD or MH Served: Subset receiving either a) SUD treatment or WM service or b) Community MH service (excludes SH and CLIP) during a month of Title 19 or CHIP Medicaid eligibility in the reporting period while <=18 yrs of age. (DBHR'sClient Uniqueid was obtained from linking the person_link_id to Pegasus.people. Encounters were extracted directly from BHSS. This was quicker than processing the multiple arrays in CODB derived from BHSS).

[27] "Chemical Dependency (CD)" treatment has been renamed Substance Use Disorder (SUD) treatment. "Detox Services" have been renamed Withdrawal Management (WM) Services.

4. SUD Served: Subset receiving a SUD treatment or WM service during a month of Title 19 Medicaid or CHIP eligibility during the reporting period while <=18 yrs of age. (DBHR'sClient Uniqueid was obtained from linking the person_link_id to Pegasus.people. Encounters were extracted directly from BHSS. This was quicker than processing the multiple arrays in CODB derived from BHSS).
5. MH Served: Subset receiving a Community MH service (excludes SH and CLIP) during a month of Title 19 Medicaid or CHIP eligibility during the reporting period while <=18 yrs of age. (DBHR's Client Uniqueid was obtained from linking the person_link_id to Pegasus.people. Encounters were extracted directly from BHSS, this was quicker than processing the multiple arrays in CODB derived from BHSS).

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, and Behavioral Health Service Summary Tables, July 30, 2018. CODB2\Buzz\Title 19 Youth Served by BHOs 073018.sas

Table D.2. Number of Medicaid Title 19 or CHIP-Eligible Youths Ages 11-18 Receiving Any SUD Treatment or WM Services, CY 2017[28]

Category	Number of Clients	Percent of Those Who Received SUD Treatment or Withdrawal Management Services	Percent of Total Medicaid Title 19 or CHIP Eligible Youths in the Demographic Category
AGE			
11-13 yrs	364	10.18%	0.29%
14-18 yrs	3,211	89.82%	1.73%
GENDER			
Female	1,402	39.22%	0.91%
Male	2,173	60.78%	1.37%
RACE/ETHNICITY			
Minority	2,115	59.16%	1.23%
Non-Hispanic White	1,460	40.84%	1.11%
Unknown	0	0.00%	0.00%
RACE/ETHNICITY — MINORITY DETAIL			
African American	507	14.18%	1.48%
American Indian	547	15.30%	2.54%
Asian	139	3.89%	0.60%
Asian/Pacific Islander	10	0.28%	2.28%
Hispanic	1,203	33.65%	1.21%
Native Hawaiian/Pacific Islander	136	3.80%	0.90%
TOTAL SERVED	**3,575**	**100.00%**	**1.15%**

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, and Behavioral Health Service Summary Tables, July 30, 2018. CODB2\Buzz\Title 19 Youth Served by BHOs 073018.sas

[28] "Chemical Dependency (CD)" treatment has been renamed "Substance Use Disorder (SUD)" treatment. Detox Services have been renamed Withdrawal Management (WM) Services.

Table D.3. Number of Medicaid Title 19 or CHIP Eligible Youths Ages 0-18 Receiving Any Community MH Services, CY 2017

Category	Number of Clients	Percent of Those Who Received Any Community MH Service	Percent of Total Medicaid Title 19 or CHIP Eligible Youths in the Demographic Category
AGE			
0-4 yrs	2,627	5.15%	1.07%
5-11 yrs	21,597	42.36%	6.58%
12-13 yrs	8,180	16.04%	9.96%
14-18 yrs	18,581	36.44%	9.98%
GENDER			
Female	25,251	49.53%	6.14%
Male	25,734	50.47%	5.98%
RACE/ETHNICITY			
Minority	26,160	51.31%	5.89%
Non-Hispanic White	24,790	48.62%	7.15%
Unknown	35	0.07%	0.07%
RACE/ETHNICITY — MINORITY DETAIL			
African American	6,975	13.68%	7.59%
American Indian	5,087	9.98%	9.81%
Asian	2,456	4.82%	4.45%
Asian/Pacific Islander	99	0.19%	14.95%
Hispanic	14,792	29.01%	5.69%
Native Hawaiian/Pacific Islander	1,753	3.44%	4.26%
TOTAL SERVED	**50,985**	**100.00%**	**6.06%**

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, and Behavioral Health Service Summary Tables, July 30, 2018. CODB2\Buzz\Title 19 Youth Served by BHOs 073018.sas

Table D.4. Types of Services Provided Through BHOs, CY 2017

Disorder	Treatment Modality
Substance Use Disorder	Case Management
Substance Use Disorder	Intensive Inpatient Residential Services
Substance Use Disorder	Outpatient Treatment
Substance Use Disorder	Recovery House Residential Services
Substance Use Disorder	Withdrawal Management
Mental Health	Brief Intervention Treatment
Mental Health	Community Hospital
Mental Health	Care Coordination Services
Mental Health	Child And Family Team Meeting
Mental Health	Crisis Services
Mental Health	Day Support
Mental Health	Evaluation & Treatment
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	Involuntary Treatment Investigation MH
Mental Health	Jail Services/Community Transition
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	Special Population Evaluation
Mental Health	Stabilization Services
Mental Health	Supported Employment
Mental Health	Therapeutic Psychoeducation

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, July 2018.

Appendix E: MCO-Contracted Mental Health Providers Serving Children by MCO and County, Calendar Year (CY) 2017

Table E.1. MCO Mental Health Providers by MCO Network and County During the First Quarter of CY 2017 (2017-Q1)

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. Values — both the total number of providers in network (#) and the percent of those providers accepting new patients (%) — exclude provider locations outside of Washington State and provider locations where the record indicates that the provider does not serve clients younger than 19 years of age. "Amerigroup" means Amerigroup Washington. "CHPW" means Community Health Plan of Washington. "Molina" means Molina Healthcare of Washington. "United" means United Health Care Community Plan. Not every MCO is contracted in each county, as indicated by (-) in the table. We excluded data from Molina due to data quality issues.

2017-Q1	MCO PLAN											
	Amerigroup		CHPW		CCW		Molina		United		All Plans	
COUNTY	#	%	#	%	#	%	#	%	#	%	#	%
All Counties	1,955	99.2%	2,336	97.4%	1,634	95.7%	Excluded Due to Data Quality Issues		614	100.0%	5,507	98.3%
Adams	1	100.0%	2	100.0%	0	-			0	-	3	100.0%
Asotin	7	100.0%	2	100.0%	24	100.0%			1	100.0%	27	100.0%
Benton	47	95.7%	72	100.0%	59	98.3%			24	100.0%	163	100.0%
Chelan	35	100.0%	103	100.0%	38	92.1%			14	100.0%	174	98.3%
Clallam	2	100.0%	2	100.0%	4	75.0%			11	100.0%	18	94.4%
Clark	68	100.0%	78	100.0%	37	100.0%			41	100.0%	225	100.0%
Columbia	1	100.0%	3	100.0%	3	100.0%			0	-	6	100.0%
Cowlitz	34	100.0%	49	98.0%	61	100.0%			13	100.0%	130	100.0%
Douglas	2	100.0%	11	100.0%	7	71.4%			0	-	19	89.5%
Ferry	6	100.0%	3	100.0%	1	100.0%			0	-	9	100.0%
Franklin	7	71.4%	23	100.0%	2	100.0%			2	100.0%	33	93.9%
Garfield	1	100.0%	0	-	0	-			0	-	1	100.0%
Grant	9	100.0%	24	100.0%	46	100.0%			2	100.0%	74	100.0%
Grays Harbor	12	100.0%	5	100.0%	3	100.0%			2	100.0%	21	100.0%
Island	21	100.0%	29	100.0%	50	100.0%			11	100.0%	93	100.0%
Jefferson	28	100.0%	19	84.2%	30	86.7%			6	100.0%	67	95.5%
King	725	98.5%	871	97.2%	544	94.5%			165	100.0%	1,979	97.8%
Kitsap	39	100.0%	81	95.1%	38	94.7%			31	100.0%	150	98.0%
Kittitas	11	100.0%	3	100.0%	3	100.0%			5	100.0%	21	100.0%
Klickitat	5	100.0%	3	100.0%	0	-			1	100.0%	8	100.0%
Lewis	23	100.0%	25	100.0%	6	83.3%			10	100.0%	55	98.2%
Lincoln	7	100.0%	1	100.0%	1	100.0%			0	-	8	100.0%
Mason	6	100.0%	8	100.0%	8	87.5%			2	100.0%	21	95.2%

2017-Q1	MCO PLAN											
	Amerigroup		CHPW		CCW		Molina		United		All Plans	
COUNTY	#	%	#	%	#	%	#	%	#	%	#	%
Okanogan	8	100.0%	12	100.0%	8	100.0%	Excluded Due to Data Quality Issues		2	100.0%	29	100.0%
Pacific	2	100.0%	2	100.0%	1	100.0%			0	-	5	100.0%
Pend Oreille	4	100.0%	2	100.0%	2	100.0%			2	100.0%	7	100.0%
Pierce	312	100.0%	258	97.7%	207	96.6%			91	100.0%	728	98.6%
San Juan	3	100.0%	5	100.0%	1	-			1	100.0%	9	100.0%
Skagit	28	100.0%	44	97.7%	19	89.5%			7	100.0%	95	96.8%
Skamania	1	100.0%	5	80.0%	8	87.5%			1	100.0%	13	84.6%
Snohomish	104	99.0%	142	96.5%	116	90.5%			59	100.0%	360	97.2%
Spokane	203	100.0%	237	96.6%	177	94.9%			105	100.0%	586	98.3%
Stevens	18	100.0%	8	87.5%	1	100.0%			2	100.0%	27	96.3%
Thurston	85	100.0%	160	95.6%	57	94.7%			50	100.0%	311	96.8%
Walla Walla	13	100.0%	18	100.0%	11	100.0%			8	100.0%	44	100.0%
Wahkiakum	0	-	0	-	0	-			0	-	0	-
Whatcom	94	100.0%	109	97.2%	37	100.0%			17	100.0%	241	98.8%
Whitman	28	100.0%	9	100.0%	28	100.0%			9	100.0%	55	100.0%
Yakima	59	98.3%	83	98.8%	74	95.9%			27	100.0%	214	98.1%

SOURCE: HCA Network Adequacy Reporting by Medicaid MCOs.

Table E.2. MCO Mental Health Providers by MCO Network and County During CY 2017-Q2

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. Values — both the total number of providers in network (#) and the percent of those providers accepting new patients (%) — exclude provider locations outside of Washington State and provider locations where the record indicates that the provider does not serve clients younger than 19 years of age. "Amerigroup" means Amerigroup Washington. "CHPW" means Community Health Plan of Washington. "Molina" means Molina Healthcare of Washington. "United" means United Health Care Community Plan. Not every MCO is contracted in each county.

2017-Q2	MCO PLAN											
	Amerigroup		CHPW		CCW		Molina		United		All Plans	
COUNTY	#	%	#	%	#	%	#	%	#	%	#	%
All Counties	1,996	88.4%	2,262	96.9%	1,698	95.6%	3,219	100.0%	603	100.0%	7,374	97.5%
Adams	1	100.0%	2	100.0%	1	100.0%	1	100.0%	0	-	5	100.0%
Asotin	7	100.0%	2	100.0%	25	100.0%	8	100.0%	1	100.0%	36	100.0%
Benton	57	93.0%	75	100.0%	64	98.4%	77	100.0%	22	100.0%	206	99.5%
Chelan	34	100.0%	95	100.0%	42	90.5%	90	100.0%	13	100.0%	217	99.1%
Clallam	3	100.0%	3	100.0%	4	75.0%	37	100.0%	12	100.0%	48	100.0%
Clark	64	98.4%	68	100.0%	38	97.4%	274	100.0%	32	100.0%	427	99.5%
Columbia	1	100.0%	3	100.0%	2	100.0%	3	100.0%	0	-	8	100.0%
Cowlitz	48	20.8%	55	98.2%	64	100.0%	77	100.0%	11	100.0%	209	81.8%
Douglas	2	100.0%	5	100.0%	7	71.4%	18	100.0%	0	-	26	96.2%
Ferry	6	50.0%	3	100.0%	1	100.0%	4	100.0%	0	-	12	75.0%
Franklin	9	55.6%	20	100.0%	4	75.0%	10	100.0%	2	100.0%	38	94.7%
Garfield	1	100.0%	0	-	48	-	2	100.0%	0	-	3	100.0%
Grant	9	100.0%	26	100.0%	0	-	21	100.0%	2	100.0%	88	100.0%
Grays Harbor	12	83.3%	6	100.0%	3	100.0%	17	100.0%	5	100.0%	39	97.4%
Island	22	86.4%	28	96.4%	49	98.0%	27	100.0%	10	100.0%	104	98.1%
Jefferson	29	89.7%	19	84.2%	29	86.2%	23	100.0%	6	100.0%	73	93.2%
King	730	84.5%	824	96.5%	555	95.3%	1,087	100.0%	160	100.0%	2,563	96.6%
Kitsap	41	95.1%	79	91.1%	33	93.9%	84	100.0%	31	100.0%	197	96.4%
Kittitas	10	100.0%	3	100.0%	3	100.0%	22	100.0%	4	100.0%	35	100.0%
Klickitat	5	100.0%	3	100.0%	0	-	4	100.0%	1	100.0%	12	100.0%
Lewis	23	95.7%	25	100.0%	5	100.0%	27	100.0%	10	100.0%	67	100.0%
Lincoln	14	71.4%	1	100.0%	1	100.0%	4	100.0%	0	-	15	73.3%
Mason	7	100.0%	9	88.9%	9	88.9%	10	100.0%	2	100.0%	27	100.0%
Okanogan	8	100.0%	12	100.0%	8	100.0%	24	100.0%	2	100.0%	44	100.0%
Pacific	2	100.0%	1	100.0%	1	100.0%	5	100.0%	0	-	9	100.0%
Pend Oreille	3	100.0%	1	100.0%	2	100.0%	5	100.0%	2	100.0%	8	100.0%
Pierce	329	96.4%	250	97.2%	220	97.3%	361	100.0%	84	100.0%	900	99.2%
San Juan	3	100.0%	6	100.0%	1	-	13	100.0%	1	100.0%	21	100.0%
Skagit	29	89.7%	40	100.0%	20	90.0%	58	100.0%	6	100.0%	129	97.7%
Skamania	1	100.0%	4	100.0%	9	88.9%	6	100.0%	1	100.0%	14	100.0%
Snohomish	102	84.3%	134	96.3%	126	89.7%	225	100.0%	60	100.0%	516	97.1%

2017-Q2	MCO PLAN											
	Amerigroup		CHPW		CCW		Molina		United		All Plans	
COUNTY	#	%	#	%	#	%	#	%	#	%	#	%
Spokane	201	89.6%	240	96.7%	189	92.6%	430	100.0%	107	100.0%	811	98.3%
Stevens	19	63.2%	7	100.0%	1	100.0%	15	100.0%	2	100.0%	38	81.6%
Thurston	85	91.8%	157	95.5%	58	94.8%	123	100.0%	41	100.0%	374	97.9%
Walla Walla	12	91.7%	18	100.0%	11	100.0%	38	100.0%	8	100.0%	68	100.0%
Wahkiakum	0	-	0	-	0	-	0	-	0	-	0	-
Whatcom	94	100.0%	103	97.1%	37	100.0%	168	100.0%	15	100.0%	377	99.5%
Whitman	30	100.0%	11	100.0%	29	100.0%	35	100.0%	9	100.0%	84	100.0%
Yakima	58	93.1%	87	98.9%	85	96.5%	84	100.0%	21	100.0%	266	99.2%

SOURCE: HCA Network Adequacy Reporting by Medicaid MCOs.

Table E.3. MCO Mental Health Providers by MCO Network and County During CY 2017-Q3

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. Values — both the total number of providers in network (#) and the percent of those providers accepting new patients (%) — exclude provider locations outside of Washington State and provider locations where the record indicates that the provider does not serve clients younger than 19 years of age. "Amerigroup" means Amerigroup Washington. "CHPW" means Community Health Plan of Washington. "Molina" means Molina Healthcare of Washington. "United" means United Health Care Community Plan. Not every MCO is contracted in each county.

2017-Q3	MCO PLAN											
	Amerigroup		CHPW		CCW		Molina		United		All Plans	
COUNTY	#	%	#	%	#	%	#	%	#	%	#	%
All Counties	2,141	95.0%	2,236	96.5%	1,800	95.0%	3,088	100.0%	1,840	100.0%	7,776	98.6%
Adams	1	100.0%	3	100.0%	1	100.0%	0	-	0	-	5	100.0%
Asotin	7	100.0%	7	100.0%	25	100.0%	7	100.0%	9	100.0%	39	100.0%
Benton	72	94.4%	81	98.8%	65	98.5%	76	100.0%	55	100.0%	235	97.9%
Chelan	52	92.3%	95	100.0%	43	93.0%	82	100.0%	70	100.0%	242	99.2%
Clallam	5	100.0%	3	100.0%	4	75.0%	35	100.0%	41	100.0%	81	100.0%
Clark	27	100.0%	71	100.0%	40	100.0%	272	100.0%	129	100.0%	485	100.0%
Columbia	1	100.0%	3	100.0%	3	100.0%	2	100.0%	0	-	7	100.0%
Cowlitz	49	100.0%	56	98.2%	64	100.0%	74	100.0%	10	100.0%	186	100.0%
Douglas	4	100.0%	7	100.0%	10	80.0%	18	100.0%	2	100.0%	30	96.7%
Ferry	6	100.0%	3	100.0%	1	100.0%	5	100.0%	0	-	11	100.0%
Franklin	12	83.3%	18	100.0%	5	80.0%	9	100.0%	2	100.0%	37	91.9%
Garfield	1	100.0%	5	100.0%	0	-	1	100.0%	0	-	7	100.0%
Grant	33	36.4%	25	100.0%	49	100.0%	19	100.0%	11	100.0%	107	83.2%
Grays Harbor	9	88.9%	7	100.0%	3	100.0%	17	100.0%	4	100.0%	35	97.1%
Island	36	97.2%	28	96.4%	48	97.9%	27	100.0%	10	100.0%	117	97.4%
Jefferson	44	84.1%	18	83.3%	36	91.7%	23	100.0%	6	100.0%	73	98.6%
King	893	91.3%	803	95.9%	614	94.6%	1,055	100.0%	595	100.0%	2,779	98.1%
Kitsap	59	88.1%	77	90.9%	34	97.1%	83	100.0%	52	100.0%	209	97.6%
Kittitas	12	91.7%	5	100.0%	2	100.0%	22	100.0%	5	100.0%	37	97.3%
Klickitat	6	100.0%	3	100.0%	0	-	5	100.0%	1	100.0%	12	100.0%
Lewis	24	100.0%	25	100.0%	9	88.9%	27	100.0%	29	100.0%	87	100.0%
Lincoln	9	100.0%	1	100.0%	1	100.0%	4	100.0%	2	100.0%	12	100.0%
Mason	10	80.0%	8	87.5%	10	90.0%	10	100.0%	5	100.0%	32	90.6%
Okanogan	12	100.0%	13	100.0%	8	100.0%	25	100.0%	17	100.0%	57	100.0%
Pacific	2	100.0%	2	100.0%	1	100.0%	5	100.0%	8	100.0%	17	100.0%
Pend Oreille	4	100.0%	1	100.0%	2	100.0%	4	100.0%	3	100.0%	9	100.0%
Pierce	319	98.4%	253	96.8%	231	94.8%	335	100.0%	281	100.0%	936	98.9%
San Juan	3	100.0%	6	100.0%	1	-	11	100.0%	3	100.0%	19	100.0%
Skagit	34	97.1%	32	100.0%	21	90.5%	54	100.0%	17	100.0%	125	98.4%
Skamania	1	100.0%	6	100.0%	9	88.9%	6	100.0%	7	100.0%	18	100.0%
Snohomish	132	96.2%	139	95.0%	151	86.1%	220	100.0%	176	100.0%	629	96.8%
Spokane	231	98.3%	240	96.3%	177	93.8%	401	100.0%	264	100.0%	898	98.9%

2017-Q3	MCO PLAN											
	Amerigroup		CHPW		CCW		Molina		United		All Plans	
COUNTY	#	%	#	%	#	%	#	%	#	%	#	%
Stevens	19	100.0%	7	100.0%	1	100.0%	14	100.0%	5	100.0%	34	100.0%
Thurston	69	95.7%	147	95.2%	63	95.2%	121	100.0%	118	100.0%	388	98.7%
Walla Walla	12	100.0%	20	95.0%	11	100.0%	35	100.0%	28	100.0%	82	98.8%
Wahkiakum	0	-	0	-	0	-	0	-	0	-	0	-
Whatcom	47	100.0%	96	96.9%	38	97.4%	158	100.0%	37	100.0%	325	98.8%
Whitman	33	93.9%	14	100.0%	31	100.0%	29	100.0%	20	100.0%	82	98.8%
Yakima	65	98.5%	78	98.7%	86	95.3%	78	100.0%	40	100.0%	253	98.8%

SOURCE: HCA Network Adequacy Reporting by Medicaid MCOs.

Table E.4. MCO Mental Health Providers by MCO Network and County During CY 2017-Q4

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. Values — both the total number of providers in network (#) and the percent of those providers accepting new patients (%) — exclude provider locations outside of Washington State and provider locations where the record indicates that the provider does not serve clients younger than 19 years of age. "Amerigroup" means Amerigroup Washington. "CHPW" means Community Health Plan of Washington. "Molina" means Molina Healthcare of Washington. "United" means United Health Care Community Plan. Not every MCO is contracted in each county.

2017-Q4	MCO PLAN											
	Amerigroup		CHPW		CCW		Molina		United		All Plans	
COUNTY	#	%	#	%	#	%	#	%	#	%	#	%
All Counties	2,153	95.0%	2,259	96.1%	1,951	95.5%	3,576	99.9%	1,883	100.0%	8,279	98.6%
Adams	0	-	3	100.0%	1	100.0%	1	100.0%	0	-	4	100.0%
Asotin	7	100.0%	9	100.0%	24	100.0%	10	100.0%	9	100.0%	41	100.0%
Benton	72	94.4%	79	97.5%	66	98.5%	80	100.0%	60	100.0%	238	97.9%
Chelan	62	93.5%	97	100.0%	47	93.6%	104	100.0%	70	100.0%	266	99.2%
Clallam	8	100.0%	2	100.0%	4	75.0%	36	100.0%	43	100.0%	83	100.0%
Clark	27	100.0%	77	100.0%	38	100.0%	566	100.0%	131	100.0%	777	100.0%
Columbia	1	100.0%	3	100.0%	3	100.0%	2	100.0%	0	-	7	100.0%
Cowlitz	49	100.0%	55	98.2%	64	100.0%	78	100.0%	12	100.0%	188	100.0%
Douglas	4	100.0%	9	100.0%	10	80.0%	20	100.0%	2	100.0%	34	97.1%
Ferry	6	100.0%	3	100.0%	1	100.0%	4	100.0%	0	-	10	100.0%
Franklin	12	83.3%	18	100.0%	5	80.0%	10	100.0%	2	100.0%	37	91.9%
Garfield	1	100.0%	6	100.0%	22	100.0%	1	100.0%	0	-	28	100.0%
Grant	33	36.4%	23	100.0%	49	100.0%	16	100.0%	11	100.0%	104	82.7%
Grays Harbor	9	88.9%	10	100.0%	3	100.0%	19	100.0%	6	100.0%	39	100.0%
Island	36	97.2%	30	96.7%	47	97.9%	26	100.0%	10	100.0%	118	97.5%
Jefferson	44	84.1%	18	88.9%	36	91.7%	17	100.0%	6	100.0%	72	97.2%
King	894	91.3%	804	96.0%	667	95.4%	1,128	100.0%	601	100.0%	2,845	98.2%
Kitsap	59	88.1%	77	90.9%	47	95.7%	76	100.0%	52	100.0%	204	98.0%
Kittitas	12	91.7%	5	100.0%	2	100.0%	18	100.0%	5	100.0%	35	100.0%
Klickitat	6	100.0%	4	100.0%	0	-	13	100.0%	1	100.0%	20	100.0%
Lewis	24	100.0%	26	96.2%	9	88.9%	27	100.0%	29	100.0%	88	98.9%
Lincoln	9	100.0%	1	100.0%	1	100.0%	3	100.0%	2	100.0%	11	100.0%
Mason	10	80.0%	11	72.7%	13	84.6%	10	100.0%	5	100.0%	38	84.2%
Okanogan	12	100.0%	15	100.0%	8	100.0%	26	100.0%	17	100.0%	60	100.0%
Pacific	2	100.0%	2	100.0%	1	100.0%	5	100.0%	8	100.0%	17	100.0%
Pend Oreille	4	100.0%	1	100.0%	2	100.0%	4	100.0%	3	100.0%	9	100.0%
Pierce	319	98.4%	256	97.3%	245	95.9%	352	100.0%	285	100.0%	948	99.2%
San Juan	3	100.0%	6	100.0%	1	-	9	100.0%	3	100.0%	18	100.0%
Skagit	34	97.1%	31	100.0%	23	91.3%	53	98.1%	17	100.0%	123	97.6%
Skamania	1	100.0%	6	100.0%	9	88.9%	7	100.0%	7	100.0%	19	100.0%
Snohomish	133	96.2%	148	94.6%	167	86.8%	235	98.7%	181	100.0%	654	96.8%
Spokane	227	98.2%	243	95.5%	208	94.7%	462	99.8%	273	100.0%	975	98.9%

2017-Q4	MCO PLAN											
	Amerigroup		CHPW		CCW		Molina		United		All Plans	
COUNTY	#	%	#	%	#	%	#	%	#	%	#	%
Stevens	19	100.0%	9	100.0%	2	100.0%	14	100.0%	6	100.0%	36	100.0%
Thurston	69	95.7%	141	95.0%	81	96.3%	128	100.0%	120	100.0%	388	99.0%
Walla Walla	12	100.0%	19	94.7%	15	100.0%	48	100.0%	30	100.0%	98	99.0%
Wahkiakum	0	-	95	-	0	-	0	-	0	-	0	-
Whatcom	47	100.0%	14	657.1%	39	97.4%	155	100.0%	37	100.0%	325	98.8%
Whitman	34	94.1%	80	17.5%	31	100.0%	29	100.0%	22	100.0%	83	98.8%
Yakima	65	98.5%	0	-	86	95.3%	89	100.0%	41	100.0%	264	97.7%

SOURCE: HCA Network Adequacy Reporting by Medicaid MCOs.

Appendix F: Language Access Through Interpreter Services for Medicaid Clients

Medicaid clients, whose primary language is not English, may receive Medicaid interpreter services. Washington was the first state in the nation to establish a healthcare interpreter certification program,[29] which has standards that apply to interpreter services that include Medicaid interpreter services as well. The certification program provides assurance that providers are sufficiently skilled at conveying the necessary medical terminology appropriately in a language other than English.[30]

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

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 help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services."[31]

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

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

Appendix G: Children and Youth Enrolled in Medicaid or CHIP With Eating Disorder Diagnoses, Calendar Year (CY) 2017

Table G.1. Number and Percent of Children and Youth (age 0–20) Enrolled in Medicaid or CHIP With Eating Disorder Diagnoses by Demographic Category, CY 2017

Demographic Breakdown	Medicaid/CHIP Eligible Youth[1] with Eating Disorder[2]	Medicaid/CHIP Eligible Youth[1]	Rate
TOTAL	**4,179**	**975,058**	**0.43%**
AGE CATEGORY			
0–5	1,480	308,615	0.48%
6–11	765	305,006	0.25%
12–17	1,361	275,768	0.53%
17–20	573	103,669	0.55%
GENDER			
Female	2,598	481,154	0.54%
Male	1,580	481,154	0.54%
RACE/ETHNICITY			
White Alone, Non-Hispanic	1,824	393,962	0.46%
Any Minority	2,140	502,770	0.43%
American Indian / Alaska Native	269	59,103	0.46%
Asian / Native Hawaiian or Pacific Islander	319	96,412	0.33%
Black	429	104,080	0.41%
Hispanic	1,337	293,032	0.46%
Unknown	215	78,596	0.27%

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

NOTES:

2. All children and youth (age 0–20) as of June 2017 who had at least one month of full-benefit Medicaid (Title 19 medical coverage) or enrolled in CHIP during CY 2017.

3. The cases of eating disorder include clients with one of the following diagnoses in CY2016-2017: Anorexia nervosa, unspecified; Anorexia nervosa, restricting type; Anorexia nervosa, binge eating/purging type; Bulimia nervosa; Other eating disorders; Binge eating disorder; Avoidant/restrictive food intake disorder; Other specified eating disorder; Eating disorder, unspecified; Rumination disorder of infancy; Other feeding disorders of infancy and early childhood; and Pica of infancy and childhood.

Table G.2. Number and Percent of Children and Youth (age 0–20) Enrolled in Medicaid or CHIP With Eating Disorder Diagnoses by County, CY 2017

County	Medicaid/CHIP Eligible Youth[1] with Eating Disorder[2]	Medicaid/CHIP Eligible Youth[1]	Rate
All Counties	4,179	975,058	0.43%
Adams	22	6,301	0.35%
Asotin	12	3,462	0.35%
Benton	127	34,584	0.37%
Chelan	89	14,369	0.62%
Clallam	29	9,780	0.30%
Clark	240	69,762	0.34%
Columbia	(Suppressed)	(Suppressed)	0.18%
Cowlitz	78	18,463	0.42%
Douglas	49	8,376	0.59%
Ferry	(Suppressed)	(Suppressed)	0.17%
Franklin	100	24,491	0.41%
Garfield	(Suppressed)	(Suppressed)	0.90%
Grant	104	24,069	0.43%
Grays Harbor	41	12,333	0.33%
Island	33	7,434	0.44%
Jefferson	12	2,979	0.40%
King	933	200,913	0.46%
Kitsap	141	25,732	0.55%
Kittitas	35	4,822	0.73%
Klickitat	10	3,320	0.30%
Lewis	46	13,771	0.33%
Lincoln	(Suppressed)	(Suppressed)	0.18%
Mason	44	9,573	0.46%
Okanogan	26	8,710	0.30%
Pacific	14	3,121	0.45%
Pend Oreille	(Suppressed)	(Suppressed)	0.28%

County	Medicaid/CHIP Eligible Youth[1] with Eating Disorder[2]	Medicaid/CHIP Eligible Youth[1]	Rate
Pierce	457	121,253	0.38%
San Juan	(Suppressed)	(Suppressed)	0.44%
Skagit	75	19,949	0.38%
Skamania	(Suppressed)	(Suppressed)	0.35%
Snohomish	382	88,993	0.43%
Spokane	409	79,466	0.51%
Stevens	28	7,765	0.36%
Thurston	160	32,195	0.50%
Walla Walla	(Suppressed)	(Suppressed)	0.36%
Wahkiakum	25	9,426	0.27%
Whatcom	152	27,366	0.56%
Whitman	13	3,908	0.33%
Yakima	264	68,820	0.38%
(Unknown)	0	142	0.00%

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

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

1. All children and youth (age 0–20) as of June 2017 who had at least one month of full-benefit Medicaid (Title 19 medical coverage) or enrolled in CHIP during CY 2017.

2. The cases of eating disorder include clients with one of the following diagnoses in CY2016-2017: Anorexia nervosa, unspecified; Anorexia nervosa, restricting type; Anorexia nervosa, binge eating/purging type; Bulimia nervosa; Other eating disorders; Binge eating disorder; Avoidant/restrictive food intake disorder; Other specified eating disorder; Eating disorder, unspecified; Rumination disorder of infancy; Other feeding disorders of infancy and early childhood; and Pica of infancy and childhood.

Appendix H: MCO-Contracted Providers Serving Children and Youth With Eating Disorder Diagnoses by County, Calendar Year (CY) 2017

Table H.1. MCO-Contracted Providers Serving Children and Youth With Eating Disorder Diagnoses by County During CY 2017, by Quarter

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. Table values — both the total number of MCO-contracted providers who submitted claims for children and youth younger than 19 years of age during CY 2017 that included eating disorder diagnoses (Serv.) and the percent of those providers accepting new patients (% Accepting) — exclude provider locations outside of Washington State and provider locations where the record indicates that the provider does not serve clients younger than 19 years of age. The eating disorders on the claims include: Anorexia nervosa, unspecified; Anorexia nervosa, restricting type; Anorexia nervosa, binge eating/purging type; Bulimia nervosa; Other eating disorders; Binge eating disorder; Avoidant/restrictive food intake disorder; Other specified eating disorder; Eating disorder, unspecified; Rumination disorder of infancy; Other feeding disorders of infancy and early childhood; and Pica of infancy and childhood.

County	2017-Q1			2017-Q2			2017-Q3			2017-Q4		
	Serv.	Acpt.	Pct.	Serv.	Acpt.	Pct.	Serv.	Acpt.	Pct.	Serv.	Acpt.	Pct.
All Counties	1,045	1,037	99.2%	1,127	1,099	97.5%	1,174	1,173	99.9%	1,185	1,154	97.4%
Adams	16	16	100.0%	18	18	100.0%	18	18	100.0%	15	15	100.0%
Asotin	2	2	100.0%	2	2	100.0%	2	2	100.0%	2	2	100.0%
Benton	37	37	100.0%	38	37	97.4%	40	40	100.0%	42	42	100.0%
Chelan	43	42	97.7%	49	47	95.9%	48	48	100.0%	48	48	100.0%
Clallam	6	6	100.0%	7	7	100.0%	8	8	100.0%	8	8	100.0%
Clark	60	60	100.0%	80	77	96.3%	92	92	100.0%	98	93	94.9%
Columbia	1	1	100.0%	1	1	100.0%	1	1	100.0%	1	1	100.0%
Cowlitz	17	17	100.0%	22	20	90.9%	22	22	100.0%	25	23	92.0%
Douglas	9	9	100.0%	16	15	93.8%	17	17	100.0%	16	15	93.8%
Ferry	0	0	-	0	0	-	0	0	-	0	0	-
Franklin	18	18	100.0%	20	19	95.0%	20	20	100.0%	22	21	95.5%
Garfield	1	1	100.0%	1	1	100.0%	1	1	100.0%	1	1	100.0%
Grant	29	28	96.6%	33	32	97.0%	33	33	100.0%	33	32	97.0%
Grays Harbor	12	12	100.0%	13	10	76.9%	13	13	100.0%	14	13	92.9%
Island	11	11	100.0%	9	9	100.0%	11	11	100.0%	11	11	100.0%
Jefferson	3	3	100.0%	3	3	100.0%	4	4	100.0%	4	4	100.0%
King	376	371	98.7%	403	395	98.0%	421	421	100.0%	427	412	96.5%
Kitsap	35	35	100.0%	37	37	100.0%	41	41	100.0%	39	37	94.9%
Kittitas	7	7	100.0%	7	7	100.0%	8	8	100.0%	8	8	100.0%
Klickitat	2	2	100.0%	0	0	-	2	2	100.0%	2	0	0.0%
Lewis	13	12	92.3%	12	12	100.0%	15	15	100.0%	14	14	100.0%
Lincoln	1	1	100.0%	2	2	100.0%	4	4	100.0%	4	4	100.0%

County	2017-Q1			2017-Q2			2017-Q3			2017-Q4		
	Serv.	Acpt.	Pct.	Serv.	Acpt.	Pct.	Serv.	Acpt.	Pct.	Serv.	Acpt.	Pct.
Mason	6	6	100.0%	7	7	100.0%	7	7	100.0%	8	7	87.5%
Okanogan	20	20	100.0%	19	19	100.0%	19	19	100.0%	18	18	100.0%
Pacific	2	2	100.0%	1	1	100.0%	3	3	100.0%	3	3	100.0%
Pend Oreille	2	2	100.0%	2	2	100.0%	2	2	100.0%	2	2	100.0%
Pierce	122	122	100.0%	128	126	98.4%	134	134	100.0%	137	133	97.1%
San Juan	2	2	100.0%	2	2	100.0%	2	2	100.0%	2	2	100.0%
Skagit	22	21	95.5%	24	23	95.8%	26	26	100.0%	25	24	96.0%
Skamania	0	0	-	0	0	-	0	0	-	0	0	-
Snohomish	64	64	100.0%	69	66	95.7%	87	87	100.0%	87	82	94.3%
Spokane	121	121	100.0%	127	125	98.4%	132	132	100.0%	131	129	98.5%
Stevens	5	5	100.0%	4	4	100.0%	4	4	100.0%	4	4	100.0%
Thurston	49	48	98.0%	53	50	94.3%	54	54	100.0%	53	49	92.5%
Walla Walla	15	15	100.0%	19	19	100.0%	12	12	100.0%	14	14	100.0%
Wahkiakum	0	0	-	0	0	-	0	0	-	0	0	-
Whatcom	27	27	100.0%	34	32	94.1%	35	34	97.1%	37	35	94.6%
Whitman	5	5	100.0%	4	4	100.0%	5	5	100.0%	5	5	100.0%
Yakima	67	67	100.0%	74	73	98.6%	78	78	100.0%	75	75	100.0%

SOURCE: ProviderOne Operational Data Store, August 2018, and HCA Network Adequacy Reporting by Medicaid MCOs.