

Behavioral health access and network adequacy for Apple Health children and youth (prenatal – age 25)

Previously referred to as the “Children and Youth Behavioral Health Access Report” and the “Access to Behavioral Services for Children” report

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

December 1, 2024

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Table of contents

Executive summary.....	4
Navigating this report.....	6
Introduction.....	7
Section 1: Behavioral health need and unmet need for children, youth, and young adults.....	12
Section 2: Network adequacy for youth-serving behavioral health providers.....	26
Section 3: Emergency department visits follow-up for behavioral health crises.....	35
Section 4: Eating disorder diagnoses, treatment, and providers.....	39
Section 5: Perinatal behavioral health need and unmet need.....	46
Conclusion.....	55
Appendix A: Data definitions.....	57
Appendix B: Additional data tables.....	66

Executive summary

In accordance with [RCW 74.09.495](#), the Health Care Authority (HCA) is reporting on several metrics regarding access to behavioral health services for children, youth, young adults, and pregnant people (prenatal–age 25) enrolled in Apple Health (Medicaid) in 2023. This executive summary provides a high-level overview of the key findings for the report. Additional details about how various metrics (such as need, unmet need, and network adequacy are defined) are included in the main body of the report.

Behavioral health need and unmet need: Using standardized measures based on claims data¹, approximately **29%** of children, youth, and young adults (0–25 years) enrolled in Apple Health had an identified need for mental health treatment, and about **6%** of youth and young adults (13–25 years) had an identified need for substance-use treatment. **One in three** of the children, youth, and young adults with identified mental health treatment needs had unmet needs, and **three in four** of youth and young adults with identified substance-use needs had unmet needs.

Behavioral health network adequacy: Data structure and quality challenges make it hard to report on the number of behavioral health providers serving Apple Health youth, as well as the percentage of those who were accepting new clients in 2023. Limited data from a survey of some behavioral health agencies serving youth suggest that about **10%** of staff speak a language other than English. Ongoing efforts may result in improved data quality in future years.

Emergency department visits and follow-up for behavioral health crises: Using national measures based on claims data,² about **one third** of all children, youth, and young adults (6–25 years) who visited the emergency department for mental health concerns did not receive follow-up care within seven days, and **the majority** of youth and young adults (13–25 years) who visited the emergency department for substance use concerns did not receive follow-up care.

Eating disorder diagnosis, treatment, and providers: Analysis of claims data suggested that fewer than **1%** of Apple Health children, youth, and young adults (0–25 years) had an identified eating disorder. **One in five** of these individuals did not receive any mental health treatment. Information from existing data sources about eating disorder providers was limited, but ongoing efforts may result in improved data quality in future years.

Perinatal behavioral health need and services: For the first time, this report also includes data about behavioral health need and access to care for pregnant individuals, **of all ages**. This update reflects an increasing acknowledgement of the bidirectional relationship between caregiver and child emotional wellbeing, especially in the early years of life ([HHS, 2024](#)). Using standardized measures based on claims data,³ **56%** of all pregnant individuals (10–64 years) enrolled in Apple Health had an identified mental health treatment need, and **17%** had an identified substance-use treatment need. About **half** of pregnant people with mental health treatment needs had unmet needs, and **two thirds** of pregnant people with substance-use treatment needs had unmet needs.

¹ [Mental health treatment rate; substance use disorder treatment rate](#)

² [Healthcare Effectiveness Data and Information Set \(HEDIS\) follow-up after emergency department visit for mental illness \(FUM\); HEDIS Follow-up after emergency department visit for substance use \(FUA\)](#)

³ [Mental health treatment rate; substance use disorder treatment rate](#)

Disparities in identification and treatment of behavioral health needs: age and racial-ethnic disparities varied across the different metrics included in this report. However, a few general trends emerged.

- Young children (0–5) had lower rates of identification and higher rates of unmet need, while young adults (18–25) had both higher rates of identification and higher rates of unmet need.
- Non-Hispanic white youth and American Indian/Alaska Native (AI/AN) had the highest rates of identification and the lowest rates of unmet need.
- Asian and Native Hawaiian/Pacific Islander (NH/PI) youth had the lowest rates of identification and the highest rates of unmet need.

Looking forward: Many of the metrics in this report point to important areas of need for the behavioral health ecosystem. Ongoing efforts will need to be sustained, and new, innovative, and cross-sector efforts will need to emerge in order to create transformative change. [Washington Thriving](#), the statewide strategic plan initiative of the Children & Youth Behavioral Health Work Group (CYBHWG), will be a key nexus point for this work.

Navigating this report

This legislative report includes multiple complex metrics about the complicated and pressing issue of behavioral health care for children, youth, and families enrolled in Apple Health. Careful and close reading, particularly of call-out boxes for understanding data, is recommended.

Introduction

The report begins with the Introduction section. The Introduction section lays out the **legislative background** for this report, including the specific requirements for this report as cited in [RCW 74.09.495](#). The introduction also provides key terms used in this report, as well as a section on understanding this data, which outlines various metrics presented in the report.

Sections 1–5

Sections 1-5 provide the results of the required metrics. Each section begins with a **Background** to provide context for the concept being measured. Each section also includes blue call-out boxes for **Understanding this data**. These call-out boxes highlight crucial considerations for interpreting the metrics used in this report, helping the reader to understand what the data does, or does not, tell us. The full **Results** are then presented in both narrative and figure form. Each section ends with a **Discussion** that reviews the key results, as well as what these findings mean in the broader context of national data, efforts to build a stronger system, and considerations for data-informed strategic action.

- **Section 1:** Behavioral health need and unmet need for children, youth, and young adults
- **Section 2:** Network adequacy for youth-serving behavioral health providers
- **Section 3:** Emergency department visits follow-up for behavioral health crises
- **Section 4:** Eating disorder diagnosis, treatment, and providers
- **Section 5:** Perinatal behavioral health need and unmet need

Conclusion

Finally, the conclusion summarizes overall themes revealed within the report and maps a potential path forward for action.

Appendix A: Data definitions

Appendix A provides detailed technical specifications for the various metrics used in the report.

Appendix B: Additional data tables

Appendix B provides additional detailed tables for metrics included in the body of the report.

Introduction

Legislative background

This section provides background information regarding the legislative requirement behind this report.

In 2016, the legislature passed [ESHB 2439](#) “Children And Youth--Mental Health Services,” beginning with the following intent:

“The legislature finds that nearly half of Washington's children are enrolled in Medicaid and have a higher incidence of serious health problems compared to children who have commercial insurance. The legislature recognizes that disparities also exist in the diagnosis and initiation of treatment services for children of color, with studies demonstrating that children of color are diagnosed and begin receiving early interventions at a later age. The legislature finds that within the current system of care, families face barriers to receiving a full range of services for children experiencing behavioral health problems. The legislature intends to identify what network adequacy requirements, if strengthened, would increase access, continuity, and coordination of behavioral health services for children and families.”

This legislation went on to establish the initial [Children and Youth Behavioral Health Work Group](#), and it also established the **requirement for this report** to be completed on an annual basis. Additional legislation passed over the years⁴ has resulted in a requirement ([RCW 74.09.495](#)) to report on several metrics, which must also be broken down by age, gender, and race/ethnicity, including:

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

⁴ [E2SSB 5432 \(2019\), Chapter 325, Section 4002](#); [E2SHB 2779 \(2018\), Chapter 175, Section 3](#); [SSB 5779 \(2017\), Chapter 226, Section 6](#); [E2SHB 1713 \(2017\), Chapter 202, Section 3](#)

Key terms used in this report

This report aims to provide information about various complicated topics, which often have varying, confusing, and overlapping names and definitions. To provide clarity, some of the key terms used in this report are outlined in this section.

Importantly, the use of these key terms are not meant to suggest that these are best practice terms, definitions, or concepts for understanding the behavioral health system. HCA recognizes that some terms used in this report may be associated with stigma (Fox et al., 2021; Haslam & Baes, 2024), and some of the referenced concepts may be intrinsically rooted in oppressive systems, such as colonialism, racism, classism, sexism, and ableism (Choudhury, 2022; Faissner et al., 2024; Green, 2019; Hirschbein, 2010; Montcrieff, 2022).

The terms, definitions, and concepts in this report were selected as the best fit for meeting the legislative requirements of this report, aligning with the most common current terminology, and ensuring clarity for the reader. Work through [Washington Thriving](#) (an initiative within the [Children and Youth Behavioral Health Work Group](#) to develop a collaborative statewide strategic plan for behavioral health system serving children, youth, young adults and their families and caregivers) may result in improved terminology for future reports.

Key terms

Behavioral health: In this report, the term “behavioral health” is used as an umbrella term to describe both mental health and substance use disorders, concerns, and treatment.

- Mental health would include conditions like depression, anxiety, PTSD, and adjustment disorders, ADHD, schizophrenia, and others.⁵
- Substance use would include conditions like opioid use disorder (OUD), alcohol use disorder, stimulant use disorders, and others.⁶

Individuals can have both mental health disorders and substance use disorders. This is referred to as **co-occurring** mental health and substance use disorders.

Development disorders, like autism spectrum disorders, are **not** included in the definition of behavioral health for this report.

Behavioral health disorder: A behavioral health disorder is commonly defined as a “clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (APA, 2013).

The term “disorder” can be stigmatizing, and various other terms may be used for this concept, such as illness, condition, or problem (Fox et al., 2021; Haslam and Baes, 2024). However, because the term “disorder” is the most consistently used (Tse and Haslam, 2023), it is used here to ensure clarity.

Behavioral health concern: The term “concern” is used in this report to refer to symptoms or experiences that may indicate the need for behavioral health services, but that do not necessarily meet the criteria for

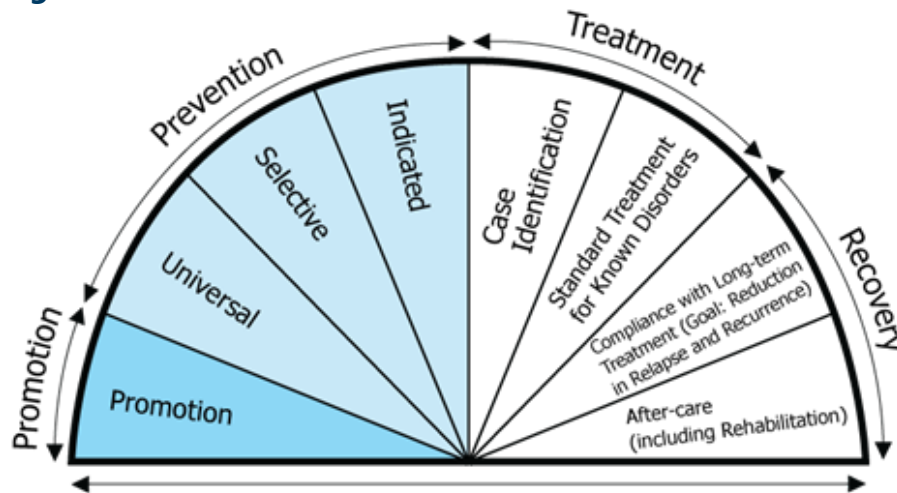
⁵ See [Appendix A: Data definitions](#) for more information.

⁶ See [Appendix A: Data definitions](#) for more information.

a behavioral health disorder. Examples of this may include individual reports of feeling sad or hopeless, visits to the emergency room for behavioral health-related concerns, or parent reports of challenging behaviors. Individuals with behavioral health concerns may have behavioral health disorders, but a concern in itself does not necessarily constitute a disorder.

Behavioral health treatment: There are many ways to conceptualize the types of behavioral health services that individuals may need and receive. One framework for this concept is the [Institute of Medicine’s model for the continuum of care](#). In this framework, behavioral health services exist on a continuum of care including promotion, prevention, treatment, and recovery (see Figure 1).

Figure 1. Institute of Medicine model for the continuum of care



In this framework, treatment begins with case identification, a process whereby a person is assessed for the presence of a mental health or substance use disorder by a provider, who then determines whether pursuing treatment services would be beneficial. There are many different treatment avenues and modalities, depending on the specific needs of a person (SAMHSA, 2024). While there are still nuances to understanding “treatment” within this framework, in general, this framework guides the understanding of treatment as described in this report.

Understanding this data

To meet the legislative requirements, this report includes multiple different metrics on complex topics. This section provides some key information that is helpful for understanding all metrics and results included in the report. Additional blue call-out boxes throughout the report will provide more detail about specific metrics.

What time period does this report cover?

This report focuses on calendar year 2023, though some data may be from previous years. When data is not from 2023, it will be noted in the report. Due to the differences in data analysis over time, data in this report is not comparable to previous years.

Who is included in this report?

This report only includes data about individuals enrolled in **Apple Health**, Washington’s

Medicaid program.⁷ There are many different eligibility groups within the broad umbrella of Apple Health coverage. For more information about which eligibility groups are included in this report, please refer to [Appendix A: Data Definitions](#).

In addition to eligibility groups, individuals enrolled in Apple Health may be enrolled in either managed care or fee-for-service. All data presented in this report is inclusive of individuals enrolled in managed care **and** fee-for-service.

What ages are included in this report?

While this report is required to include data on children and youth from birth to age 18, most metrics in this report now include children, youth, and young adults from birth through age 25. This update reflects a growing recognition of young adulthood as a unique developmental phase ([Silverstein et al., 2021](#)). For children, youth, and young adults, the following age categories were used, including:

- **0-5 years:** young children
- **6-12 years:** older children
- **13-17 years:** youth⁸
- **18-25 years:** young adults.

For the first time, this report also includes data in [Section 5](#) about behavioral health need and access to care for pregnant individuals, of all ages. This update reflects an increasing acknowledgement of the bidirectional relationship between caregiver and child emotional wellbeing, especially in the early years of life ([HHS, 2024](#)). Standard age categories for age during pregnancy were used for this report, including:

- **10-17 years:** adolescent
- **18-25 years:** young adult
- **26-39 years:** middle adult
- **40-64 years:** older adult.

Additional information about behavioral health access and outcomes for Apple Health enrollees across the lifespan (i.e., inclusive of both children and adults) can be found in HCA's annual legislative [Behavioral Health Outcomes report](#), although this report has historically focused on the managed care population. Please refer to HCA's [Legislative Reports](#) page to find the 2024 report, which covers calendar year 2023.

How is race/ethnicity defined?

This report is legislatively required to break down all metrics by race/ethnicity. For all metrics, race/ethnicity data is reported **inclusively**, which means that children and youth may be

⁷ While Medicaid plays an important role in access to behavioral health care for many children and families, the needs of children, youth, and families who are uninsured or are privately insured are also important to consider, especially since private insurance coverage is sometimes associated with diminished access to care ([Graaf and Snowden, 2019](#)).

⁸ One exception to these categories is within [Section 2](#), which focuses on network adequacy. Because current and some federal definitions refer to all individuals under age 18 or 21 as "youth," the term "youth" is used in this section to refer to all individuals 0-18 or 0-21 years.

identified in multiple racial/ethnic categories. Some individuals may not have any race/ethnicity data available, and they are grouped in a category called “Unknown.”

Where do the results come from?

Measuring important concepts for behavioral health like need for care, treatment received, and the workforce can be extremely complex. This report uses different data sources, standardized metrics, and analytic approaches to best meet the requirements set in legislation. Most of these sources, metrics, and approaches have limitations that must be carefully considered in interpreting the results. Throughout the report, call-out boxes (like this one) will provide information to help readers understand the data source, definitions, and limitations. Additional information about some metrics is also available in [Appendix A: Data definitions](#).

Section 1: Behavioral health need and unmet need for children, youth, and young adults

Background

Behavioral health disorders typically start during childhood, adolescence or young adulthood, with 50% of all lifetime behavioral health disorders beginning by age 14 and 75% beginning by age 24 (Kessler et al., 2005). National parent survey data and administrative healthcare data suggest that between 11–21% of children have a diagnosed behavioral health disorder each year (Bethell et al., 2021; Tkacz & Brady, 2021; Whitney & Peterson, 2019). Various indicators of behavioral health concerns have also increased in recent years, especially following the onset of the COVID pandemic (Dellazoppa, et al., 2024; Bevilacqua et al., 2023; Lebrun-Harris et al., 2022), with a national emergency in child and adolescent mental health declared in 2021. When Governor Jay Inslee issued a Washington State-specific emergency proclamation on the child and youth mental health crisis that same year, the national non-profit Mental Health America ranked Washington as 35th in the nation for Youth Mental Health⁹ (Reinart et al., 2021); three years later, Washington has fallen to 48th (Reinart et al., 2024).

Decades of research point to a variety of treatments approaches that are successful in addressing behavioral health disorders among children, youth, and young adults (Fadus et al., 2019; Reinart et al., 2024; Tanner-Smith et al., 2016). Unfortunately, parent reports from the National Survey of Children's Health suggests that about half of all children with diagnosed mental health disorders do not receive treatment (Whitney & Peterson, 2019). While data on treatment of substance use disorders among youth is more limited, research suggests that most youth do not receive needed treatment (Clemens-Cope et al., 2021), and listening sessions in 2023 found that access to care for youth substance use disorder treatment in Washington State is extremely limited (HCA, 2023).

Disparities in access to care

Children and youth of color may be at increased risk of behavioral health concerns and disorders and are more likely to have unmet behavioral health needs,¹⁰ due to systemic racism and other types of oppression and marginalization (APA, 2023; Casseus, 2023; Chen et al., 2024; Prichett et al., 2024; Rogers et al., 2021; Stone et al., 2023). The COVID-19 pandemic only exacerbated racial disparities in access to and utilization of behavioral health treatment services for many communities (Hawks, 2023; Williams et al., 2023), including the Apple Health population (Patton et al., 2023).

Behavioral health challenges can vary across the developmental spectrum. Attention to the mental health needs of young children has been limited, but the prevalence of mental health disorders in young children is likely comparable to school-age children (Vasileva et al., 2021). Although treatment at this stage may be especially effective for improving outcomes and reducing costs for health care, school readiness, criminal justice, and child welfare systems (Oppenheim & Bartlett, 2022), young children with mental health

⁹ Mental Health America state rankings for Youth Mental Health are based on several different metrics, including the prevalence of various mental health disorders, unmet need for mental health treatment, quality of coverage for mental health services under private insurance, the effectiveness of treatment services, and youth's learning, resilience, and self-regulation skills. Please refer to the [detailed report](#) for more information.

¹⁰ Unmet need is a concept to refer to when someone has a health care problem but doesn't receive formal care, or when the care received is insufficient or inadequate.

disorders are less likely to receive treatment than older children (Ghandour et al., 2020). On the other end of the spectrum, behavioral health disorders often first appear or increase in severity during young adulthood. While providing treatment at this stage can lay a foundation for health and well-being over the life span (Markoulakis et al., 2023; Silvers, 2023), young adults are less likely to receive needed treatment (SAMHSA, 2023).

Barriers to accessing treatment

Unmet need for behavioral health treatment is an important component of understanding access. It is important to remember that many factors may influence whether children, youth, young adults, and their families receive behavioral health treatment (Acevedo et al., 2020; Baker-Ericzén et al., 2014; Fatimah et al., 2015; Grubb, 2019; Reardon et al., 2017).

Research often groups these factors into two categories. Some of these factors may be considered **structural** or logistical, such as:

- Not knowing how or where to get treatment.
- Not being able to find an available provider, especially a provider who provides developmentally, culturally, and linguistically appropriate services.
- Not being able to navigate cumbersome administrative systems.
- Not being able to find a provider close to home or struggling to find transportation.
- Not having enough time to attend treatment, including not being able to take time off work.

But others may be **attitudinal** or personal, such as:

- Not feeling like treatment is needed.
- Thinking you should have been able to handle your behavioral health challenges on your own.
- Feeling dismissed or blamed by providers.
- Being worried about stigma and what others may think.
- Not being ready to start treatment.
- Not believing that mental health treatment will be effective.
- Worrying that information shared during sessions won't be confidential.
- Thinking no one will care if you get better.

Comprehensive data about why younger children and families may not access treatment services is more limited. However, the Substance Abuse and Mental Health Treatment Administrative conducts an annual national survey of youth and adults ages 12 and older, which includes a question about why individuals with a need for treatment did not get treatment. This survey found that, among adolescents aged 12 to 17 with an unmet treatment need for depression, the most common reason for not receiving treatment, shared by 85% of the group, was that they thought **they should have been able to handle their mental health, emotions, or behavior on their own** (SAMHSA, 2023).

Efforts to address unmet needs and improve access will need to take into account strategies for resolving structural and system barriers, while also meeting individuals and communities where they're at.

Measuring need and unmet need

As noted earlier, understanding need and unmet need for behavioral health treatment is crucial to measuring trends over time, addressing health care disparities, and appropriately allocating resources to improve care. However, measuring these concepts is a complicated issue (NASEM, 2024; Satorius, 2015).

There are many ways to measure need and unmet need. In some of these methods, need and unmet need are identified by the individuals or their caregivers, while in other methods, need is identified by health care providers or research scientists. Some methods gather their data from surveys or other standardized questionnaires, while others may use health care data such as clinical documentation or claims data.¹¹

Even when data is collected in a similar way, there are still different ways to **define** need and unmet need. Some definitions may only include diagnosed behavioral health disorders, while others may include broader behavioral health concerns, such as symptoms or experiences. Some definitions of unmet need may see a need as met if at least one behavioral health service is provided, while others may take a more comprehensive approach and require specific type(s), frequency, intensity, or quality of services. Each approach has different pros and cons, and each approach will create slightly different results.

It is important to remember that most current measures of need and unmet need take a population-level approach: a standardized way to measure behavioral health need and unmet need for all individuals within a given population. Because behavioral health needs are complex, multi-faceted, and individualized, any population-level measure of behavioral health need or unmet need will not apply perfectly to each individual. While population-level metrics are extremely helpful in understanding broad trends, they are not intended to represent the appropriate course of treatment for each individual.

Summary

Early diagnosis and appropriate treatment services for children and their families can make a difference, especially when those services are family- and youth-driven, community-based, and culturally and linguistically appropriate (Stroul et al., 2021). Despite challenges to measuring these concepts, understanding behavioral health needs and unmet needs for children, youth, and young adults across age, gender, and race/ethnicity is crucial to working towards a comprehensive system of care. Because understanding need and unmet need for behavioral health treatment is a complicated task, we recommend a close reading of the “Understanding this data” data call-out box.

Understanding this data

The data in Section 1 primarily comes from two metrics: the **mental health treatment rate** and the **substance use disorder treatment rate**. These metrics were **originally developed** by the Department of Social and Health Services Research and Data Analysis division (DSHS-RDA), in collaboration with Medicaid delivery system stakeholders. While they are not nationally standardized metrics, they are part of the **Washington State Common Measure**

¹¹ Claims data is a type of health care data that is created when providers and/or insurance companies submit information about services they have provided, in order to receive or substantiate payment. Claims data usually includes information about the service provided and health issue(s) being addressed, as well as other demographic data about the client and provider.

Set, a set of standard statewide measures of health performance to inform health care purchasers and set benchmarks, including for Apple Health.¹²

Both metrics consist of two components: 1) the number of individuals who have a **need** for mental health or substance use treatment, and 2) the number of individuals with need, who received mental health or substance use **treatment**. Conversely, by looking at the number of individuals with need who did not receive treatment services, these metrics also measure the number of individuals with **unmet need**. In order to understand both need and unmet need, these components are reported separately. More information about how each component is defined (as well as limitations to their definitions) is provided in the respective sections.

These metrics primarily use claims data to identify mental health or substance-use need and treatment services. **Claims data** is a type of health care data that is created when providers and/or insurance companies submit information about services they have provided, in order to receive payment. Claims data includes information about the service provided and health issue(s) being addressed, as well as other demographic data about the client and provider.

Limitations to this data

As noted prior, these metrics use claims data as a primary source of information. Because claims data is generated by health care providers, it may be more standardized than data sources that rely on individuals' reports of their own need and unmet need. However, health care providers' perceptions, especially of need for treatment, may not align with individuals' perception of their own needs (**NASEM, 2024**). In addition, many individuals may have needs that are not identified by health care providers. Systemic factors such as social determinants of health, access to developmentally and culturally appropriate health care, discrimination, stigma, and historical trauma likely contribute to the under-identification of need by health care providers (**APA, 2023; Prichett et al., 2024**).

These metrics also rely on the assumption that health care claims data is both accurate and comprehensive. It is possible, however, that some health care claims data may be erroneously reported or miscoded; it is also possible that not all disorders, concerns, services, or medications are reported in claims data (**Ferver et al., 2009**). A recent study measured the validity of diagnosis codes in claims data, by directly comparing them to information included in clinical documentation (i.e., chart abstraction), and it found that diagnostic codes were quite reliable for identifying selected childhood mental, behavioral, and emotional disorders (**Shi et al., 2024**). While this study provides a positive indication for the use of claims data in understanding behavioral health disorders, more research is needed to understand the reliability of claims data for measuring behavioral health concepts broadly.

A final limitation is that while these metrics may share certain aspects in common with other standardized national definitions of need, they were developed specifically for Washington

¹² These metrics are also considered performance metrics for Apple Health managed care organizations. Additional reports on these metrics by managed care plan are available on HCA's [Managed Care Reports webpage](#).

State and the Apple Health population. Any comparison to other metrics of behavioral health need or unmet should be interpreted with an abundance of caution.

Need for mental health and substance use treatment

Understanding the need for mental health and substance use treatment is an important step in building a responsive behavioral health system of care. Defining the need for behavioral health treatment is a complicated task, and so we recommend a close reading of the “Understanding this data” call-out box.

Understanding this data

As noted earlier, the data in Section 1 comes from two metrics: the mental health treatment rate and the substance use disorder treatment rate. This subsection looks specifically at the metric component for individuals with a mental health or substance use treatment **need**.

Individuals are classified as having a need for treatment if they have any of the following recorded in their claims data:

- Certain mental health or substance use disorders
- Certain mental health or substance use concerns (e.g., incidents of self-harm or overdose)
- Certain mental health or substance use treatment services
- Certain medications

For more information about the specific disorders, concerns, services, and medications included in this definition, please refer to [Appendix A: Data Definitions](#).

Limitations to this data

As components of the mental health treatment rate and the substance use disorder treatment rate, this definition of need shares similar limitations [outlined in the previous “Understanding this data” call-out box](#). However, there are also limitations specific to the definition of need.

These metrics define need for treatment more broadly than just the presence of a diagnosed behavioral health disorder. Individuals with certain serious behavioral health concerns (such as incidents of self-harm or overdose) are also assumed to need treatment services, even if they have not received an official diagnosis of a behavioral health disorder. While this approach provides a more comprehensive and inclusive estimation of need, it may overestimate (or complicate the meaning of) the number of individuals with a need for treatment.

In addition, individuals who receive certain treatment services or medications are also considered to have a need for treatment, even if they do not have a diagnosed behavioral health disorder. This analytic approach may appear circular in nature, but it is actually a commonly used approach, including by Substance Abuse and Mental Health Services Administration, or SAMHSA ([SAMHSA, 2023](#)). This approach is meant to account for the fact that data shows that many individuals receiving behavioral health services lack diagnosable

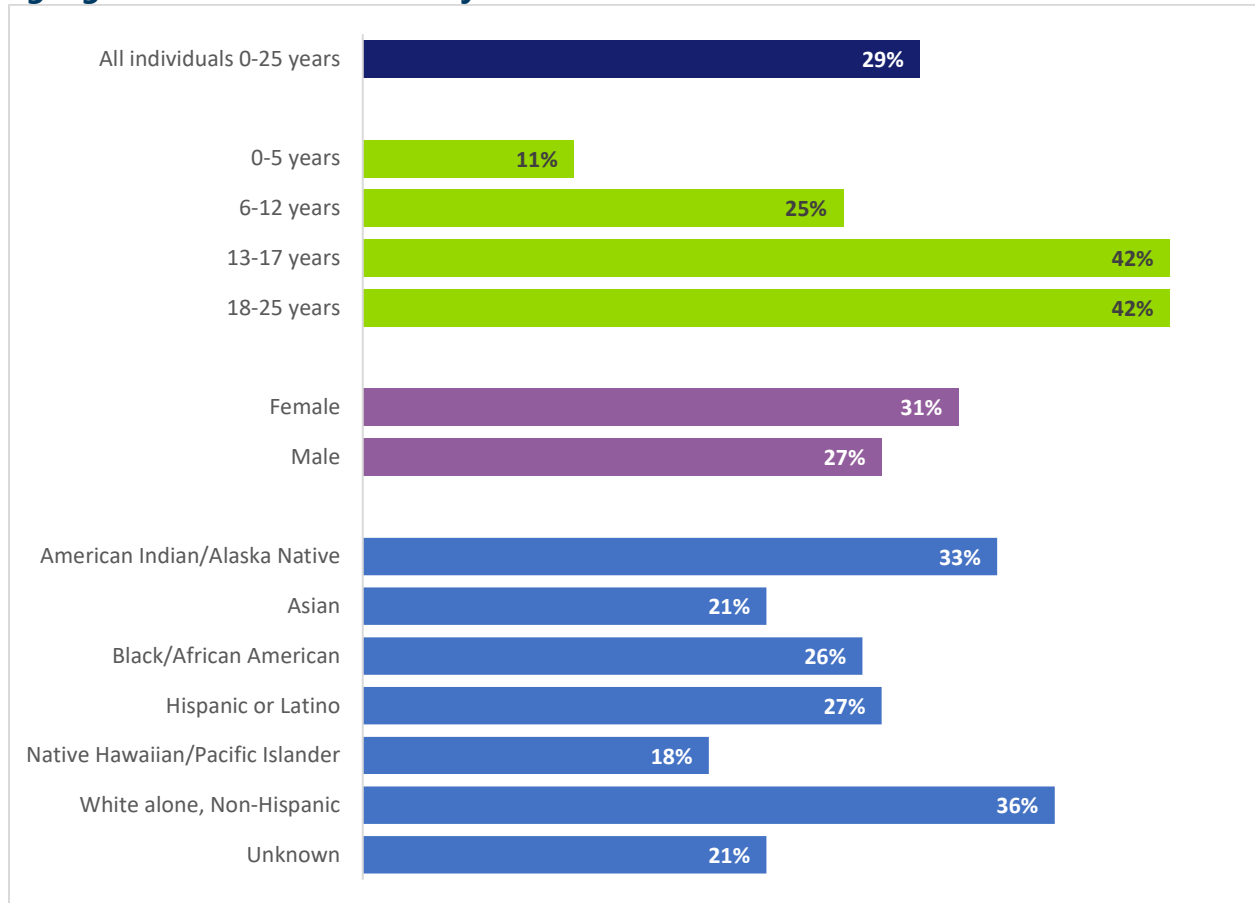
conditions or significant impairments (Germack et al., 2020; NASEM, 2024). While this approach may be considered standard, it can overestimate (or complicate the meaning of) the number of individuals with treatment needs.

Despite these limitations, these metrics are still an important benchmark of care to understand, since they are considered core performance measures for Apple Health.

Mental health

In 2023, about **29%** of all children, youth, and young adults (0–25 years) enrolled in Apple Health had an identified need for mental health treatment. Identified needs varied with age: about **10%** of young children (0–5 years) had identified mental health treatment needs, while almost **half** of youth and young adults had identified mental health treatment needs (13–25 years). There was also some variation across racial/ethnic groups in the percentage of children, youth, and young adults with identified mental health treatment needs: non-Hispanic white and AI/AN individuals had the highest rates of identified mental health treatment needs, while NH/PI and Asian individuals had the lowest rates (see Figure 2).

Figure 2: Percent of all Apple Health-enrolled children, youth, and young adults (0–25 years) who had an identified need for mental health treatment in 2023, by age, gender, and race/ethnicity

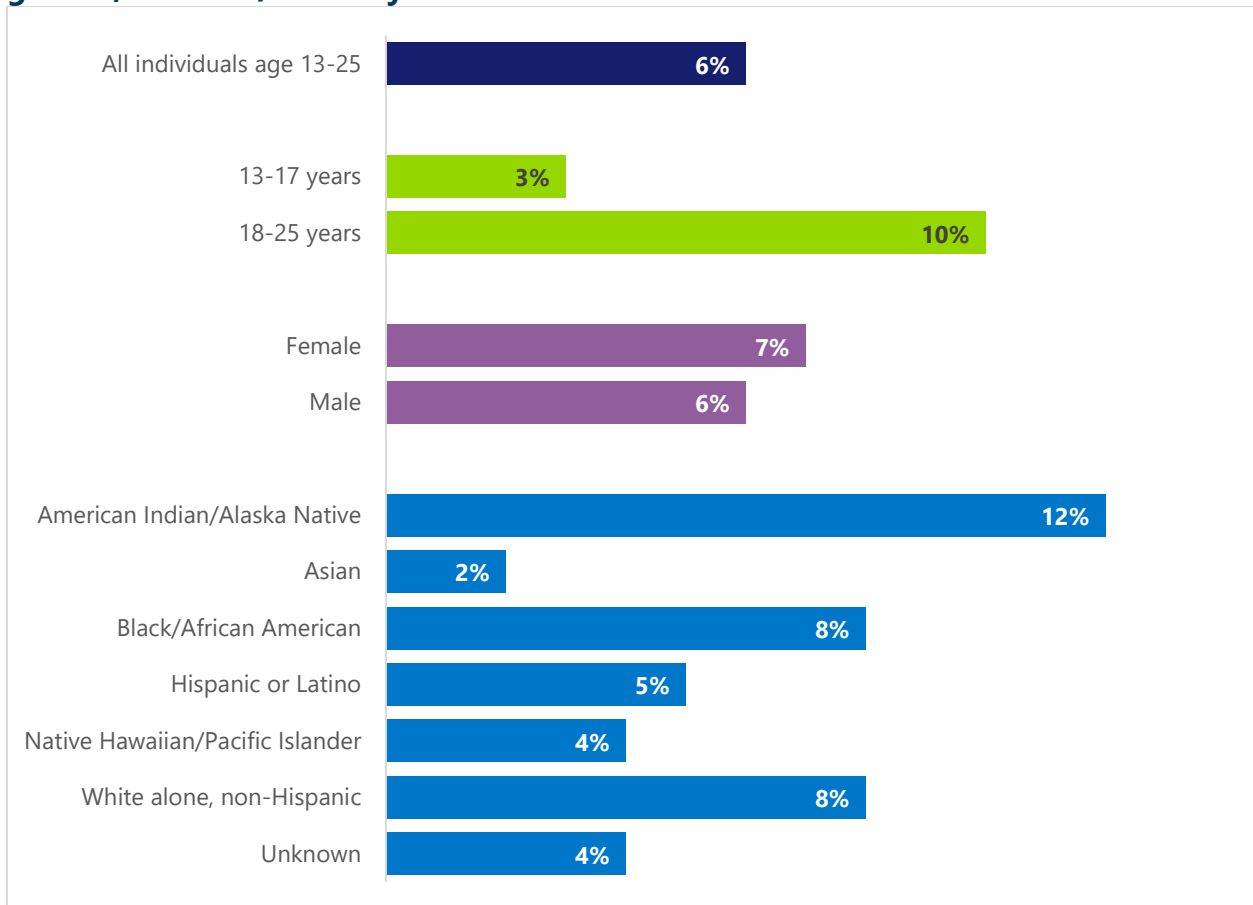


For the number of individuals in each category, refer to [Appendix B: Additional data tables](#).

Substance use

In 2023, **6%** of all youth and young adults (13–25 years) enrolled in Apple Health had an identified need for substance-use treatment. A higher percentage of young adults (18–25 years) needed treatment than youth (13–17 years). There was also variation in need for substance-use treatment across racial-ethnic groups: a higher percentage of AI/AN, Black/African American, and non-Hispanic white individuals had identified needs for substance use treatment (see Figure 3).

Figure 3: Percent of all Apple Health-enrolled youth and young adults (13–25 years) who had an identified need for substance-use treatment in 2023, by age, gender, and race/ethnicity



For the number of individuals in each category, refer to [Appendix B: Additional data tables](#).

Unmet need for mental health and substance use treatment

Unmet need refers to when someone has a health care problem but doesn't receive formal care, or when the care received is insufficient or inadequate. Unmet need is an important measure of access to care. However, like measuring need, measuring unmet is a complicated task, so we recommend a close reading of the "Understanding this data" call-out box .

Understanding this data

As noted earlier, the data in Section 1 comes from two metrics: the mental health treatment rate and the substance use disorder treatment rate. This subsection looks specifically at the metric component that counts the number of individuals with a mental health or substance use treatment need who **received treatment**, and conversely, those with an **unmet need** for treatment.

These metrics define mental health or substance use treatment through claims data. Individuals are classified as having received treatment if they had **certain types of treatment services** recorded in their claims data. For more information about the specific treatment services included in this definition, please refer to [Appendix A: Data definitions](#).

Limitations to this data

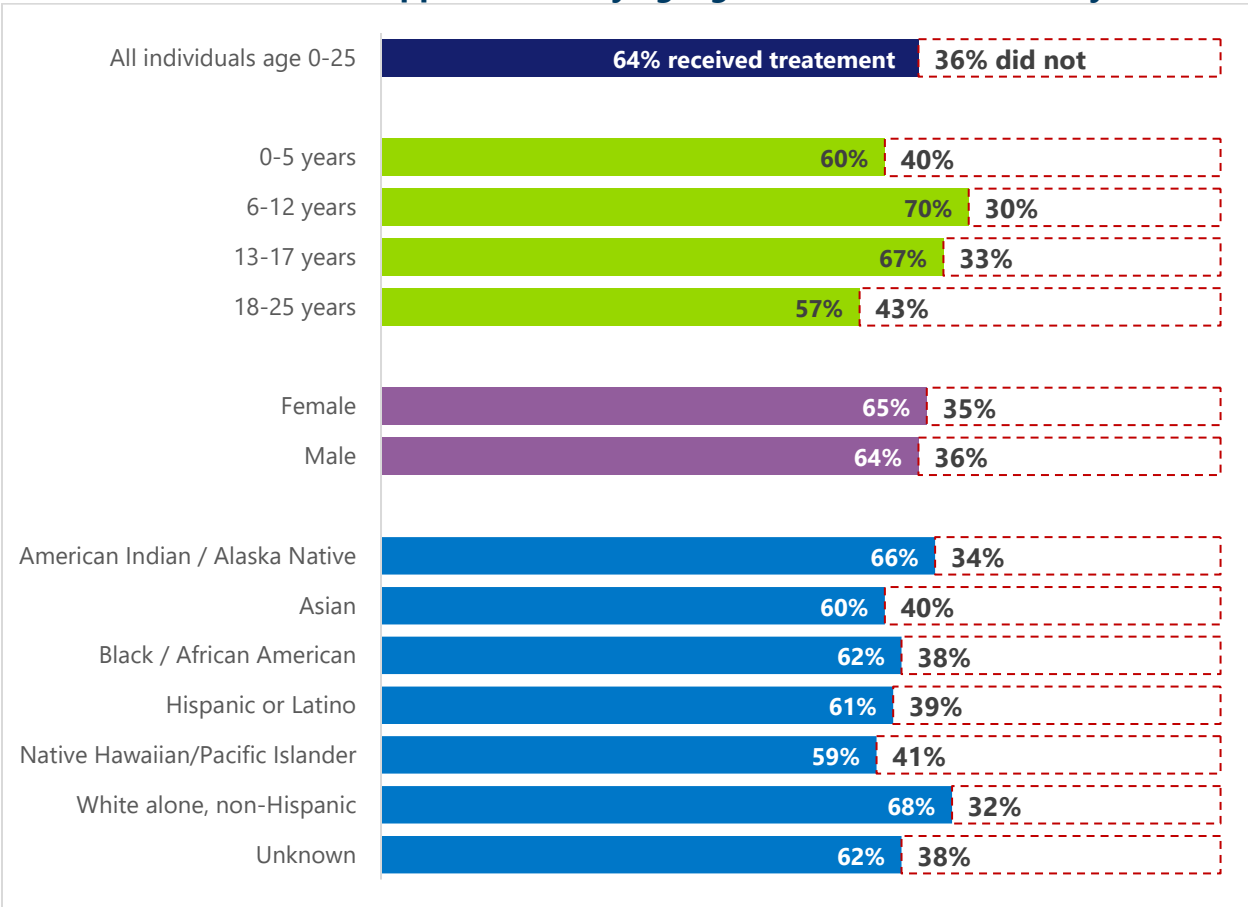
As components of the mental health treatment rate and the substance use disorder treatment rate, this definition of having received treatment/unmet need shares similar limitations [outlined in earlier sections](#), including a reliance on claims data and the inability to be easily compared to other national measures of need. In addition, this data only calculates the percentage of individuals who received **any treatment** service. However, it does **not** help us to understand if individuals received the appropriate type, frequency, intensity, or quality of treatment services.

Mental health

During 2023, **64%** of the children, youth, and young adults enrolled in Apple Health with identified needs received any mental health treatment. In other words, about **one in three** children, youth, and young adults with identified needs had an unmet need for mental health treatment

Young children (0–5 years) and young adults (18–25 years) were more likely to have unmet needs than older children and youth (6–17 years). There was also some variation across racial/ethnic groups: non-Hispanic white and AI/AN individuals had the lowest rates of unmet need, and NH/PI and Asian individuals had the highest rates (see Figure 4).

Figure 4: Mental health treatment rate in 2023 for children, youth, and young adults (0–25) enrolled in Apple Health, by age, gender, and race/ethnicity



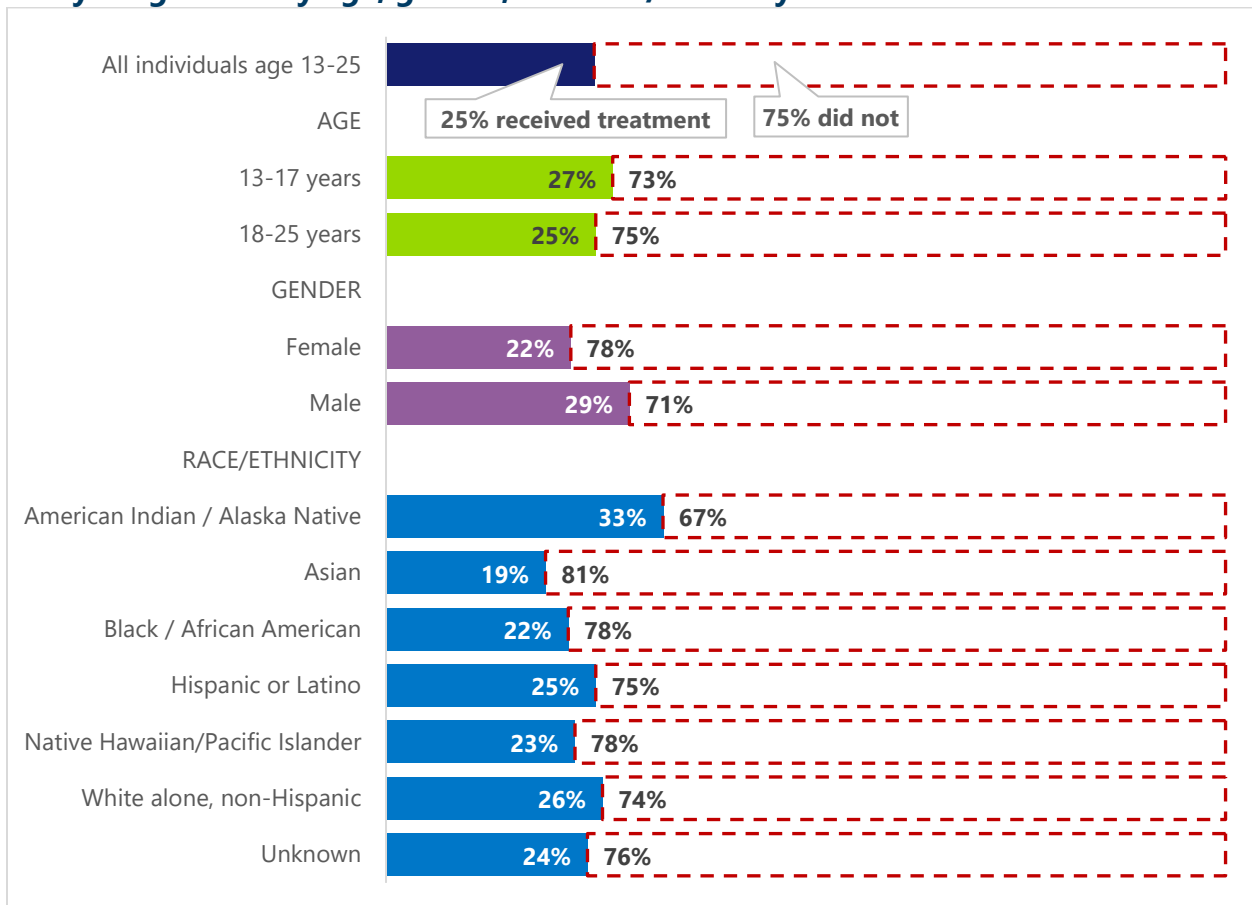
For the number of individuals in each category, refer to [Appendix B: Additional data tables](#).

Substance use

During 2023, only **25%** of the youth and young adults (13-25 years) enrolled in Apple Health (Medicaid) with an identified need received any substance-use treatment. In other words, approximately **three in four** youth and young adults with identified needs had an unmet need for substance-use treatment.

There was some variation across age, gender, and racial/ethnic groups in the percentage of youth and young adults with unmet needs for treatment (see Figure 5), but for all groups, the majority had unmet needs.

Figure 5: Substance-use treatment rates in 2023 for Apple Health-enrolled youth and young adults by age, gender, and race/ethnicity



For the number of individuals in each category, refer to [Appendix B: Additional data tables](#).

Discussion

Understanding behavioral health needs can be the first step in using data to improve access to care. Data in this report about need comes from two metrics: the mental health treatment rate and the substance use disorder treatment rate. According to these metrics, about **30%** of children, youth, and young adults had an identified need for mental health treatment, and **6%** of youth and young adults had an identified need for substance-use treatment services.

Identifying needs is only the first step in a data-informed approach to improving access; once a behavioral health need is identified, it is crucial to ensure care is provided. This report also used the mental health treatment rate and the substance use disorder treatment rate to determine unmet need. According to these metrics, **one in three** children, youth, and young adults with need for mental health treatment had an unmet need, and **three in four** youth and young adults with need for substance-use treatment had an unmet need.

Several key efforts are underway to ensure children and youth are connected to the supports and resources they need to thrive. For example, [Kids Mental Health Washington](#) is standing up community-wide teams in each region of the state to improve collaborative communication and service connection processes to help children and families in accessing what they are seeking and develop plans of stability. Another initiative, [The Center of Parent Excellence](#), or COPE, helps parents to access and navigate behavioral health services on behalf of their child. COPE is staffed by parent support specialists hired for their lived experience, and they provide one-on-one supports, as well as support and affinity groups. As one parent shared,

“Thank you to everyone for being here when my daughter and I needed you! I don’t have words to express how much weight has been lifted from both of us. Having this resource to help point us in the right direction and come up ideas to get my daughter on the right track has been invaluable!!”

Data considerations

While the data in this report does provide important information about the state of behavioral health access for children, youth, and young adults in Apple Health, it has many limitations. Data in this report about behavioral health treatment need and unmet need comes from two metrics: mental health treatment rate and the substance use disorder treatment rate. These metrics were developed in Washington State specifically to evaluate the performance of Apple Health, and they use claims data as a primary source of information.

A key limitation for these metrics is that a reliance on claims data may result in both the overidentification and under-identification of need and unmet need. In addition to concerns about the validity of claims data (Shi et al., 2024), health care providers’ perceptions of need and unmet need may not align with individuals’ perception of their own needs ([NASEM, 2024](#)). In addition, many individuals may have needs that are not identified by health care providers, due to discrimination, stigma, and historical trauma ([APA, 2023](#); [Prichett et al., 2024](#)). These metrics likely underestimate need for individuals who face inequities in access to developmentally and culturally appropriate care, but they may also overestimate need, if individuals are inappropriately diagnosed or do not feel their condition requires treatment, as defined by the traditional behavioral health care system.

In addition, these metrics only calculate the percentage of individuals who received **any** treatment service, which means that they do not provide insight into whether individuals received the appropriate type, frequency, intensity, or quality of treatment services. Because many behavioral health disorders require coordinated and ongoing care from a range of specialty providers, this approach to defining unmet need may underestimate need as experienced by individuals. On the other hand, it is also possible that these metrics overestimate unmet need, especially if individuals receive services outside the bounds of traditional behavioral health care system and what is documented by health care providers.

Shared understanding of the best practices for identifying and treating behavioral health conditions is constantly evolving, as are the various codes meant to capture behavioral health disorders, concerns, services, and medications (Conley, 2024). While numerous stakeholders and subject matter experts inform the decisions about which codes to include within these definitions for mental health treatment rate and the substance use disorder treatment rate, the definitions remain complex and lengthy, and they may not always reflect the most up-to-date conceptions of care.

Using metrics that are developed here in Washington specifically for the Apple Health population may be helpful in providing more targeted data, that takes into the account the nuances of the Washington behavioral health system. However, an unfortunate result is that quick comparisons to other metrics of need or unmet may be challenging, and any comparison to other metrics should be interpreted with an abundance of caution.

Given these considerations, a fuller understanding of whether children, youth, and young adults are truly getting the care they need will likely require resource-intensive, multi-dimensional analytic approaches that go both wider and deeper than our current metrics allow.

Disparities in identification and access to care

Disparities in identification and access to care have long been documented for different age groups of youth, as well for different racial-ethnic groups. Per RCW 74.09.495, this report must break down metrics by age, race, and gender, which helps to illuminate potential disparities. In 2023, three primary disparities emerged: disparities for **young children** (0–5 years), **young adults** (18–25), and **children, youth, and young adults of color**.

Young children

Data in this report found that young children have lower rates of both identification and treatment of mental health conditions. In 2023, only 11% of young children (0–5) had an identified need for mental health treatment, even though national data suggests that 20% of young children have a mental health condition (Vasileva et al., 2021). Even when young children had identified mental health treatment needs, they were less likely to get treatment than older children. Work through the [Mental Health Assessment for Young Children](#) (MHAYC) policy is helping to align reimbursement policies with best practices and to train providers in mental health screening, assessment, and diagnosis for young children, which may result in better and earlier identification of mental health needs for children and their families. Additional training initiatives like the [Child-Parent Psychotherapy \(CPP\) Learning Collaboratives](#) are helping to build provider skills in providing mental health treatment for young children and their families, especially those who have experienced trauma. Lastly, in 2023, Washington became the second state in the nation to [enact continuous eligibility for Apple Health \(Medicaid\) coverage](#) for young children (0–5 years).

Research shows that continuous enrollment has a positive impact on both the identification and treatment of health concerns ([Chen, 2024](#)), and so this change may help to support young children and their families in getting the care they need.

Young adults

Data in this report found that young adults were more likely to have identified mental health and substance use treatment needs, but they were less likely to receive needed treatment. National data often shows similar trends ([SAMHSA, 2023](#)), as young adults are experiencing many different life transitions, and many care systems are often not built with their needs in mind. Initiatives like the [Healthy Transitions Project](#) are helping to create non-stigmatizing, trauma-informed opportunities to connect youth and young adults who might otherwise not have accessed mental health services. Recently, the Healthy Transitions Project supported [the opening of Evergreen Bright Start](#) in Bremerton, a brand new 30-unit apartment complex for young adults transitioning from foster care or facing homelessness. Another initiative, [Collegiate Recovery Support Programs](#), focuses on connecting with college students in recovery from substance use or interested in supports for substance use concerns and supporting them in experiencing the opportunities in the college environment. Since initiation, the program has supported the expansion of collegiate recovery at seven locations across the state. Lastly, the [Statewide Youth Network](#) is designed to be youth-led, youth-directed, and youth-driven network to involve youth with lived experience in behavioral health system change initiatives. The network provides education, skill learning, and networking opportunities to youth across the state.

Children, youth, and young adults of color

Ensuring that all children, youth, and young adults have equitable access to high quality behavioral health care is a key component of HCA's [commitment to health equity](#). Due to the overarching and complicated impacts of racism and systemic oppression, racial and ethnic disparities in behavioral health care often vary by service type, setting, data set, and how race and ethnicity are categorized ([APA, 2023](#); [Alegria et al., 2011](#); [Marrast et al., 2016](#); [Rogers et al., 2021](#)). However, two fairly consistent patterns emerged in 2023 data.

Non-Hispanic white and American Indian/Alaska Native individuals

First, non-Hispanic white individuals and AI/AN individuals had the highest rates of identification of behavioral health needs and had the lowest rate of unmet need. While these patterns mostly align with national trends ([APA, 2017](#); [IHS, 2023](#); [NCUIH, 2024](#)), the relatively low rate of unmet need for AI/AN individuals in Washington State is striking. Several Apple Health programs are [actively partnering with Tribes](#) to improve access to care for (AI/AN) youth, including [Wraparound with Intensive Services](#), or WISe. The number of WISe providers who serve individuals enrolled in Apple Health without managed care (also known as fee-for-service, FFS) has increased, an important component of access to care, since half of all Apple Health AI/AN youth are enrolled in FFS. In addition, WISe program materials have been adapted to be more culturally appropriate, launching a Tribal WISe training with Native trainers, and WISe providers are meeting with Tribes in their region to explore improved ways to coordinate care for Tribal members and individuals that access care from Indian Health Care Providers (IHCPs).

Asian and NH/PI individuals

Second, Asian individuals and NH/PI individuals had the lowest rates of identification and highest rates of unmet need, across most metrics. These two populations, although often grouped together, consist of approximately 50 subpopulations, speaking more than 100 languages, and very diverse in terms of ethnicity, culture, religion, and history (APA, 2020). National data tends to find that need for behavioral health care among NH/PI individuals is similar to that of non-Hispanic white individuals (APA, 2020), which may mean that behavioral health needs are under-identified for NH/PI youth enrolled in Apple Health. Both cultural and structural barriers contribute unmet need for behavioral health care for Asian and NH/PI individuals (Jang et al., 2019; APA, 2020; Subica et al., 2022), and so concerted and culturally informed efforts will be needed to close this gap (The White House, 2023). In 2023, the five Apple Health managed care organizations (MCOs) worked on a Performance Improvement Project to address these disparities, but ultimately found that continued work and efforts were needed in this capacity. For more information about these efforts, please refer to the Apple Health EQR report for measurement year 2023, which is anticipated to be published on HCA's [Apple Health and Managed Care Reports webpage](#) by January 2025.

Summary

Understanding population-level behavioral health need and unmet need can be an important step in building out stronger systems of care. The data used in this report to measure need and unmet have substantial limitations, and more resource-intensive, multidimensional analytic approaches are likely needed to truly understand the landscape. Despite these limitations, this data does reveal gaps in care for many children, youth, and young adults. Continued efforts to increase access to substance-use treatment for youth and young adults are needed, as well as specialized efforts to increase access for young children, young adults, and children, youth and young adults of color.

Section 2: Network adequacy for youth-serving behavioral health providers

Background

This report is legislatively required to “better assure and understand issues related to **network adequacy** and access to services.” Network adequacy is best understood as one component of access, which is impacted by both the available workforce and insurance plan contracting.

Because of the complexities of the topic, this section provides a brief overview of the behavioral health workforce shortage, highlighting why workforce-focused metrics like network adequacy may be of interest. It also provides information on the concept of network adequacy, such as how it can be measured, specific federal requirements for Medicaid network adequacy, and critical and emerging issues.

Understanding the behavioral health workforce shortage

As seen in Section 1, there are considerable gaps in access to behavioral health care, and the workforce shortage may be a primary driver of these gaps (Counts, 2023). The national average wait time for behavioral health services is 48 days (HRSA, 2023), and by 2025, estimates suggest that the US will be short at least 31,000 mental health practitioners (HRSA Workforce Projections). The availability of the behavioral health workforce has been elevated as critical challenge in Washington State (Gattman et al., 2017). Almost half of all Washingtonians live in areas with a shortage of mental health providers (KFF, 2024), and the WA Workforce Sentinel network has found that many behavioral health facilities have “exceptionally long vacancies” for key positions (Washington Workforce Board, 2024). A 2023 legislative report on rural and Tribal access to behavioral health services under Apple Health found “a pervasive lack” of available behavioral health providers in rural areas and some Tribal communities.

Finding behavioral health providers who serve children, youth, and young adults can be especially challenging. Washington State is categorized as facing a “severe shortage” of child and adolescent psychiatrists (AACAP, 2022). Robust qualitative data collection efforts have identified that shortages specifically of infant-early childhood mental health and youth substance use providers prevent access to developmentally appropriate care (Cole and Fabian, 2024; HCA, 2023), and the shortages likely drive the overall disparities in access experienced by these populations as well (see Section 1 of this report).

A shortage of providers who can deliver culturally and linguistically aligned services is also a concern for access (HRSA Area Health Resources, 2023). This is especially important given the rising percentage of Washingtonians who speak a language other than English (Washington Office of Financial Management, 2024). The most recent census data shows that over 20% of families in Washington speak a language other than English, with about 10% speaking Spanish (Census Reporter, 2024). Individuals who speak English less than very well are more likely to experience delays in behavioral health treatment, inadequate care, and misdiagnosis (SAMHSA, 2024; Ohtani et al., 2015). While most mental health facilities nationally provide services in languages other than English, about half of those facilities use interpreters, rather than bilingual or multilingual clinical staff (Loho and Rosenheck, 2021). Although interpretation services can

support families in accessing care,¹³ the linguistic match between providers and clients further improves access to and increases the effectiveness of behavioral health services (NASEM, 2024; Marquine & Jimenez, 2021; Griner & Smith, 2006).

Understanding network adequacy

The impact of a limited workforce on access to care can be exacerbated if there are even further limits on the number of providers who are in-network¹⁴ for an individual’s insurance plan, including Medicaid plans like Apple Health. Several recent studies have found that providers are less likely to accept new patients enrolled in Medicaid, and Medicaid acceptance rates are particularly low for behavioral health providers (Ludomirsky et al., 2022; MACPAC, 2021; OIG, 2024).

The concept of whether insurance plans contract with enough providers is called “network adequacy.” An adequate network of providers means that the insurance plan has contracted with enough providers to meet the needs of their clients, without unreasonable delay. When networks are not adequate, individuals may be forced to wait or travel long distances for care, pay higher costs for treatment from a non-network provider, or go without care altogether (Weber, 2020).

Network adequacy is best understood as a component of access to care that is necessary but not sufficient (Ndumele et al., 2017; Zhu et al., 2022a). Network adequacy is not a measure of **realized access**, which looks specifically at whether individuals actually accessed care (for example, see Section 1 of this report). However, network adequacy is a measure of **potential access**, or the conditions that must be in place to allow individuals realized access to care (CMS, 2024a; HHS, 2021).

Network adequacy requirements for Medicaid

Since Apple Health is a Medicaid program, federal Medicaid rules set the minimum requirements for how Apple Health operates, and there are several specific federal requirements for measuring, monitoring, and enforcing network adequacy for Medicaid programs. Because Medicaid enrollees are by definition low-income and often unable to afford out-of-network care, the adequacy of the MCO provider network is critical to their ability to access needed services (Corlette, 2022).

Federal law (42 CFR § 447) requires that state Medicaid programs monitor access to services for FFS plans, but there are no specific requirements to monitor FFS network adequacy explicitly, as a component of access. However, federal law does require state Medicaid programs to monitor managed care plans’ performance with regards to “provider network management, including provider directory standards” and “availability and accessibility of services, including network adequacy standards” (42 CFR 438.66). At a minimum, states must develop and enforce quantitative network adequacy standards for 11 critical provider types, including mental health and substance use disorder providers (42 CFR 438.68(b)(1)).¹⁵

States have flexibility to select which quantitative network adequacy standard(s) they use, including:

- Wait times for an appointment

¹³ Per 42 C.F.R. § 438.10(c)(4), Apple Health (Medicaid) providers are required to make available interpreter services and translated written materials for clients with a primary language other than English. Learn more on HCA’s [Interpreter Services](#) webpage.

¹⁴ “In-network” means that a health care provider has been contracted to provide services through an individual’s specific insurance plan. Most insurance plans primarily cover services provided by in-network providers, with some exceptions.

¹⁵ States must also require managed care plans to demonstrate that their networks include sufficient **Indian Health Care Providers** to ensure timely access to services (42 CFR 438.14(b)(1)).

- Provider-to-enrollee ratios
- Travel time or distance to providers
- Percentage of contracting providers accepting new patients
- Hours of operation requirements
- Combinations of these quantitative measures ([CMS, 2024](#); [CMS, 2023a](#))

When selecting network adequacy standards, states must consider factors such as expected utilization of services, number of providers accepting new Medicaid patients, the ability of network providers to communicate with limited-English-proficient enrollees in their preferred language, and the geographic location of providers and enrollees ([42 CFR 438.68\(c\)](#)).

Critical and emerging issues for network adequacy

Network adequacy is, in theory, a simple concept but one that has proven complex to operationalize. There is tremendous variation in how network adequacy standards are defined for different states, programs, and services ([MACPAC, 2018](#); [OIG, 2014b](#); [Zhu et al., 2022a](#)), and there is not a clear evidence-based consensus on recommended provider-population ratios, drive times, or wait times, especially for behavioral health ([Haeder et al., 2023](#); [Hall & Ginsburg, 2017](#)).

Once network adequacy standards have been defined, monitoring and enforcing those standards is vital, but a complicated and resource-intensive task ([AMA, 2024](#); [Haeder et al., 2023](#); [HHS, 2021](#)). State approaches to monitoring and enforcement of network adequacy are incredibly diverse ([KFF, 2023](#); [MACPAC, 2018](#)). Although the intent of network adequacy standards is to promote timely access to care, the evidence to support its success is limited ([Ndumele et al., 2017](#)). Workforce shortages are a known barrier to the development of strong provider networks ([HCA, 2023](#); [Weber, 2020](#)), but the reliability of provider network data is an additional factor ([Burman, 2022](#); [OIG, 2014a](#)).

A number of studies over the years have attempted to validate Medicaid managed care provider network data sources by comparing provider lists and directories to submitted claims data, or by using secret-shopper surveys to contact providers in real-time. Many of these studies have found alarming rates of inaccurate information, especially for behavioral health providers. Common data issues include providers' contact information being incorrect or out-of-date, and providers being listed as in-network despite the fact that they do not actually serve Medicaid clients ([Burman, 2022](#); [Burman & Haeder, 2022](#); [Burman et al., 2023](#); [Haeder et al., 2016](#); [Ludomirsky et al., 2022](#); [OIG, 2014a](#); [Tenner et al., 2022](#)). Close to home, a recent study of Medicaid managed care in Oregon found that only about half of all listed behavioral health providers provided any services to individuals enrolled in Medicaid ([Zhu et al., 2022b](#)).

Network adequacy data can be hard to accurately track given its dynamic nature, including the fact that many providers work at multiple office locations and there are frequent changes in network participation ([Busch & Kyanko, 2021](#)). The accuracy of the data is also a shared responsibility: plans must collect and publish provider information, and providers must supply updates, which adds to already-high levels of administrative burden for behavioral health providers ([HHS, 2021](#); [Zhu et al., 2022b](#)).

Despite these inherent challenges, ensuring the accuracy of provider network data is a critical task. Unreliable provider network information creates systems-level problems, including making it hard to accurately monitor and enforce managed care plans' performance. But more importantly, inaccurate

behavioral provider network information creates administrative burden¹⁶ and frustration for vulnerable individuals seeking help (Baruchman, 2023; Busch & Kyanko, 2021). It can also lead to delayed, discontinued, or forgone care, which can have serious consequences for those with behavioral health conditions (Blau, 2024; Zhu et al., 2023), and evidence suggests that these negative impacts disproportionately affect disadvantaged populations (Burman, 2022).

Pediatric (i.e., youth-serving¹⁷) provider networks are a particularly important component of network adequacy. Pediatric mental health and substance use providers are one of the 11 critical provider types for which state Medicaid agencies must set and monitor specific network adequacy standards for managed care plans (42 CFR 438.68(b)(1)). Recent guidance from CMS also emphasizes that states are required to ensure the availability of providers who are qualified and willing to deliver services to youth under age 21 under federal EPSDT (Early, Periodic Screening, Diagnosis, and Treatment) requirements, for both managed care and FFS (CMS, 2024b). Understanding network adequacy for behavioral providers serving children, youth, and young adults enrolled in Apple Health (Medicaid) is a crucial part of improving access to care.

Number and availability of youth-serving behavioral health providers

Note: There are several upcoming changes to both federal and state requirements for Apple Health network adequacy standards. This call-out box describes the current state of network adequacy standards, as was applicable in 2023 (the reporting period for this report). Additional details about upcoming changes will be described in the [Discussion](#) section.

Understanding this data

This report is legislatively required to cover “issues related to **network adequacy**,” including three specific metrics:

- Number of behavioral health providers who serve children in Apple Health
- Percentage of those providers who are accepting new clients
- Languages spoken by those providers

These metrics are examples of possible network adequacy standards (CMS, 2023), but they do not necessarily align with the current network adequacy standards used for Apple Health managed care.

As noted in the Background, state Medicaid agencies must set and monitor specific managed care network adequacy standards for mental health and substance use treatment

¹⁶ ‘Administrative burden’ for clients or individuals refers to any challenge imposed on people that makes it significantly more difficult to access or maintain a benefit for which they would otherwise be eligible (Center for American Progress, 2022).

¹⁷ Federal and state definitions often refer to the pediatric population as individuals under the age of 18 or 21, but definitions are not consistent across all requirements and language. The term ‘youth’ is used in this section to refer to anyone under the age of 18 or 21, and where clarity regarding the specific age limit is provided, it will be noted. Individuals ages 21-25 are typically not included in federal or state definitions of pediatric or youth populations, and so both regulations and data regarding network adequacy for this population are limited.

providers,^{18,19} for both adult and pediatric populations. The specific network adequacy standards HCA has historically selected for these provider types in Apple Health managed care are **distance and drive-time standards**. The current standards require that a minimum of 80% of Medicaid enrollees in every county have access to a behavioral health provider within 25 miles and 30–90 minutes of travel time, depending on urban or rural location and mode of transportation ([Apple Health Integrated Managed Care Contract Section 6.11](#)). The standards are the same for both adult and youth-serving (pediatric) providers.

To monitor whether Apple Health MCOs meet these standards, HCA requires MCOs to provide a Network Provider Submission to HCA each quarter ([Apple Health Integrated Managed Care Contract Section 6.01](#)). This submission must list all their contracted mental health and substance use providers with corresponding geo-location data, which HCA then uses to calculate distance and drive-time indicators. The submission also includes other details about providers, such as whether they serve youth (defined as individuals under age 18),²⁰ are accepting new clients, and can provide services in a non-English language.

While the primary purpose of this submission is to monitor the selected managed care network adequacy standards (i.e., the distance and drive-time standards), this data can be used to explore other network adequacy or workforce-related indicators for Apple Health. Given this, this report has historically attempted to use Network Provider Submissions as a primary data source to report on the network adequacy indicators outlined in the report requirements.

Limitations to this data

As noted in the Background section, federal law ([42 CFR § 447](#)) requires state Medicaid programs to monitor FFS **access**, but FFS provider networks are not subject to the same federal network adequacy standards as managed care programs. To date, HCA has not established network adequacy standards or monitoring processes for FFS provider networks. While only 6% of **all** Apple Health youth are enrolled in FFS, 49% of AI/AN youth and 10% of Hispanic youth are enrolled in FFS (see [Apple Health Client Eligibility Dashboard](#)). A 2023 legislative report focused on access to behavioral health services for rural and Tribal communities recommended that HCA establish network adequacy standards for FFS networks, in line with HCA's [commitment to health equity](#) (HCA, 2023).

Similar to previous years' reports ([HCA, 2023c](#); [HCA, 2022](#)), provider network submission data about youth-serving mental health and substance use providers demonstrated substantial variability. This suggests inaccuracies and/or inconsistencies in how this data was collected by MCOs. Information

¹⁸ Historically, mental health providers have been defined as individual mental health providers (i.e., clinicians), while substance use providers have been defined as behavioral health agencies (i.e., facilities) that provide substance-use services. This difference stems from different approaches and standards to Apple Health provider contracting prior to Integrated Managed Care in 2018. Efforts to align provider definitions in future years will be described in the [Discussion](#) section.

¹⁹ Because provider network information is collected separately for mental health and SUD providers, reporting on provider networks for co-occurring mental health and substance use treatment would require additional analysis, which was not conducted this year.

²⁰ While this definition of youth is in line with some federal and state definitions, it does mean that there is no specific data about whether providers serve transition age youth or young adults (ages 16-25).

provided by MCOs confirmed this, with MCOs reporting that they use different methods for collecting and updating these fields. Due to these concerns, HCA is not including this data in this report.

Implementing new tools and strategies to monitor data accuracy and measure timely access to services will be crucial to making progress in this area. HCA is involved in several updates that may result in improved data quality in future years, including increased monitoring and data validation, as well as updates to network adequacy standards. These efforts will be reviewed in the [Discussion](#) section.

Languages spoken by youth-serving behavioral health providers

Although HCA was unable to use managed care provider network submission data to measure the languages spoken by youth-serving behavioral health providers,²¹ another data source has historically been available and used to measure this indicator: the Behavioral Health Provider Survey.

Understanding this data

The [Behavioral Health Provider Survey](#) is an annual survey sent to all publicly funded behavioral health agencies, inclusive of those who serve Apple Health managed care and FFS clients. The survey includes a question about whether BHAs serve youth (defined as those under age 18), as well as the total number of clinical staff employed by the agency. It also includes a question on how many of those clinical staff can provide services in a non-English language (NEL), as well as which language(s).

Limitations to this data

The 2023 survey had a response rate of **44%**, which means that **the majority of BHAs are not represented** in this data. Another limitation is that since this survey is only sent to BHAs, it does not include information about behavioral health providers working outside of licensed BHAs (i.e., in private practice, primary care settings, etc.).²² The last limitation is that while BHAs do report on whether they serve youth **as an agency**, they do not report on how many or which clinical staff serve youth. Therefore, the data from this survey reflects the number of all staff who can provide services in a non-English language, even those staff who may only serve adults.

In 2023, data from the Behavioral Health Provider Survey suggests that, among behavioral health agencies serving youth, **8%** of clinical staff could provide services in non-English language. The most common non-English language was **Spanish**, spoken by 6% of staff.²³

²¹ This report is legislatively required to report on the languages spoken by youth-serving behavioral health providers. Many individuals who speak a non-English language may be able to access behavioral health care through interpretation services. Per 42 C.F.R. § 438.10(c)(4), Apple Health (Medicaid) providers are required to make available interpreter services and translated written materials for clients with a primary language other than English. Learn more on HCA's [Interpreter Services](#) webpage.

²² An [HCA analysis](#) found that, in 2019, almost twice as many children received behavioral health services within primary care settings than in behavioral health agency settings. Understanding culturally and linguistically appropriate mental health services in all service settings is a critical component of HCA's commitment to integrated care and equity.

²³ Additional information about other languages spoken by providers is available [in the full report](#).

Discussion

The availability of the behavioral health workforce is a critical challenge in Washington State, which is exacerbated if there are even further limits on the number of providers who are in-network for insurance plans like Apple Health. While network adequacy is not a measure of whether individuals actually access the care they need, it does provide critical information about the conditions needed to support access to care.

Unfortunately, this report was largely unable to provide meaningful information about network adequacy for behavioral health providers serving youth in Apple Health. While federal law ([42 CFR § 447](#)) requires that state Medicaid programs monitor access to services for FFS plans, there are no specific requirements to monitor FFS network adequacy explicitly. To date, HCA has not established network adequacy standards or monitoring processes for Apple Health FFS provider networks, though a recent legislative report recommended this as a step for the future ([HCA, 2023b](#)).

HCA does have network adequacy standards for Apple Health managed care, as required by federal law. In fact, Apple Health's behavioral network adequacy standards have been lauded up as some of the most comprehensive in the nation ([HHS, 2021](#)). However, the current standards do not necessarily align with the network adequacy metrics required for this report. In addition, the network adequacy data provided by MCOs for youth-serving behavioral health providers in 2023 demonstrated substantial variability, suggesting inaccuracies and/or inconsistencies in how this data was collected and validated by MCOs. Implementing new tools and strategies to monitor data accuracy and measure timely access to services will be crucial to making progress in this area. There are several changes at the state and federal levels that may result in improved data quality in future years.

Internal HCA processes to monitor and validate data quality

HCA has already begun to take steps to validate and improve the accuracy of data submitted by MCOs to meet network adequacy standards. HCA has established processes to monitor whether providers included in provider network submissions are listed as active Apple Health providers in ProviderOne, the Apple Health Medicaid Management Information System (MMIS). HCA has also established processes to monitor whether providers included in provider network submissions are actively serving Apple Health enrollees, by comparing network submission data to submitted encounter and claims data, a nationally recommended strategy for network adequacy monitoring ([AMA, 2024](#); [HHS, 2021](#); [Ludomirsky et al., 2022](#)). HCA's capacity to conduct encounter-comparison monitoring efforts on an ongoing basis has been limited, but monitoring for behavioral health providers is planned for 2025.

New regional network adequacy standards for Apple Health behavioral health

At the state level, legislation passed in 2023 ([2ESHB 1515](#)), requires HCA to develop new regional behavioral health network adequacy standards for Apple Health by January 2025. Prior to the passage of 2ESHB 1515, HCA had been working with a subcommittee of the legislatively mandated Behavioral Health System Coordination Committee ([RCW 71.24.861](#)) to address various behavioral health access challenges, such as wait times, workforce shortages, and reporting processes. When 2ESHB 1515 passed in 2023, the subcommittee paused previous efforts and pivoted to developing these new standards. After several months of work, the subcommittee agreed to [updated standards](#), informed by recommendations

collected from regions across the state; these standards will go into effect January 2025. HCA is currently updating its provider network submission templates to align with the new standards, which will support improved data collection and quality. The 2025 standards will serve as a baseline for future years, as HCA refines standards over time based on community voice.

Updated External Quality Review (EQR) protocols

At the federal level, 2023 was the first year that validation of managed care network adequacy was a federally required component of Medicaid managed care external quality review²⁴ processes ([42 CFR 438.358\(b\)\(1\)\(iv\)](#)). Beginning in 2024, EQRs must independently validate each MCOs' performance on network adequacy standards required by 42 CFR 438.68, as well as those specific to Indian Health Care Providers under 42 CFR 438.14(b)(1).

To validate network adequacy, the EQR must use specific protocols designed by CMS ([CMS, 2023a](#); [CMS, 2023b](#)). As part of these [protocols](#), the EQR must assess whether MCOs' information systems are sufficient to accurately capture network adequacy data, such as evaluating how MCOs' internal systems track providers over time, across multiple office locations, and through changes in participation in the MCOs' network. The EQR must also provide recommendations for improving the reliability and validity of each MCOs' process for monitoring network adequacy, including implications for the MCOs' data systems, methods, and staffing. The Apple Health EQR report for measurement year 2023 is anticipated to be published on HCA's [Apple Health and Managed Care Reports webpage](#) by January 2025, and recommendations regarding network adequacy data validation may be used to inform future work.

New CMS Rule on managed care access and network adequacy: wait time standards and secret-shopper surveys

New federal rules released in May 2024 regarding Medicaid managed care access ([CMS, 2024a](#)) will create additional requirements for measuring network adequacy in the future. By 2027, all states will be required to develop additional network adequacy metric: appointment wait time standards.²⁵ New wait time standards will apply to six critical provider types, including outpatient mental health and substance use providers, serving both adults and youth. Wait time standards must be no longer than 10 business days, but states can choose to set shorter wait time standards ([42 CFR 438.68\(e\)](#)).²⁶

The new rule also increases the requirements for monitoring and validating managed care network adequacy. By 2028, states will be required to monitor compliance with wait-time standards (as well as the accuracy of data in all managed care plans' provider directories) using secret-shopper surveys conducted by an external entity ([42 CFR 438.68\(f\)](#)). Secret-shopper surveys are a research methodology where

²⁴ External quality review (EQR) is a federally required evaluation of the quality, timeliness, and access to the health care services provided by MCOs, which is conducted by an external organization (i.e., neither the state Medicaid agency nor the MCO themselves) ([42 CFR 438 Subpart E](#)).

²⁵ The new required wait time standards will be *in addition* to the existing requirement for a state-selected quantitative network adequacy standard (such as provider-to-enrollee ratios, travel time or distance to providers, or percentage of contracting providers accepting new patients).

²⁶ Apple Health managed care contracts already have wait time standards for mental health and substance use. However, these wait time standards have not historically been considered 'network adequacy standards' for Apple Health, and monitoring and enforcement of these standards has been limited. Current monitoring relies on grievance and appeal data, as well as case-specific concerns brought to HCA. More information about wait times may be available in HCA's annual legislative [Behavioral Health Outcomes report](#). Please refer to HCA's [Legislative Reports](#) page to find the 2024 report.

“secret shopper” callers, who do not identify themselves as evaluators, pose as enrollees trying to schedule an appointment with a provider. By putting the evaluator directly into the enrollee’s shoes, these surveys produce credible, unbiased, and actionable data that reflect the true experience of an enrollee trying to schedule an appointment, if intentionally designed and implemented (CMS, 2024a; Liu & Machlete, 2024).

While not required, states can leverage their secret-shopper surveys to identify access barriers and inequities for marginalized groups. For example, secret-shopper surveys can be designed to gather information on physical accessibility, language access, and discrimination and disparities on the basis of various demographic characteristics. In this way, secret-shopper surveys may prove to be powerful tools not only in monitoring and enforcing network adequacy, but also in measuring and advancing health equity (Liu & Machlete, 2024).

Recent guidance from CMS on adhering to existing federal EPSDT requirements recommends that state Medicaid agencies take steps to specifically focus on youth-serving provider networks, as part of compliance with these new regulations. Recommended steps include evaluating youth-specific provider-to-enrollee ratios and developing more-specific network adequacy standards for subspecialists serving youth (CMS, 2024b).

Summary

The availability of the behavioral health workforce has been elevated as critical challenge in access to care in Washington State. Network adequacy can provide critical information about the conditions needed to support access to care. Unfortunately, this report was largely unable to provide meaningful information about network adequacy for behavioral health providers serving youth in Apple Health. Implementing new tools and strategies to monitor data accuracy and measure timely access to services will be crucial to making progress in this area, and ongoing work at the state and federal levels may result in improved data quality in future years.

Section 3: Emergency department visits follow-up for behavioral health crises

Background

In the absence of a robust community behavioral health system, the emergency department (ED) can become the de facto provider of behavioral health services, particularly for those in crisis. Nationally, the number of mental health-related ED visits for children and youth is on the rise, including a five-fold increase in suicide-related visits from 2011 to 2020 (Bommersbach et al., 2023; Saidinejad et al., 2023). EDs around Washington have reported record-high numbers of pediatric patients presenting in a behavioral health crisis (Seattle Children’s Hospital Community Health Assessment, 2022).

When youth do present in the ED for behavioral health concerns, preventing prolonged stays (i.e., boarding), and increasing timely follow-up care is critical to ensuring their health and safety (Ibeziako et al., 2024). Youth who seek care in ED may be particularly vulnerable, and an ED visit may be their first contact with a mental health specialist (Marin et al., 2024). Research shows that attendance at a follow-up mental health appointment within one week of ED discharge is associated with half the risk for suicide (Fontanella et al., 2020). However, national data suggests that less than half of Medicaid clients receive mental health follow-up care within one week (NCQA, 2024), and only about a quarter of clients receive follow-up care within one week for substance use disorders (NCQA, 2024).²⁷ Understanding the follow-up care provided to vulnerable children, youth, and young adults who seek help from EDs is critical to safeguarding their health and wellbeing.

Follow-up care after ED visits

Understanding this data

This report uses nationally standardized metrics called HEDIS measures²⁸ to understand follow-up after ED visits. The measures include:

- Follow-up after ED visit for mental illness within 7 and 30 days (HEDIS FUM)
- Follow-up after ED visit for substance use within 7 and 30 days (HEDIS FUA)²⁹

For more information about measure definitions, please see visit the HEDIS links above.

²⁷ Please note that the current available data on the national average for these metrics are from Medicaid managed care populations in 2022 and are not specific to the child, youth, and young adult population.

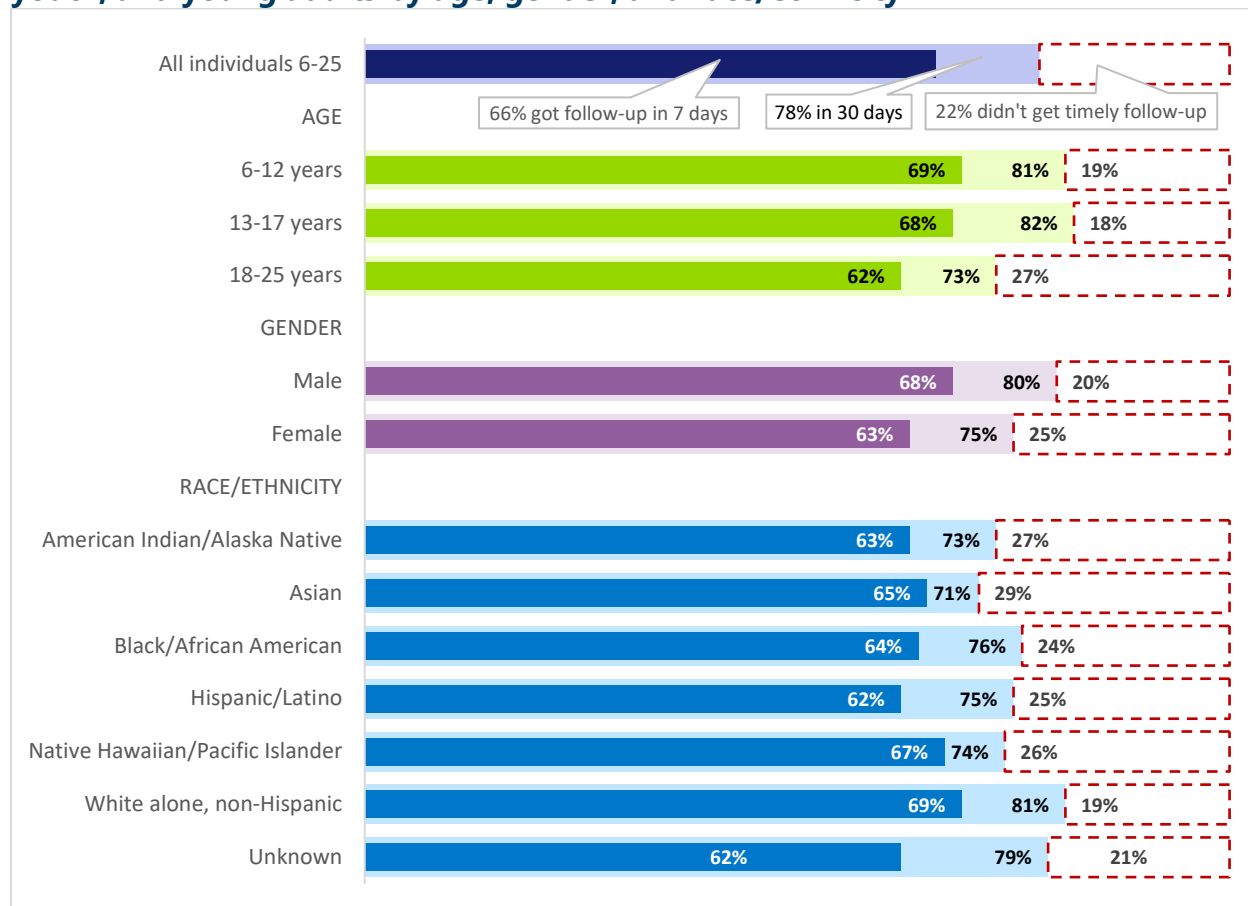
²⁸ HEDIS stands for the Healthcare Effectiveness Data and Information Set. HEDIS metrics are published by the NCQA, or the National Committee for Quality Assurance, and they are one of health care’s most widely used performance improvement tools.

²⁹ These metrics are also considered performance metrics for MCOs. Additional reports on these metrics by region and managed care plan are available on HCA’s [Managed Care Reports webpage](#).

Mental health

In 2023, **34%** of the children, youth, and young adults (6–25 years) who were seen within an ED setting for mental health disorder symptoms did not receive follow-up care within one week, and **22%** did not receive care within 30 days. Similar to rates of unmet need for any mental health care, young adults (18–25 years) were less likely to receive follow-up care than older children and youth, and there was some variation across racial/ethnic groups (see Figure 6).

Figure 6: Mental health ED follow-up in 2023 for Apple Health-enrolled children, youth, and young adults by age, gender, and race/ethnicity

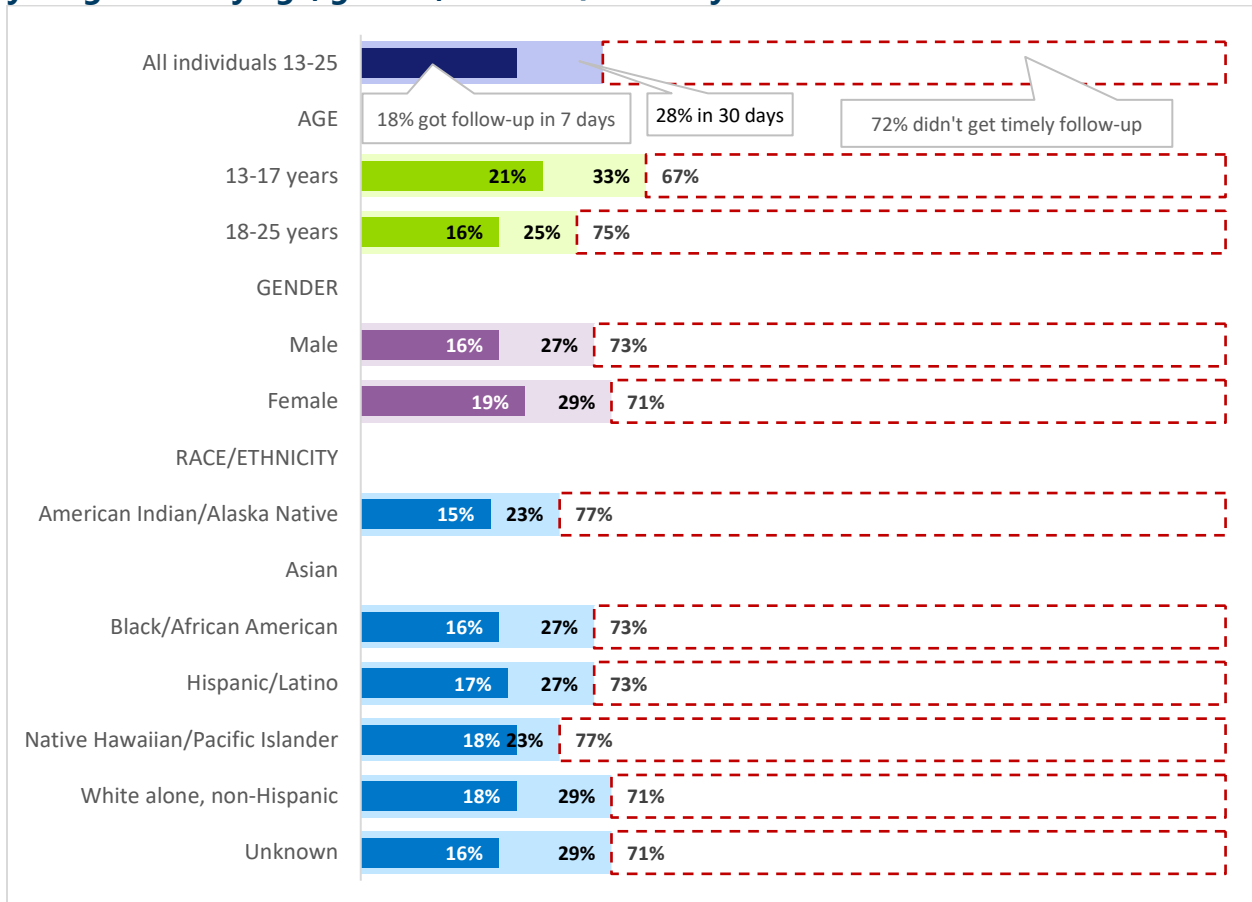


For the number of individuals in each category, refer to [Appendix B: Additional data tables](#).

Substance use

In 2023, **82%** of the youth and young adults (13–25 years) who were seen within an ED setting due to substance-use concerns did not receive follow-up services within one week of their ED visit, and **73%** did not receive care within 30 days. There was some variation across age, gender, and racial/ethnic groups in the percentage of youth and young adults who did not receive needed substance use care (see Figure 7), but similarly to the overall substance-use treatment rate, the majority of the youth and young adults in all groups did not receive needed care.

Figure 7: Substance use ED follow-up in 2023 for Apple Health-enrolled youth and young adults by age, gender, and race/ethnicity



For the number of individuals in each category, refer to [Appendix B: Additional data tables](#).

Discussion

This report used nationally standardized metrics to measure follow-up care for children and youth after ED visits for behavioral health reasons. These metrics are a crucial barometer for access, since a follow-up mental health appointment within one week of ED discharge is associated with a decreased risk for suicide (Fontanella et al., 2020). In 2023, 66% of children and youth received follow-up mental health care within 7 days, compared to the **national average** of about 40%. In addition, only 20% of youth received follow-up substance use disorder care within 7 days, compared to the **national average** of about 25%.³⁰

Given the vulnerability and immediacy of behavioral health crises situations, urgent action is needed to ensure all youth in crisis are fully supported. HCA is rolling out national best practices in crisis care for youth, called **Mobile Response and Stabilization Services** (MRSS), which bring the crisis continuum to the family by providing both the crisis intervention phase and the separate but connected in-home stabilization phase, wherever the youth is. By implementing this model, teams can identify youth in need earlier, divert families from EDs and law enforcement, connect families to providers through warm handoffs, and keep kids safe in their homes, schools, and communities. Since 2022, the number of teams has increased from four teams covering five counties, to 14 teams covering 18 counties. In addition, the Medicaid State Plan was amended to expand Apple Health coverage of in-home/community stabilization services from 14 days to eight weeks, in alignment with the **MRSS model**.

Understanding follow-up care provided to vulnerable individuals who seek help from EDs is critical to safeguarding their health and wellbeing, and continued efforts will be needed to ensure children, youth, and young adults get the high-quality and developmentally appropriate support they need.

³⁰ Note that the current available data on the national average for these metrics are from Medicaid managed care populations in 2022, and are not specific to the child, youth, and young adult population.

Section 4: Eating disorder diagnoses, treatment, and providers

Background

Eating disorders have the second highest fatality rate of all behavioral health conditions ([Derenne & Lock, 2016](#)), and about 235 Washingtonians die every year from an eating disorder ([STRIPED, 2021](#)). Best estimates suggest that 9% of people will develop an eating disorder during their lifetime, and that about 2.2% of women and 0.7% of men have an eating disorder in a given year ([Marie et al., 2019](#)). Nationally, COVID-19 has led to an increase of eating disorders ([FAIRHealth, 2023](#)), and a special report found that eating disorder prevalence almost doubled for Apple Health clients between March 2020 and December 2021 ([Lucenko et al., 2024](#)).

Adolescence and young adulthood are critical periods for eating disorders, since most eating disorders develop by age 25, with the average age of onset between 12-13 years ([Swanson et al., 2011](#)). A meta-analysis of international studies suggest that 6-8% of adolescents have an eating disorder at any given time ([Marie et al., 2019](#)). Eating disorders are also increasing for youth ([Bevilacqua et al., 2023](#); [FAIRHealth, 2023](#); [Lin et al., 2021](#)), and in 2021, about half of all Apple Health clients with identified eating disorders were 12-25 years old ([Lucenko et al., 2024](#)). A Seattle Time investigation found that, in 2021, children and youth made up the majority of eating disorder hospitalizations in Washington State for the first time since 2016, and, of the 20 most expensive psychiatric stays among Washington youth, 40% involved those with an eating disorder ([Furfaro, 2023](#)).

Although previously misunderstood as affecting mostly white, adolescent girls, eating disorders are increasingly recognized across all ages, races, ethnicities, and genders. However, diagnosis and care may be delayed for certain groups due to provider bias, as well as disparities in screening and treatment ([Moreno et al., 2023](#); [Hornberger et al., 2021](#), [Marques et al., 2011](#)).

Eating disorders treatment is multidisciplinary, often requiring both behavioral and physical health services, and it often requires long-term treatment crossing care levels. The American Psychiatric Association (APA) outlines stepwise level-of-care guidelines for patients with eating disorders including outpatient treatment; intensive outpatient treatment, partial hospitalization, residential treatment, and inpatient hospitalization ([Crone et al., 2023](#)). There is strong evidence to suggest the efficacy of a family-focused, developmentally appropriate, and multidisciplinary approach to care for children and youth with eating disorders ([Mairs & Nichols, 2016](#); [Moreno et al., 2023](#)). Economic research demonstrates a good return on investment for eating disorder prevention and treatment services ([Faller et al., 2024](#)), and when treatment is provided, 70% of youth successfully recover from eating disorders ([Hornberger et al., 2021](#)).

However, challenges in accessing eating disorder treatment are well-documented ([Kazdin et al., 2018](#)). Studies show that most individuals do not receive the recommended frequency or intensity of eating disorder care ([Tamargo, 2022](#)), and individuals with Medicaid may be even less likely to receive recommended treatment services ([Moreno et al., 2023](#)). One contributing factor is the lack of eating disorder providers across levels of care. There are a limited number of residential programs across the country ([Deloitte Access Economics, 2020](#)), and at the outpatient level, many providers may not have the expertise to provide quality treatment ([Hornberger et al., 2021](#)). Another barrier is insurance coverage. In

2022, the federal government reported on how some insurers' limits on eating disorder treatment violated mental health parity laws ([Report to Congress, 2022](#)). Several investigative reports in the past few years have also highlighted the role of insurance companies in restricting access to appropriate eating disorder care ([Calucchia, 2023](#); [Gordon, 2021](#)), including Medicaid (Apple Health) coverage in Washington State ([Furfaro, 2023](#)). Understanding the landscape of eating disorders among Apple Health youth is a crucial component of assessing the state of whole-person, integrated care and mental health parity in our system.

Identified eating disorders

Understanding this data

This report used claims data to understand how many individuals had identified eating disorders. Specifically, the analysis looked to see if certain eating disorders were included anywhere in individuals' claims data. For more information about specific disorders included in this definition, please see [Appendix A: Data definitions](#).

Limitations to this data

This approach uses claims data to understand the prevalence of eating disorders. Because claims data is generated by health care providers, it may be more standardized than data sources that rely on individuals' reports of their own diagnosed eating disorder. However, health care providers' perceptions may not align with individuals' perception of their own health care conditions ([NASEM, 2024](#)).

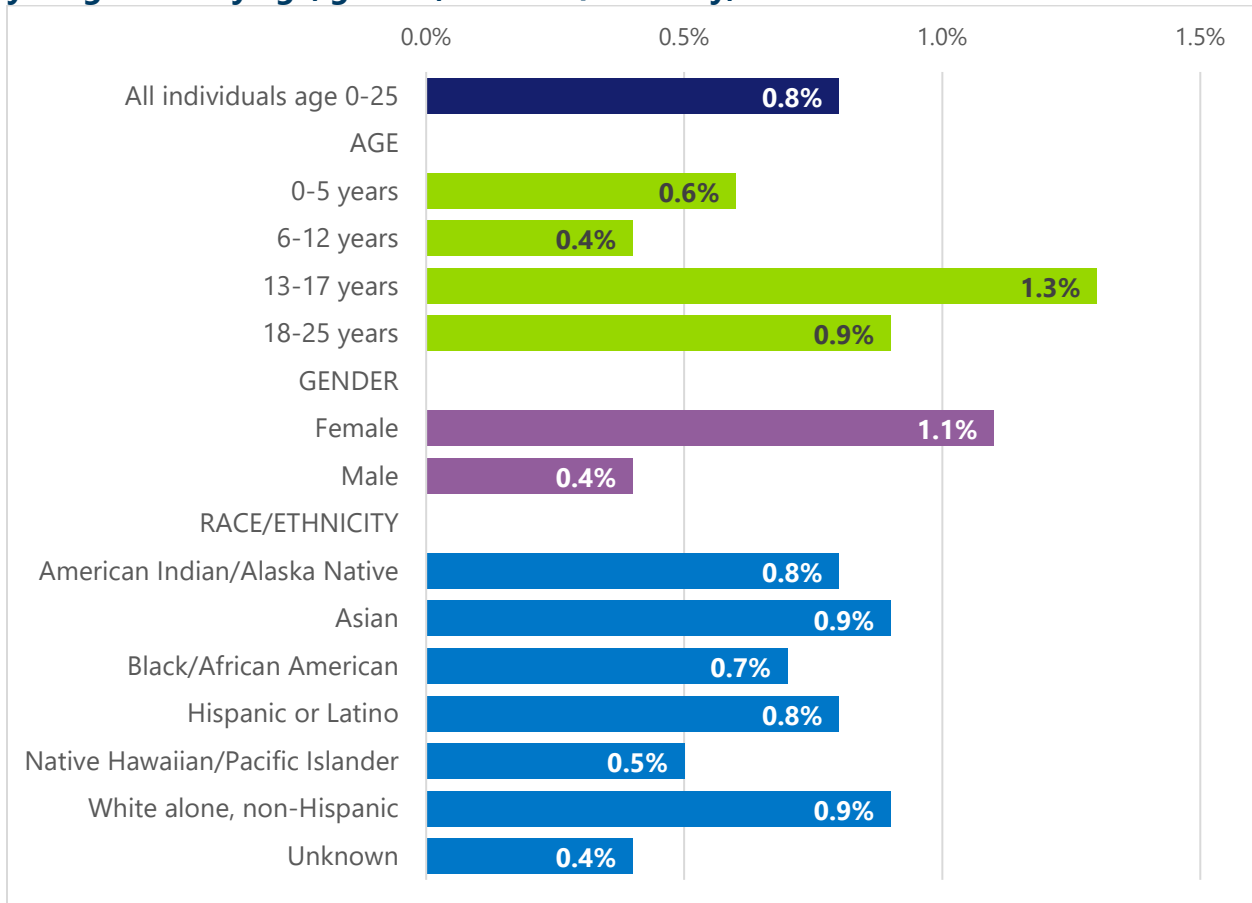
In addition, many individuals may have eating disorders that are not identified by health care providers. Systemic factors such as social determinants of health, access to developmentally and culturally appropriate health care, discrimination, stigma, and historical trauma likely contribute to the under-identification of eating disorder by health care providers ([Moreno et al., 2023](#); [Hornberger et al., 2021](#), [Marques et al., 2011](#)).

These metrics also rely on the assumption that health care claims data is both accurate and comprehensive. It is possible that some health care claims data may be erroneously reported or miscoded; it is also possible that not all disorders, concerns, services, or medications are reported in claims data ([Ferver et al., 2009](#)). A recent study measured the validity of diagnosis codes in claims data, by directly comparing them to information included in clinical documentation (i.e., chart abstraction), and it found that diagnostic codes were quite reliable for identifying selected childhood mental, behavioral, and emotional disorders (Shi et al., 2024). While this study provides a positive indication for the use of claims data for understanding behavioral health disorders, more research is needed to understand the reliability of claims data for measuring behavioral health concepts broadly.

A final limitation is that this data does not represent a standard metric of prevalence. Any comparison to other reports of eating disorder prevalence should be interpreted with an abundance of caution.

During 2023, fewer than 1% of children, youth, and young adults (0–25 years) enrolled in Apple Health had an identified eating disorder. A higher percentage of youth (13–17 years) had identified eating disorders compared to other age groups; although the percentage of youth (13–17 years) with eating disorders was higher than other age groups at 1.3%, it was still lower than the estimated national prevalence cited above (6–8%). A higher proportion of female than male individuals had identified eating disorders, and there was also variation in rates of identified eating disorders across racial/ethnic groups (see Figure 8).

Figure 8: Eating disorder diagnoses for Apple Health-enrolled children, youth, and young adults by age, gender, and race/ethnicity, 2023



For the number of individuals in each category, refer to [Appendix B: Additional data tables](#).

Eating disorder treatment

As noted in the Background section, recommended treatment for eating disorders can include both behavioral health and physical health services, and treatment often crosses a continuum of outpatient, partial hospitalization, residential, and inpatient care. The complexity of the mixture of care can make data analysis on this topic complicated.

Understanding this data

This report focuses on whether individuals with identified eating disorders received any **mental health** treatment. Specifically, analysis looked at the claims data of individuals with identified eating disorders to see if they received any mental health treatment services, including crisis, outpatient, and inpatient care. For more information about the specific mental health treatment services included, please see [Appendix A: Data definitions](#).

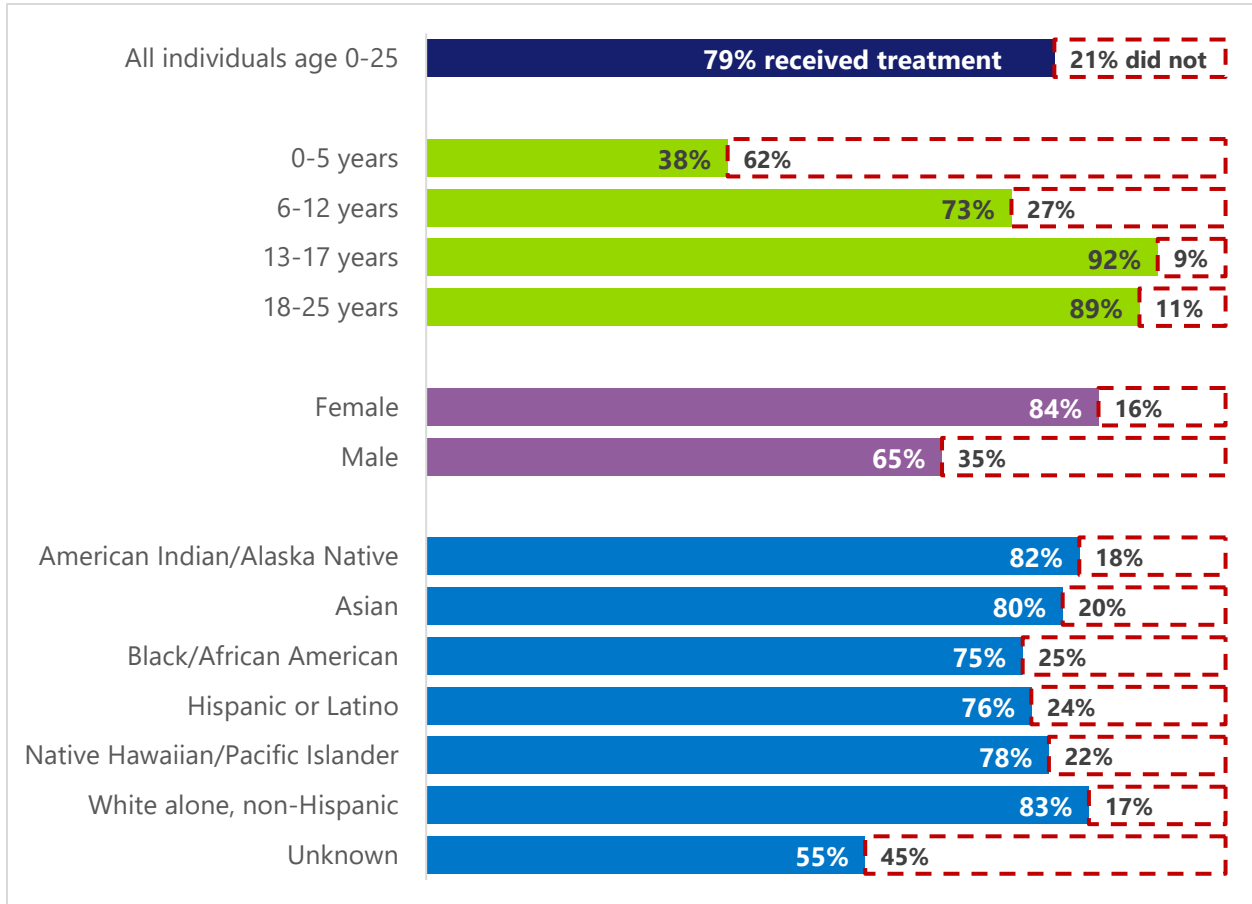
Limitations to this data

This definition of having received mental health treatment shares similar limitations outlined above, regarding the identification of eating disorder diagnoses, including a reliance on claims data and the inability to be easily compared to other national measures of need.

However, there are also unique limitations to this definition of treatment. This data does not specify whether individuals received mental health treatment **specifically to address** their eating disorders. Individuals with eating disorders often have co-occurring mental health conditions ([Lucenko et al., 2024](#)), and even if they received mental health treatment, those services may have focused on addressing other mental health conditions. Another limitation is that this data only shows whether individuals received any mental health treatment in the past year; it does not show whether individuals received the appropriate type, frequency, intensity, or quality of treatment. Lastly, since this data focuses on mental health treatment, it does not provide information about other types of treatment that may be needed to treat eating disorders, such as physical health treatments like nutrition supports or dietician services.

During 2023, **79%** of the children, youth, and young adults enrolled in Apple Health with identified eating disorders received any mental health treatment. In other words, about **one in five** children, youth, and young adults with identified eating disorders did not receive any mental health treatment. Young children (0–5 years) with identified eating disorders were less likely to receive mental health treatment compared to their older peers (6–25 years), and male individuals were less likely to receive mental health treatment than their female peers. There was also some variation across racial/ethnic groups, and youth with unknown race/ethnicity had the lowest rates of receiving mental health treatment (see Figure 9).

Figure 9: Percent of all Apple Health-enrolled youth and young adults (13–25 years) with an eating disorder diagnosis who received any mental health treatment in 2023



For the number of individuals in each category, refer to [Appendix B: Additional data tables](#).

Eating disorder providers

Various behavioral and physical health care provider types, including behavioral health specialists, nutritionists, primary care providers, and hospitals, provide eating disorder treatment. Nationally, no specific taxonomy or provider type captures a specialty in eating disorder treatment. This can make understanding the eating disorder workforce challenging.

Understanding this data

In a special report from the DSHS-RDA, claims data was used to analyze the number of eating disorder **specialty providers** who provided any health services to any Apple Health client (all ages) in 2021. This report defined “specialty providers” as those who delivered at least 25% of their services to individuals with identified eating disorders and who noted on their website that their sole specialty was eating disorder treatment (i.e., they only provided treatment for eating disorders). The report was inclusive of providers serving both managed care and FFS enrollees (Lucenko et al., 2024).

Limitations to this data

This definition of “eating disorder specialty provider” is not based on any sort of clinical criteria or certification. It does not specifically look at whether these providers provided treatment **specifically for eating disorders**; rather, it quantifies providers who provided any kind of health service to **an individual with an identified eating disorder**. Relatedly, it is not specific to providers who provided **mental health services** to individuals with an identified eating disorder, but is inclusive of providers who provided **any kind of health service**. Given the fact that this definition is focused on providers with a sole specialty in eating disorder treatment, it excludes providers who provide treatment for multiple conditions, such as Seattle Children’s Hospital and their affiliated Eating Disorder Clinic.

In addition, distinct providers were defined by distinct billing NPIs (National Provider Identification³¹), so a single provider may represent multiple locations or offices under the same umbrella organization. This means that this data may not provide a count of providers that aligns with the experience of individuals seeking services.

Lastly, the data analyzed was from 2021, so it does not provide the most current information.

The report identified **24** eating disorder specialty providers in 2021, 22 of which were agencies or facilities; the other two were individual providers. Importantly for network access, **half** of the identified providers were located out of state.

Discussion

Eating disorders are an important mental health condition for consideration, given their high fatality rate, high prevalence in adolescence, and complex mixture of care. Data used for this report found that less than 1% of Apple Health youth had an identified eating disorder in 2023. International prevalence data

³¹ A [National Provider Identifier \(NPI\)](#) is a unique identification number for covered health care providers. A ‘[billing NPI](#)’ is the NPI of the billing entity responsible for billing a patient for healthcare services.

suggests that 6–8% of adolescents have an eating disorder at any given time ([Marie et al., 2019](#)), which suggests that eating disorders may be under-identified among Apple Health youth. However, due to the differences in how the data in this report and national prevalence data are collected, analyzed, and reported, any comparison between the two rates should be interpreted with an abundance of caution.

The data in this report was only able to provide limited information about the treatment available for and provided to youth with eating disorders. Given the increasing attention on access to and coverage of eating disorder treatment, it will be important to continue building stronger data systems to understand this topic. A recently completed special report ([Lucenko et al., 2024](#)) provides an in-depth review of the prevalence of eating disorders among Apple Health youth in 2021 and the types of mental health treatment services provided. A follow-up study is also underway, which will look at data through 2023 and will provide additional information about eating disorder providers and treatment services.

In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) recently announced the [launch of the National Center of Excellence for Eating Disorders](#) (NCEED), the first center of excellence dedicated to eating disorders. The purpose of the newly improved NCEED is to expand the scope of the training and technical assistance developed and disseminated to healthcare practitioners and other stakeholders on issues related to addressing eating disorders and to advance efforts to recognize the signs of eating disorders through the provision of appropriate intervention and services. Training and technical assistance through this Center of Excellence may support efforts in Washington State to get individuals the care they need.

Lastly, understanding early indicators for eating disorders may also be a helpful next step ([Lucenko et al., 2024](#)). The [Healthy Youth Survey](#), an annual statewide survey of 6th to 12th grade students, recently added new questions about disordered eating and weight stigma. Initial results from 2023 found that a high percentage of youth reported behaviors that are indicators of disordered eating, ranging from 7% to 56%, depending on the specific behavior ([HYS 2023 Results](#)). This information may help to identify trends and patterns to support future prevention, safety, and health promotion initiatives.

While the data this report was able to provide on eating disorders was limited, it still reveals critical gaps in the identification and treatment of these conditions. Continued efforts to improve data collection and analysis, comprehensive coverage policies, and availability of treatment services is needed to ensure children, youth, and young adults with these conditions are able to access high quality, developmentally appropriate care.

Section 5: Perinatal behavioral health need and unmet need

Background

In 2024, Governor Jay Inslee proclaimed May as Maternal Mental Health month in Washington State. [The proclamation](#) emphasizes the importance of emotional wellbeing in the perinatal period. Perinatal depression and related mood disorders affect approximately 20% of new and expectant parents, and they can occur anytime in the first year after giving birth ([APA, 2023](#)). Unfortunately, national estimates suggest that only about half of those who report postpartum depression symptoms receive any mental health care ([Haight et al., 2024](#)). In fact, the leading cause of pregnancy related deaths is mental health conditions, including from suicides and overdose/poisoning related to substance use disorders ([Maternal Mortality Review Panel, 2023](#)). Increasing attention has also been drawn to the issue of substance use during pregnancy, with ongoing attempts to criminalize substance use during pregnancy, which put pregnant, substance-using women at risk of detection, arrest, and punishment ([Wilkinson, 2024](#); [Stone, 2015](#)).

A key factor in perinatal behavioral health is the impact of racial disparities. Research has shown that access to mental health care is lower for postpartum people of color ([Haight et al., 2024](#)), and significant racial disparities have been documented in prescribing practices for pregnant individuals who would benefit from medication for opioid use disorder ([Austin, et al., 2023](#)). Pregnant and postpartum people of color have shared that key barriers include past trauma with medical care, as well as feelings that clinicians lacked the skills and cultural competency to establish trusting relationships and communicate in different languages ([Iturralde et al., 2021](#)).

Given the bidirectional relationship between caregiver and child emotional wellbeing, especially in the early years of life ([HHS, 2024](#)), understanding the behavioral health needs and access to care for pregnant people is an important component of fully understanding access to care for children, youth, and families.

Understanding this data

The data in Section 5 primarily comes from two metrics: the mental health treatment rate and the substance use disorder treatment rate. These metrics were [originally developed](#) by DSHS-RDA, in collaboration with Medicaid delivery system stakeholders. While they are not nationally standardized metrics, they are part of the Washington State Common Measure Set, a set of standard statewide measures of health performance to inform health care purchasers and set benchmarks, including for Apple Health.³²

Both metrics consist of two components: 1) the number of individuals who have a **need** for mental health or substance use treatment, and 2) the number of individuals with need who received mental health or substance use treatment. Conversely, by looking at the number of individuals with need who **did not receive treatment services**, these metrics also measure

³² These metrics are also considered performance metrics for Apple Health MCOs. Additional reports on these metrics by managed care plan are available on HCA's [Managed Care Reports webpage](#).

the number of individuals with **an unmet need**. In order to understand both need and unmet need, these components are reported separately. More information about how each component is defined (as well as limitations to their definitions) is provided in the respective sections.

These metrics use claims data to identify mental health or substance-use need and treatment services. **Claims data** is a type of health care data that is created when providers and/or insurance companies submit information about services they have provided, in order to receive or substantiate payment. Claims data usually includes information about the service provided and health issue(s) being addressed, as well as other demographic data about the client and provider.

Limitations to this data

As noted above, these metrics use claims data as a primary source of information. Because claims data is generated by health care providers, it may be more standardized than data sources that rely on individuals' reports of their own need and unmet need. However, health care providers' perceptions, especially of need for treatment may not align with individuals' perception of their own needs ([NASEM, 2024](#)). In addition, many individuals may have needs that are not identified by health care providers. Systemic factors such as social determinants of health, access to developmentally and culturally appropriate health care, discrimination, stigma, and historical trauma likely contribute to the under-identification of need by health care providers ([APA, 2023](#); [Prichett et al., 2024](#)).

These metrics also rely on the assumption that health care claims data is both accurate and comprehensive. It is possible that some health care claims data may be erroneously reported or miscoded; it is also possible that not all disorders, concerns, services, or medications are reported in claims data ([Ferver et al., 2009](#)). A recent study measured the validity of diagnosis codes in claims data, by directly comparing them to information included in clinical documentation (i.e., chart abstraction), and it found that diagnostic codes were quite reliable for identifying selected childhood mental, behavioral, and emotional disorders (Shi et al., 2024). While this study provides a positive indication for the use of claims data for understanding behavioral health disorders, more research is needed to understand the reliability of claims data for measuring behavioral health concepts broadly.

A final limitation is that while these metrics may share certain aspects in common with other standardized national definitions of need, these metrics were developed specifically for Washington State and the Apple Health population. Any comparison to other metrics of behavioral health need or unmet should be interpreted with an abundance of caution.

Need for mental health and substance use treatment

Understanding the need for mental health and substance use treatment is an important step in building a responsive behavioral health system of care. Defining the need for behavioral health treatment is a complicated task, and so we recommend a close reading of the "Understanding this" data call-out box.

Understanding this data

As noted above, the data in Section 1 comes from two metrics: the mental health treatment rate and the substance use disorder treatment rate. This subsection looks specifically at the metric component for individuals with a mental health or substance use treatment **need**.

Individuals are classified as having a need for treatment if they have any of the following recorded in their claims data:

- Certain mental health or substance use disorders
- Certain mental health or substance use concerns (e.g., incidents of self-harm or overdose)
- Certain mental health or substance use treatment services
- Certain medications

For more information about the specific disorders, concerns, services, and medications included in this definition, please refer to [Appendix A: Data definitions](#).

Limitations to this data

As components of the mental health treatment rate and the substance use disorder treatment rate, this definition of need shares similar limitations outlined above, including a reliance on claims data and an inability to be easily compared to other national measures of need. However, there are also limitations to these metrics specific to the definition of need.

These metrics define “need for treatment” more broadly than the presence of a diagnosed behavioral health disorder. Individuals with certain serious behavioral health concerns (such as incidents of self-harm or overdose) are also assumed to need treatment services, even if they have not received an official diagnosis of a behavioral health disorder. While this approach provides a more comprehensive and inclusive estimation of need, it may overestimate (or complicate the meaning of) the number of individuals with a need for treatment.

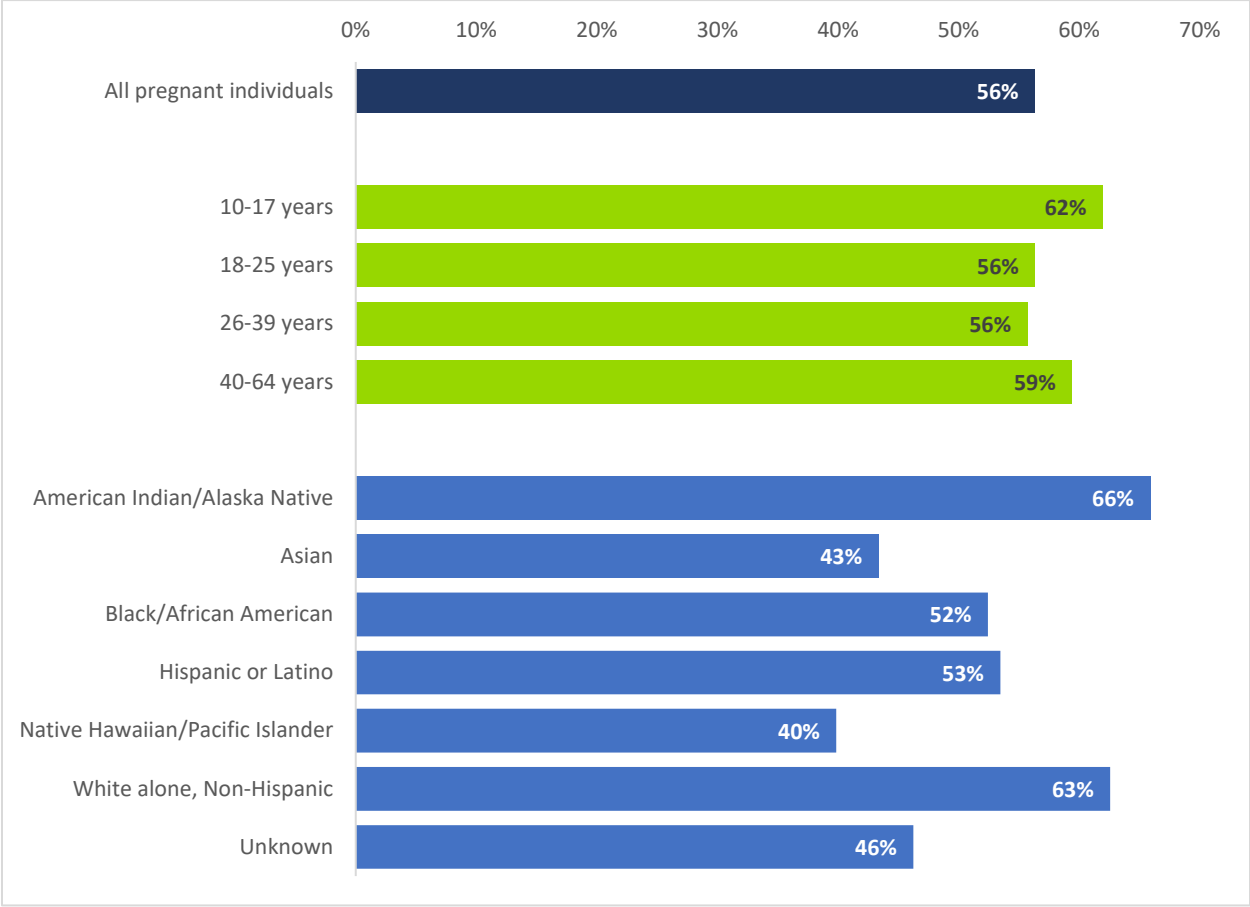
In addition, individuals who receive certain treatment services or medications are also considered to have a need for treatment, even if they do not have a diagnosed behavioral health disorder. This analytic approach may appear circular in nature, but it is actually a commonly used approach, including by SAMHSA ([SAMHSA, 2023](#)). This approach is meant to account for the fact that nationally, many individuals receiving behavioral health services lack diagnosable conditions or significant impairments ([Germack et al., 2020](#); [NASEM, 2024](#)). While this approach may be considered standard, it can overestimate (or complicate the meaning of) the number of individuals with treatment needs.

Despite these limitations, these metrics are still an important benchmark of care to understand, since they are considered core performance measures for Apple Health.

Mental health

In 2023, **56%** of all pregnant individuals enrolled in Apple Health (10–64 years) had an identified need for mental health treatment services. Adolescent (10–17 years) and middle adult (40–64 years) pregnant people were more likely to have identified mental health needs, compared to young adult (18–25 years) and grown adults (26–39 years). In addition, a greater proportion of AI/AN and non-Hispanic white pregnant people had identified mental health needs, whereas a smaller portion of Asian and NH/PI pregnant people did (see Figure 10).

Figure 10: Percent of all Apple Health-enrolled pregnant individuals (10–64 years) who had an identified need for mental health services in 2023, by age and race/ethnicity

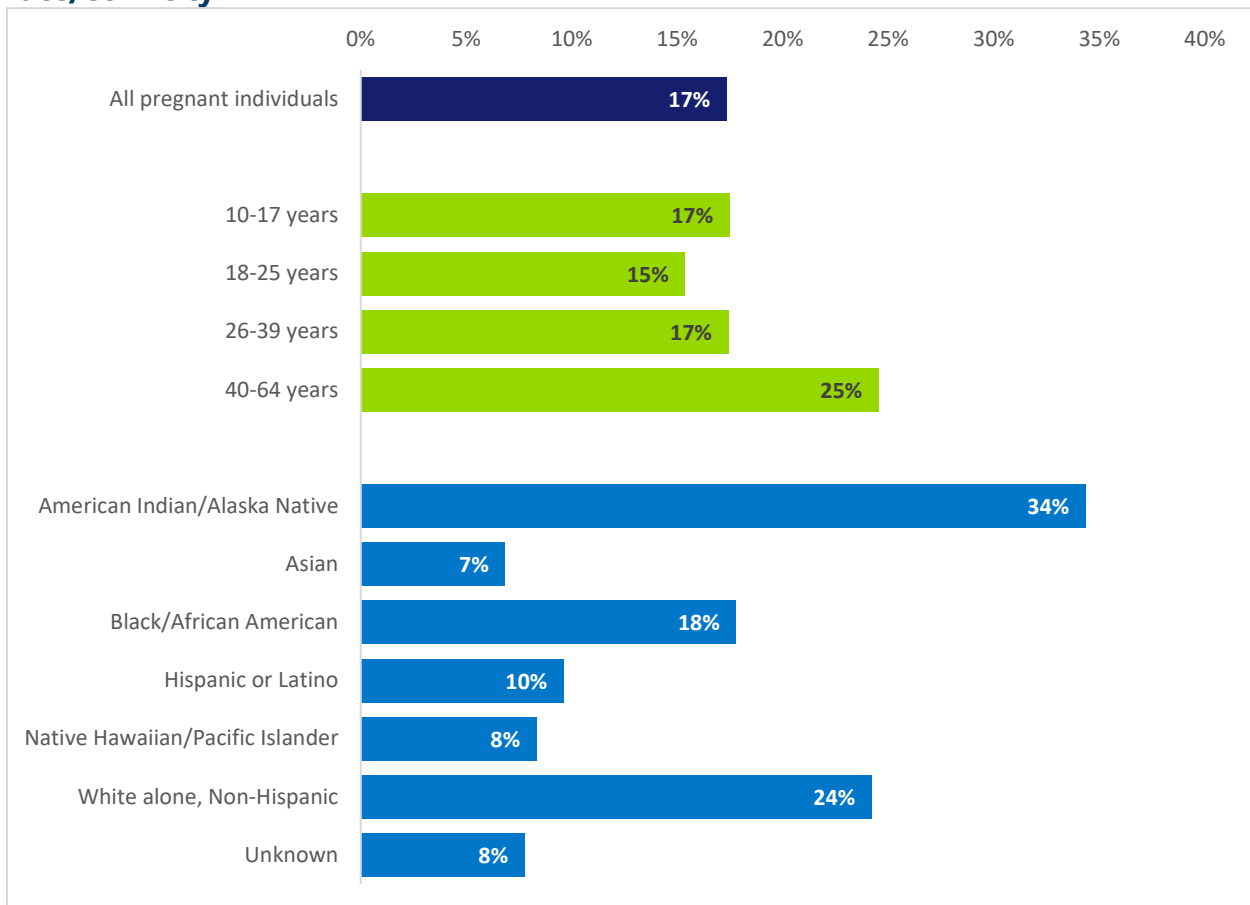


For the number of individuals in each category, refer to [Appendix B: Additional data tables](#). For more information about how this data is collected and defined, see [Appendix A: Data Sources & definitions](#)

Substance use

In 2023, **17%** of all pregnant individuals enrolled in Apple Health had an identified need for substance-use treatment services. A higher percentage of middle adult pregnant people (40–64 years) had identified substance-use needs, compared to their younger peers (10–39 years). Rates of identified substance-use need varied considerably across racial/ethnic groups; almost a third of all pregnant AI/AN pregnant people and a quarter of all non-Hispanic white pregnant people had an identified substance-use need. In contrast, 10% or less of Asian, Hispanic or Latino, Native Hawaiian/Pacific Islander, and pregnant people with unknown race/ethnicity had an identified substance use need (see Figure 11).

Figure 11: Percent of all Apple Health-enrolled pregnant individuals (10–64 years) who had an identified need for substance-use services in 2023, by age and race/ethnicity



For the number of individuals in each category, refer to [Appendix B: Additional data tables](#).

Mental health and substance use treatment services

Unmet need refers to when someone has a health care problem but doesn't receive formal care, or when the care received is insufficient or inadequate. Unmet need is an important measure of access to care. However, like measuring need, measuring unmet is a complicated task, and so we recommend a close reading of the "Understanding this data" call-out box.

Understanding this data

As noted above, the data in Section 1 comes from two metrics: the mental health treatment rate and the substance use disorder treatment rate. This subsection looks specifically at the metric component that counts the number of individuals with a mental health or substance use treatment need who **received treatment**, and conversely, those with an **unmet need** for treatment.

These metrics define mental health or substance use treatment through claims data.³³ Individuals are classified as having received treatment if they had **certain types of treatment services**³⁴ recorded in their claims data. For more information about the specific treatment services included in this definition, please refer to [Appendix A: Data definitions](#).

Limitations to this data

As components of the mental health treatment rate and the substance use disorder treatment rate, this definition of having received treatment/unmet need shares similar limitations outlined above, including a reliance on claims data and the inability to be easily compared to other national measures of need. However, there are also limitations specific to the definition of having received treatment/unmet need.

The primary limitation is that this data only calculates the percentage of individuals who received **any treatment** service. However, it does not help us to understand if individuals received the appropriate type, frequency, intensity, or quality of treatment services.

³³ Claims data is a type of health care data that is created when providers and/or insurance companies submit information about services they have provided, in order to receive or substantiate payment. Claims data usually includes information about the service provided, as well as the health issue being addressed, in addition to other demographic data about the client and provider.

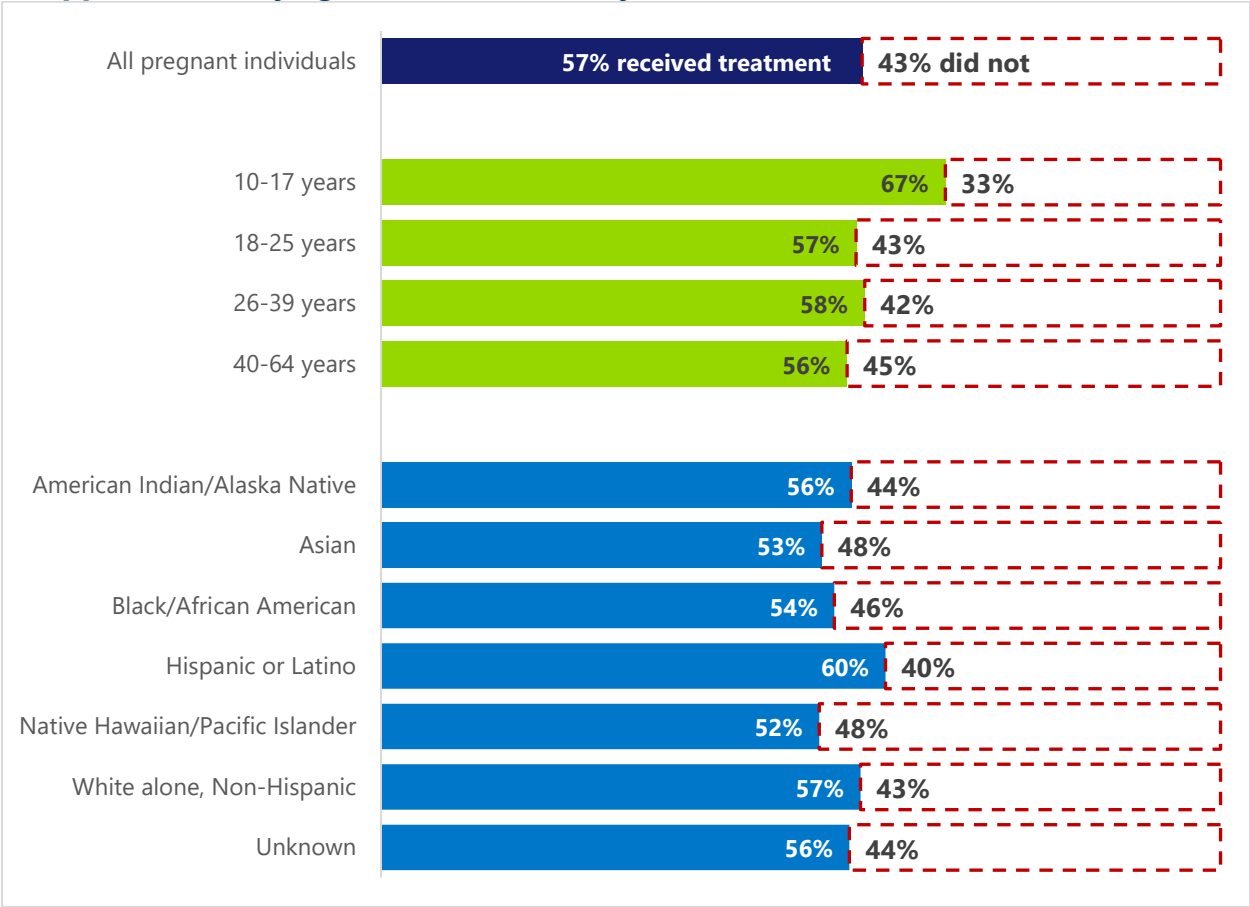
³⁴ For more detail about the specific types of services included, refer to [Appendix A: Data Definitions](#).

Mental health

During 2023, only **57%** of pregnant individuals with an identified need for mental health treatment received any mental health treatment. In other words, about **1 in 2** pregnant individuals with an identified mental health treatment need had an unmet need.

Adolescent pregnant people (10-17 years) were less to have unmet need than adults (18-64 years). There was also some variation across racial/ethnic groups in the percentage of pregnant people with unmet need: Hispanic or Latino pregnant people had the lowest rates of unmet need, while NH/PI, Asian, and Black pregnant people had the highest rates (see Figure 12).

Figure 12: Mental health treatment rate in 2023 for pregnant individuals enrolled in Apple Health, by age and race/ethnicity



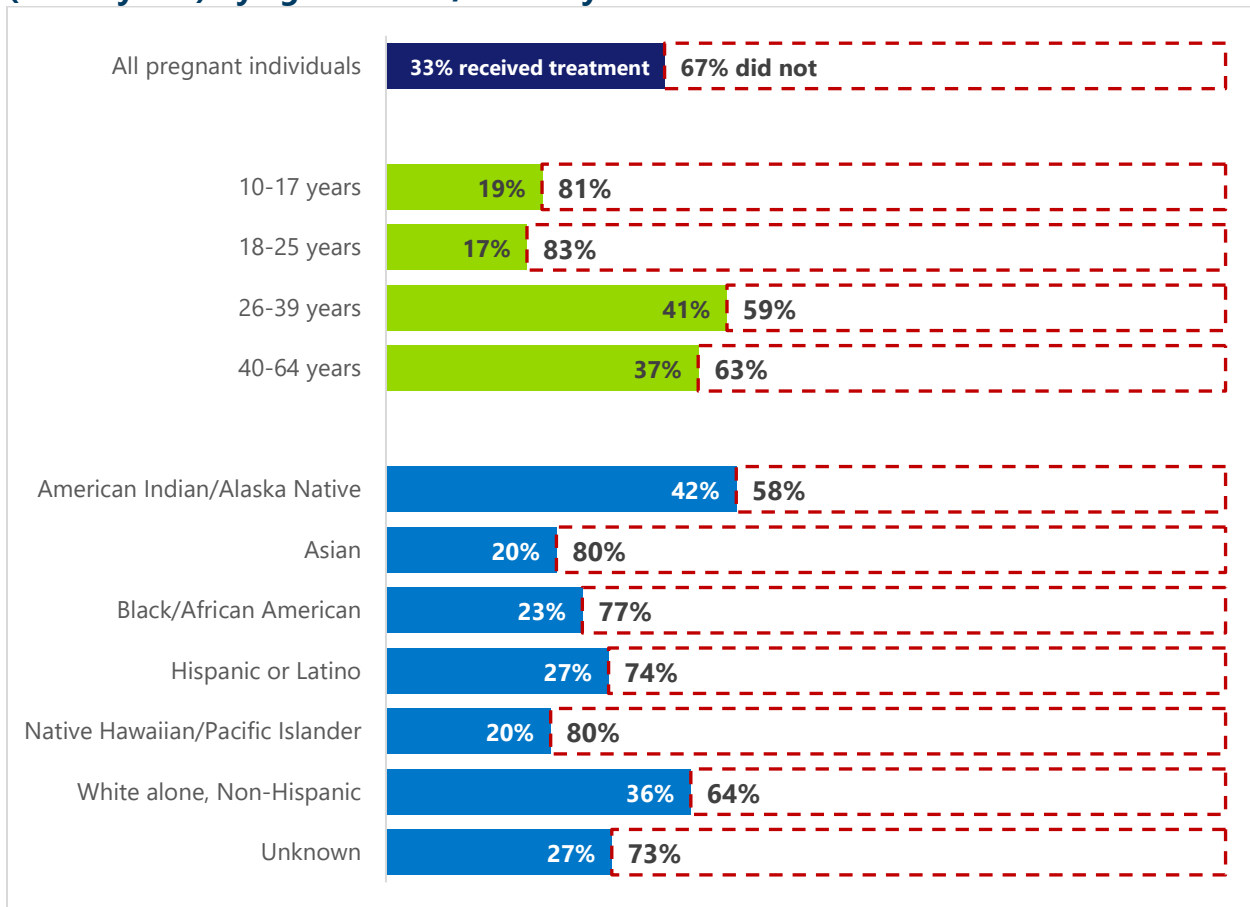
For the number of individuals in each category, refer to [Appendix B: Additional data tables](#).

Substance use

During 2023, only **33%** of pregnant individuals with an identified need for substance-use treatment received it. In other words, **two in three** pregnant individuals with an identified need for a substance-use treatment need had unmet need.

Adolescent and young adult pregnant people (10-25 years) were more likely to have unmet need than their older peers (26-64 years). There was also some variation across racial/ethnic groups in the percentage of pregnant individuals with unmet need (see Figure 13), but for all groups, the majority had unmet need.

Figure 13: SUD treatment rates in for Apple Health-enrolled pregnant individuals (10–64 years) by age and race/ethnicity in 2023



For the number of individuals in each category, refer to [Appendix B: Additional data tables](#).

Discussion

For the first time, this report included data about behavioral health access to care for pregnant individuals enrolled in Apple Health. This addition reflects the increasing recognition of the bidirectional relationship between caregiver and child emotional wellbeing, especially in the early years of life (HHS, 2024).

Data about perinatal behavioral health need and unmet came from the same source used for children, youth, and young adults: mental health treatment rate and the substance use disorder treatment rate. There are numerous limitations to these metrics [as outlined earlier in the report](#), but this information still provides a critical first look into the state of perinatal behavioral health for individuals enrolled in Apple Health

According to these metrics, **56%** of all pregnant individuals had an identified need for mental health care, and **one in two** of these individuals had an unmet need for treatment. Increasing access to perinatal mental health care will involve building out stronger support for the perinatal workforce. While Washington received a B- rating on our [Maternal Mental Health report card](#), we received a D on the “Providers and Programs” category, and many recommendations in the [Washington State Maternal Mortality Review Panel 2023 Report](#) focus on bolstering the workforce. One example of progress in this area is the [Perinatal Psychiatric Consultation Line](#), a free telephone consultation service for health care providers caring for patients with behavioral health conditions who are pregnant, postpartum, or planning pregnancy. Any health care provider in Washington State can receive consultation, recommendations, and referrals to community resources from a UW psychiatrist with expertise in perinatal mental health. As one health care provider shared,

“This service has allowed me to feel more comfortable treating perinatal patients; if this service didn't exist, I think I would be referring more patients out for care, rather than continuing to provide care for them during the pregnancy.”

In addition, **17%** of pregnant individuals had an identified substance-use treatment need, and **two in three** of these individuals had an unmet need for treatment. Perinatal substance use has been a growing area of concern, especially given its connection with the child welfare system. A recent series of interviews with pregnant and parenting people in Washington who use substances revealed that fear of child welfare involvement stops pregnant people from getting help and makes it harder for providers to effectively support them. In addition, despite widespread recognition for whole-family care, operational barriers make it nearly impossible for providers to offer it ([Bloom Works, 2024](#)). Continued work to provide whole-person, whole-family, and whole-community care will be critical to addressing this gap in care.

Understanding population-level behavioral health needs and unmet needs for pregnant individuals can be an important step in building out stronger systems of care. Despite the limitation of the data used in this report, it does reveal gaps in care for this vulnerable population. Continued efforts to increase access to mental health and substance-use treatment for pregnant individuals are needed, with a special focus on attending to the interactions between behavioral health needs and child welfare involvement.

Conclusion

Access to necessary behavioral health care is a central part of wellbeing for many children, youth, and families, including those enrolled in Apple Health. As required by legislation, this report included several metrics that help paint a picture of the landscape of behavioral health care in Washington State. Notable gaps emerged from these metrics, including:

- High levels of unmet need for both mental health and substance use treatment.
- Disparities in the identification and treatment of behavioral health conditions for certain populations.
- Lack of clear, consistent, and high-quality data on many key aspects of care.

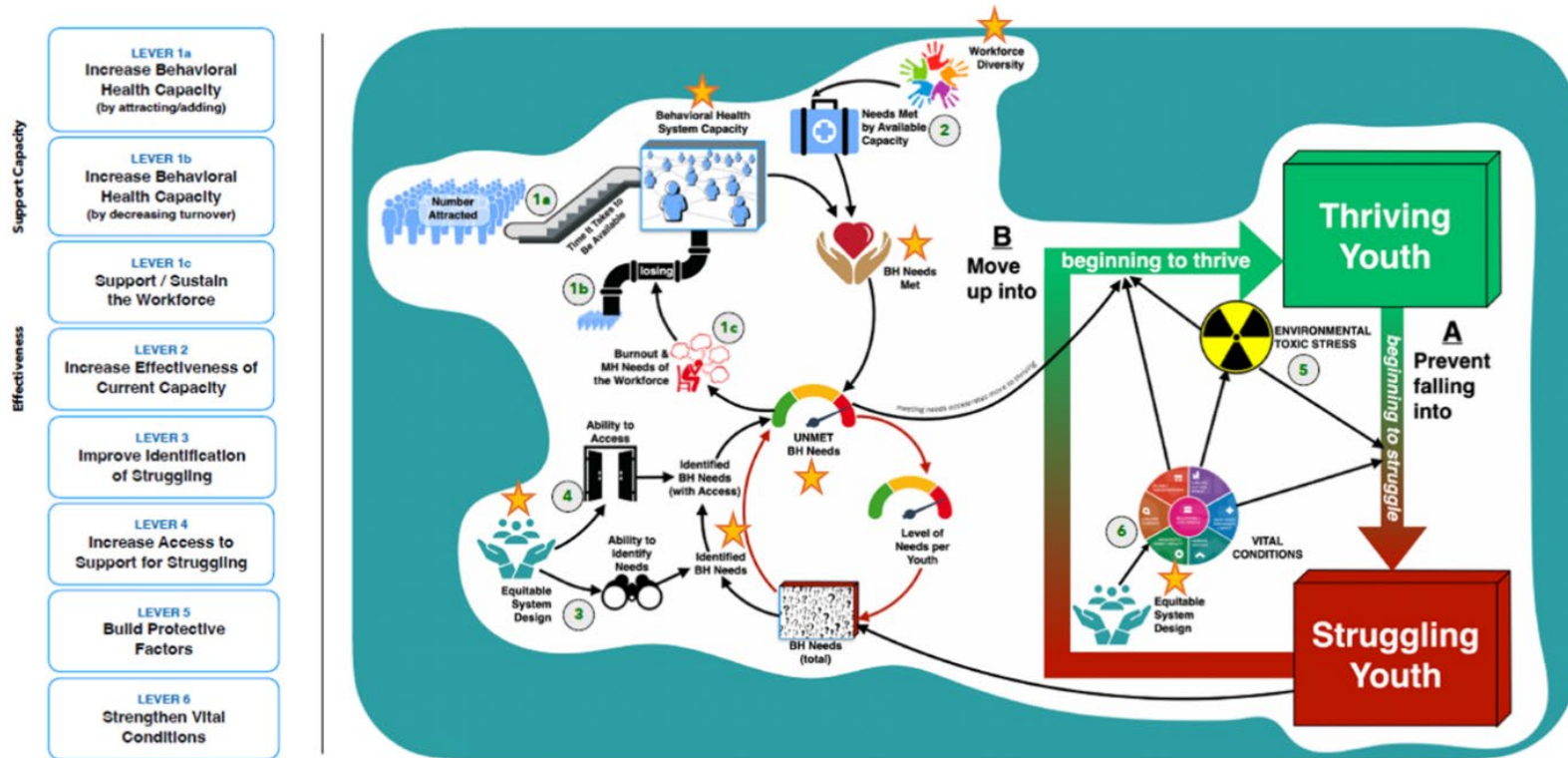
Importantly, the information in this report can help in building a strong ecosystem of behavioral health care. The same legislation ([E2SHB 2439, Laws of 2016](#)) that required this report also initially formed the Children and Youth Behavioral Health Work Group (CYBGWG). The CYBGWG provides recommendations to the Governor and the Legislature to improve behavioral health services and strategies for children, youth, young adults, and their families. As part of this work group, the [Washington Thriving](#) initiative was launched: a collaborative statewide effort to develop a strategic plan that will transform the behavioral health system serving children, youth, young adults, and their families and caregivers.

Transforming systems as complicated and crucial as the behavioral health system will require strategic decision-making and data-informed action. For example, Figure X: Strategy map for the CYBGWG outlines components of a functioning behavioral health ecosystem, as well as key levers that can influence systemic change. The stars added to the map represent areas described in this report, showing how this data can help inform strategic efforts, but also where more information is needed.

Ultimately, it will take all of us to build towards the vision of Washington Thriving, where all children and young people, as well as their caregivers and families, will be able to access high-quality, developmentally-appropriate, culturally-attuned care when and where they look for it.

Figure 14: Strategy map for the CYBHWG

WASHINGTON'S CHILDREN & YOUTH BEHAVIORAL HEALTH ECOSYSTEM
 A Strategy Map for the CYBHWG



Appendix A: Data definitions

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

Section 1: Behavioral health need and unmet need for children, youth, and young adults

Mental health need and unmet need

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

Population: all children, youth, and young adults (0-25 years) enrolled in Apple Health for at least 11 months during 2023. See the [Apple Health eligibility groups](#) at the end of this appendix for more detailed information about how enrollment in Apple Health is defined.

Definition of need and unmet need for mental health treatment: These metrics are calculated using the [mental health treatment rate](#). [View a full definition of this metric.](#)

- **Mental health need** is defined when an individual has any of the following within their paid claims/accepted encounter data.
 - certain mental health **disorders**,
 - certain mental health **concerns**,
 - receipt of certain mental health **treatment services**, or
 - receipt of certain mental health **medications**.
- **Need is considered to be met** if an individual of the following within their paid claims/accepted encounter data.
 - certain mental health **treatment services** or
 - certain mental health **medications**.

Individuals with identified need who have not received any these treatment services or medications would be considered to have unmet need.

Definitions of each of these components are outlined fully in the [measure definition](#) and [value set](#), and are summarized here.

- **Mental health disorders** include
 - Anxiety disorders
 - Attention deficit and hyperactivity disorders
 - Bipolar and manic disorders
 - Conduct disorders
 - Depressive disorders
 - Dissociative and conversion disorder
 - Eating disorders
 - Impulse disorders
 - Obsessive-compulsive disorders

Behavioral health access and network adequacy for children and youth (prenatal – age 25)

December 1, 2024

Page | 57

- Personality disorders
- Somatoform disorders
- Stress, trauma, and adjustment disorders

For more information, please refer to the “MI Diagnosis” value subset within the [MHRS Value Set](#) (Excel file download).

- **Mental health concerns**, primarily include incidents of self-harm. For more information, please refer to the “MI Diagnosis” value subset within the [MHRS Value Set](#) (Excel file download).
- **Mental health treatment services**: broadly, this category is understood to include outpatient mental health services, mental health crisis services, and other mental health services. However, the complexities of the current value subsets for this concept were too complicated to be summarized for this report. Readers should refer to the measure definition and relevant value subsets within the [MHRS Value Set](#) (Excel file download).
- **Mental health medications**: please refer to the full list of medications by National Drug Code (NDC) in the “Psychotropic-NDC-5mcgs” value subset within the [MHRS Value Set](#) (Excel file download).

Substance use need and unmet need

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

Population: all youth and young adults (13–25 years) enrolled in Apple Health for at least 11 months during 2023. See the [Apple Health eligibility groups](#) at the end of this appendix for more detailed information about how enrollment in Apple Health is defined.

Definition of need and unmet need for substance-use treatment: These metrics are calculated using the [substance use treatment rate](#). [View a full definition of this metric](#).

- **Substance-use need** is defined when an individual has any of the following within their paid claims/accepted encounter data.
 - certain substance use **disorders**,
 - certain substance use **concerns**,
 - certain **services** to address substance use concerns
 - certain substance use **treatment services**, or
 - certain substance use **medications**.
- **Need is considered to be met** if an individual of the following within their paid claims/accepted encounter data.
 - certain substance-use **treatment services**, or
 - certain substance-use **medications**.

Individuals with identified need who have not received any **treatment services** or **medications** would be considered to have unmet need.

Definitions of each of these components are outlined fully in the [measure definition](#) and [measure value set](#), and are summarized here.

- **Substance use disorders** include
 - Alcohol related disorders
 - Opioid related disorders
 - Cannabis related disorders
 - Sedative related disorders
 - Cocaine related disorders
 - Other stimulant related disorders
 - Hallucinogen related disorders
 - Inhalant related disorders
 - Other psychoactive substance related disorders

For more information, please refer to the “SUD-Dx-Value-Set” within the [SUD TX Rate Value Set](#).

- **Substance use concerns** include
 - incidents of overdose,
 - substance use complicating pregnancy or that causes damage to the fetus, and
 - alcoholic liver diseases.

For more information, please refer to the “SUD-Dx-Value-Set” value subset within the [SUD TX Rate Value Set](#).

- **Services to address substance use concerns** (which are not considered treatment services) include
 - Screening, Brief Intervention, and Referral to Treatment (SBIRT), and
 - withdrawal management (sometimes called “detox.”)

For more information, please refer to the “SBIRT-Proc-Value-Set (3169)” and “Detox-Value-Set” value subsets within the [SUD TX Rate Value Set](#).

- **Substance-use treatment services and medications** include:
 - **Medication for Opiate Use Disorder (MOUD)** and **Medication for Alcohol Use Disorder (MAUD)** services and medications (refer to “MOUD-MAUD-Value Set” and “MOUD-Procedure-Value-Set” within the [SUD TX Rate Value Set](#)).
 - **Peer services** (refer to “Proc-w-any-SUD-Dx (4881)” within the [SUD TX Rate Value Set](#))
 - **Outpatient services** (i.e., ASAM Level 1 and 2.1) (refer to “Proc-w-any-SUD-Dx (4881)” and “SUD-OP-Tx-Proc-Value-Set (3156)” within the [SUD TX Rate Value Set](#))
 - **Opioid Treatment Programs** (refer to “SUD-OST-Value-Set (MCG 3148)” within the [SUD TX Rate Value Set](#)).

- **Recovery services** (refer to “SUD-OP-Tx-Proc-Value-Set (3156)” within the [SUD TX Rate Value Set](#))
- **Residential services:** intensive, long-term, and recovery house (i.e., ASAM Level 3.1, 3.3, and 3.5) (refer to “SUD-OP-Tx-Proc-Value-Set (3156)” within the [SUD TX Rate Value Set](#))
- **Sobering services** (refer to “Proc-w-any-SUD-Dx (4881)” within the [SUD TX Rate Value Set](#))
- **Any service provided by a substance use disorder specialty provider** (refer to “SUD-Taxonomy-Value-Set (3170)) **specifically to address a substance use disorder or qualified substance use concern** (i.e., must have a principal diagnosis from the “SUD-Dx-Value-Set”), **except assessment services** (refer to “SUD-ASMT-Value-Set (3149)” within the [SUD TX Rate Value Set](#))

Section 2: Network adequacy for youth-serving behavioral health providers

Languages spoken by providers

Data source: These data are from the Behavioral Health Provider Survey, an online survey conducted from February through July 2023. The target population for the survey consists of Department of Health licensed, community-based mental health (MH) and substance use disorder (SUD) treatment agencies providing publicly funded services in Washington State.

Population: The sample originally included 760 agencies, with each location considered a distinct entity. However, agencies with multiple sites were allowed to consolidate them into one survey. Accounting for survey consolidation and agency closures, the adjusted population size is 643 agencies. A total of from 282 agencies participated in the survey, resulting in a response rate of 44%. The survey identified 144 agencies that provide behavioral health (either mental health, substance use, or both) services to children and youth, representing 51% of the agencies responding to the survey. These 144 agencies were the population of focus for this report.

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

For more information, please refer to the [full report](#).

Section 3: Emergency department visit follow-up for behavioral health crises

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

Definition of unmet need for timely follow-up care after an ED visit: The definitions for these metrics come from four HEDIS (Healthcare Effectiveness Data and Information Set) measures that track care after

a child or youth is seen in the ED for a SUD or mental health disorder symptom presentation. More information about the definition of these measures is available at these links from the National Committee for Quality Assurance (NCQA):

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

Section 4: Eating disorder diagnoses, treatment, and providers

Eating disorder diagnoses

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

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

Definition of eating disorder: The following ICD-10 codes were used to define a diagnosis of an eating disorder within paid claims/accepted encounter data.

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

Eating disorder treatment

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

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

Mental health treatment services: broadly, this category is understood to include outpatient mental health services, mental health crisis services, and other mental health services. However, the complexities of the current value subsets for this concept were too complicated to be summarized for this report. Readers should refer to the [measure definition](#) and relevant value subsets within the [MHRS Value Set](#) (Excel file download).

Section 5: Perinatal behavioral health need and unmet need

Mental health need and unmet need

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

Population: all pregnant individuals (10-64 years) enrolled in Apple Health for at least 11 months during 2023. See the [Apple Health eligibility groups](#) at the end of this appendix for more detailed information about how enrollment in Apple Health is defined.

Definition of need and unmet need for mental health treatment: These metrics are calculated using the [mental health treatment rate](#). [View a full definition of this metric](#).

- **Mental health need** is defined when an individual has any of the following within their paid claims/accepted encounter data.
 - certain mental health **disorders**,
 - certain mental health **concerns**,
 - receipt of certain mental health **treatment services**, or
 - receipt of certain mental health **medications**.
- **Need is considered to be met** if an individual of the following within their paid claims/accepted encounter data.
 - certain mental health **treatment services** or
 - certain mental health **medications**.

Individuals with identified need who have not received any these treatment services or medications would be considered to have unmet need.

Definitions of each of these components are outlined fully in the [measure definition](#) and [value set](#), and are summarized here.

- **Mental health disorders** include
 - Anxiety disorders (including obsessive-compulsive disorders)
 - Attention deficit and hyperactivity disorders
 - Bipolar and manic disorders
 - Conduct disorders
 - Depressive disorders
 - Dissociative and conversion disorder
 - Eating disorders
 - Impulse disorders
 - Obsessive-compulsive disorders

Behavioral health access and network adequacy for children and youth (prenatal – age 25)

December 1, 2024

Page | 62

- Personality disorders
- Somatoform disorders
- Stress, trauma, and adjustment disorders

For more information, please refer to the “MI Diagnosis” value subset within the [MHRS Value Set](#) (Excel file download).

- **Mental health concerns**, primarily include incidents of self-harm. For more information, please refer to the “MI Diagnosis” value subset within the [MHRS Value Set](#) (Excel file download).
- **Mental health treatment services**: broadly, this category is understood to include outpatient mental health services, mental health crisis services, and other mental health services. However, the complexities of the current value subsets for this concept were too complicated to be summarized for this report. Readers should refer to the measure definition and relevant value subsets within the [MHRS Value Set](#) (Excel file download).
- **Mental health medications**: please refer to the full list of medications by National Drug Code (NDC) in the “Psychotropic-NDC-5mcgs” value subset within the [MHRS Value Set](#) (Excel file download).

Substance use need and unmet need

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

Population: all pregnant individuals (10-64 years) enrolled in Apple Health for at least 11 months during 2023. See the [Apple Health eligibility groups](#) at the end of this appendix for more detailed information about how enrollment in Apple Health is defined.

Definition of need and unmet need for substance-use treatment: These metrics are calculated using the [substance-use treatment rate](#). [View a full definition of this metric](#).

- **Substance use need** is defined when an individual has any of the following within their paid claims/accepted encounter data.
 - certain substance use **disorders**,
 - certain substance use **concerns**,
 - certain **services** to address substance use concerns
 - certain substance-use **treatment services**, or
 - certain substance-use **medications**.
- **Need is considered to be met** if an individual of the following within their paid claims/accepted encounter data.
 - certain substance-use **treatment services**, or
 - certain substance-use **medications**.

Individuals with identified need who have not received any **treatment services** or **medications** would be considered to have unmet need.

Definitions of each of these components are outlined fully in the [measure definition](#) and [measure value set](#), and are summarized here.

- **Substance use disorders** include
 - Alcohol related disorders
 - Opioid related disorders
 - Cannabis related disorders
 - Sedative related disorders
 - Cocaine related disorders
 - Other stimulant related disorders
 - Hallucinogen related disorders
 - Inhalant related disorders
 - Other psychoactive substance related disorders

For more information, please refer to the “SUD-Dx-Value-Set” within the [SUD TX Rate Value Set](#).

- **Substance use concerns** include
 - incidents of overdose,
 - substance use complicating pregnancy or that causes damage to the fetus, and
 - alcoholic liver diseases.

For more information, please refer to the “SUD-Dx-Value-Set” value subset within the [SUD TX Rate Value Set](#).

- **Services to address substance use concerns** (which are not considered treatment services) include
 - Screening, Brief Intervention, and Referral to Treatment (SBIRT), and
 - withdrawal management (sometimes called “detox.”)

For more information, please refer to the “SBIRT-Proc-Value-Set (3169)” and “Detox-Value-Set” value subsets within the [SUD TX Rate Value Set](#).

- **Substance-use treatment services and medications** include:
 - **Medication for Opiate Use Disorder (MOUD)** and **Medication for Alcohol Use Disorder (MAUD)** services and medications (refer to “MOUD-MAUD-Value Set” and “MOUD-Procedure-Value-Set” within the [SUD TX Rate Value Set](#)).
 - **Peer services** (refer to “Proc-w-any-SUD-Dx (4881)” within the [SUD TX Rate Value Set](#))
 - **Outpatient services** (i.e., ASAM Level 1 and 2.1) (refer to “Proc-w-any-SUD-Dx (4881)” and “SUD-OP-Tx-Proc-Value-Set (3156)” within the [SUD TX Rate Value Set](#))
 - **Opioid Treatment Programs** (refer to “SUD-OST-Value-Set (MCG 3148)” within the [SUD TX Rate Value Set](#)).

- **Recovery services** (refer to “SUD-OP-Tx-Proc-Value-Set (3156)” within the [SUD TX Rate Value Set](#))
- **Residential services:** intensive, long-term, and recovery house (i.e., ASAM Level 3.1, 3.3, and 3.5) (refer to “SUD-OP-Tx-Proc-Value-Set (3156)” within the [SUD TX Rate Value Set](#))
- **Sobering services** (refer to “Proc-w-any-SUD-Dx (4881)” within the [SUD TX Rate Value Set](#))
- **Any service provided by a substance use disorder specialty provider** (refer to “SUD-Taxonomy-Value-Set (3170)”) **specifically to address a substance use disorder or qualified substance use concern** (i.e., must have a principal diagnosis from the “SUD-Dx-Value-Set”), **except assessment services** (refer to “SUD-ASMT-Value-Set (3149)” within the [SUD TX Rate Value Set](#))

Apple Health eligibility groups

This table outlines which Apple Health eligibility groups are included in the Apple Health population referenced in this report.

Table 1: Apple Health eligibility groups

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

Appendix B: Additional data tables

Section 1: Behavioral health need and unmet need for children, youth, and young adults

Table 1: Apple Health-enrolled children, youth, and young adults (0–25 years) who had an identified need for mental health (MH) treatment in 2023, by age, gender, and race/ethnicity

Category	% with a MH treatment need	# with a MH treatment need	# all Apple Health clients
All individuals 0-25 years	29%	246,564	848,086
AGE			
0-5 years	11%	20,772	197,826
6-12 years	25%	70,954	282,757
13-17 years	42%	83,293	199,015
18-25 years	42%	71,545	168,488
GENDER			
Female	31%	133,555	425,016
Male	27%	113,009	423,070
RACE/ETHNICITY			
American Indian/Alaska Native	33%	13,043	39,899
Asian	21%	7,792	36,343
Black/African American	26%	21,088	80,827
Hispanic or Latino	27%	78,107	285,355
Native Hawaiian/Pacific Islander	18%	6,980	38,802
White alone, Non-Hispanic	36%	109,210	307,112
Unknown	21%	18,435	88,662

Table 2. Apple Health-enrolled youth and young adults (13–25 years) who had an identified need for substance use disorder (SUD) treatment in 2023, by age, gender, and race/ethnicity

Category	% with a need for SUD treatment	# with a need for SUD treatment	# of all Apple Health clients
All individuals age 13-25	6%	23,264	367,503
AGE			
13-17 years	3%	6,769	199,015
18-25 years	10%	16,495	168,488
GENDER			
Female	7%	12,748	190,539
Male	6%	10,516	176,964
RACE/ETHNICITY			
American Indian/Alaska Native	12%	2,189	17,536
Asian	2%	379	17,170
Black/African American	8%	2,528	33,510
Hispanic or Latino	5%	6,722	128,515
Native Hawaiian/Pacific Islander	4%	598	15,463
White alone, non-Hispanic	8%	10,784	137,636
Unknown	4%	990	28,278

Table 3: Mental health (MH) treatment rate for Apple Health-enrolled children, youth, and young adults (0–25 years) in 2023, by age, gender, and race/ethnicity

Category	% with a need for MH treatment, who received any MH treatment	# with a need for MH treatment, who received any MH treatment	# who needed MH treatment
All individuals age 0-25	64%	158,522	246,564
AGE			
0-5 years	60%	12,385	20,772
6-12 years	70%	49,502	70,954
13-17 years	67%	56,017	83,293
18-25 years	57%	40,618	71,545
GENDER			
Female	65%	86,197	133,555
Male	64%	72,325	113,009
RACE			
American Indian / Alaska Native	66%	8,551	13,043
Asian	60%	4,685	7,792
Black / African American	62%	13,092	21,088
Hispanic or Latino	61%	47,740	78,107
Native Hawaiian/Pacific Islander	59%	4,143	6,980
White alone, non-Hispanic	68%	74,002	109,210
Unknown	62%	11,490	18,435

Table 4: Substance use disorder (SUD) treatment rate for Apple Health-enrolled children, youth, and young adults (13–25 years) in 2023, by age, gender, and race/ethnicity

Category	% with a need for SUD treatment, who received any SUD treatment	# with a need for SUD treatment, who received any SUD treatment	# who needed SUD treatment
All individuals age 13-25	25%	5,884	23,264
AGE			
13-17 years	27%	1,823	6,769
18-25 years	25%	4,061	16,495
GENDER			
Female	22%	2,810	12,748
Male	29%	3,074	10,516
RACE/ETHNICITY			
American Indian / Alaska Native	33%	722	2,189
Asian	19%	71	379
Black / African American	22%	545	2,528
Hispanic or Latino	25%	1,667	6,722
Native Hawaiian/Pacific Islander	23%	136	598
White alone, non-Hispanic	26%	2,753	10,784
Unknown	24%	238	990

Section 2: Network adequacy for youth-serving behavioral health providers

Table 5. Individual mental health providers serving youth and accepting new clients, by quarter and managed care organization in 2023

Year Qtr	MCO	Total # of Providers	# Serving Youth	% Serving Youth	# Serving Youth & Accepting New Clients	% Serving Youth & Accepting New Clients
2023 Q1	CCWF	8,137	223	3%	223	100%
2023 Q2	CCWF	7,621	201	3%	201	100%
2023 Q3	CCWF	3,855	147	4%	147	100%
2023 Q4	CCWF	4,331	156	4%	156	100%
2023 Q1	CCWM	8,121	223	3%	223	100%
2023 Q2	CCWM	7,348	197	3%	197	100%
2023 Q3	CCWM	3,807	145	4%	145	100%
2023 Q4	CCWM	4,280	154	4%	154	100%
2023 Q1	CHPW	6,746	5,921	88%	5,449	92%
2023 Q2	CHPW	6,668	5,860	88%	5,323	91%
2023 Q3	CHPW	6,149	5,395	88%	4,877	90%
2023 Q4	CHPW	6,910	5,999	87%	5,461	91%
2023 Q1	MHW	6,613	2,321	35%	1,238	53%
2023 Q2	MHW	6,316	2,178	35%	1,190	55%
2023 Q3	MHW	6,907	2,408	35%	1,298	54%
2023 Q4	MHW	6,868	2,400	35%	1,332	56%
2023 Q1	UHC	3,381	2,640	78%	2,435	92%
2023 Q2	UHC	4,448	3,464	78%	3,242	94%
2023 Q3	UHC	4,518	3,528	78%	3,307	94%
2023 Q4	UHC	4,422	3,436	78%	3,268	95%
2023 Q1	WLP	6,821	81	1%	63	78%
2023 Q2	WLP	7,008	26	0%	13	50%
2023 Q3	WLP	7,288	23	0%	12	52%
2023 Q4	WLP	6,465	19	0%	9	47%

Table 6. Substance use disorder facilities serving youth and accepting new clients, by quarter and managed care organization in 2023

Year Qtr	MCO	Total # of Providers	# Serving Youth	% Serving Youth	# Serving Youth & Accepting New Clients	% Serving Youth & Accepting New Clients
2023 Q1	CCWF	244	126	52%	126	100%
2023 Q2	CCWF	243	126	52%	126	100%
2023 Q3	CCWF	243	126	52%	126	100%
2023 Q4	CCWF	220	114	52%	114	100%
2023 Q1	CCWM	244	126	52%	126	100%
2023 Q2	CCWM	243	126	52%	126	100%
2023 Q3	CCWM	243	126	52%	126	100%
2023 Q4	CCWM	220	114	52%	114	100%
2023 Q1	CHPW	218	115	53%	114	99%
2023 Q2	CHPW	239	140	59%	139	99%
2023 Q3	CHPW	228	131	57%	131	100%
2023 Q4	CHPW	227	131	58%	131	100%
2023 Q1	MHW	213	103	48%	103	100%
2023 Q2	MHW	208	112	54%	112	100%
2023 Q3	MHW	207	109	53%	109	100%
2023 Q4	MHW	202	106	52%	106	100%
2023 Q1	UHC	149	73	49%	73	100%
2023 Q2	UHC	149	73	49%	73	100%
2023 Q3	UHC	149	73	49%	73	100%
2023 Q4	UHC	147	72	49%	72	100%
2023 Q1	WLP	201	86	43%	86	100%
2023 Q2	WLP	152	65	43%	65	100%
2023 Q3	WLP	169	70	41%	70	100%
2023 Q4	WLP	151	65	43%	65	100%

Section 3: Emergency department visits follow-up for behavioral health crises

Table 7: Follow-up after mental health (MH) related emergency department (ED) visits in 2023 for Apple Health-enrolled youth and young adults (13–25 years) by age, gender, and race/ethnicity

Category	Received follow-up within 7 days		Received follow-up within 30 days		Had a MH-related ER visit
	%	#	%	#	
All individuals 6-25	66%	2,071	78%	2,452	3,145
AGE					
6-12 years	69%	354	81%	414	514
13-17 years	68%	941	82%	1,132	1,385
18-25 years	62%	776	73%	906	1,246
GENDER					
Male	68%	1,323	80%	1,558	1,959
Female	63%	748	75%	894	1,186
RACE/ETHNICITY					
American Indian/Alaska Native	63%	152	73%	178	243
Asian	65%	40	71%	44	62
Black/African American	64%	260	76%	306	404
Hispanic/Latino	62%	492	75%	593	795
Native Hawaiian/Pacific Islander	67%	55	74%	61	82
White alone, non-Hispanic	69%	1052	81%	1237	1524
Unknown	62%	103	79%	130	165

Table 8: Follow-up after substance use disorder (SUD) related emergency department (ED) visits in 2023 for Apple Health-enrolled children, youth, and young adults (6–25 years) by age, gender, and race/ethnicity

Category	Received follow-up within 7 days		Received follow-up within 30 days		Had a SUD-related ER visit
	%	#	%	#	
All individuals 13-25	18%	431	28%	681	2,452
AGE					
13-17 years	21%	156	33%	251	757
18-25 years	16%	275	25%	430	1,695
GENDER					
Male	16%	191	27%	311	1,169
Female	19%	240	29%	370	1,283
RACE/ETHNICITY					
American Indian/Alaska Native	15%	38	23%	57	251
Asian	*	*	*	*	33
Black/African American	16%	51	27%	84	315
Hispanic/Latino	17%	125	27%	194	721
Native Hawaiian/Pacific Islander	18%	12	23%	15	66
White alone, non-Hispanic	18%	197	29%	317	1,081
Unknown	16%	15	29%	27	94

Section 4: Eating disorder diagnoses, services, and providers

Table 9: Number and percentage of Apple Health-enrolled children, youth, and young adults (0–25 years) with eating disorder diagnoses in 2023

Category	% with eating disorder diagnosis	# with eating disorder diagnosis	All Apple Health clients
All individuals age 0-25	0.8%	9,772	1,294,233
AGE			
0-5 years	0.6%	1,729	303,675
6-12 years	0.4%	1,426	381,598
13-17 years	1.3%	3,598	268,746
18-25 years	0.9%	3,019	340,214
GENDER			
Female	1.1%	7,017	650,637
Male	0.4%	2,753	643,268
RACE/ETHNICITY			
American Indian/Alaska Native	0.8%	1,179	156,580
Asian	0.9%	852	91,318
Black/African American	0.7%	643	97,342
Hispanic or Latino	0.8%	3,242	419,928
Native Hawaiian/Pacific Islander	0.5%	408	83,775
White alone, non-Hispanic	0.9%	4,076	477,870
Unknown	0.4%	317	88,062

Table 10: Number and percentage of Apple Health-enrolled children, youth, and young adults (0–25 years) with eating disorder diagnoses who received any mental health (MH) treatment services in 2023, by age, gender, and race/ethnicity

Category	% with eating disorder diagnosis who received MH services	# with eating disorder diagnosis who received MH services	# with eating disorder diagnosis
All individuals ages 0-25	79%	7,679	9,772
AGE			
0-5 years	38%	651	1,729
6-12 years	73%	1,044	1,426
13-17 years	92%	3,291	3,598
18-25 years	89%	2,693	3,019
GENDER			
Female	84%	5,901	7,017
Male	65%	1,776	2,753
RACE/ETHNICITY			
American Indian/Alaska Native	82%	696	1,179
Asian	80%	512	852
Black/African American	75%	879	643
Hispanic or Latino	76%	2,454	3,242
Native Hawaiian/Pacific Islander	78%	318	408
White alone, non-Hispanic	83%	3,378	4,076
Unknown	55%	174	317

Section 5: Perinatal behavioral health need and unmet need

Table 11: Apple Health-enrolled pregnant individuals who had an identified need for mental health (MH) treatment in 2023, by age and race/ethnicity

Category	% with a MH treatment need	# with a MH treatment need	# of all Apple Health clients
All pregnant individuals	56%	26,155	46,445
AGE			
10-17 years	62%	612	988
18-25 years	56%	8,088	14,355
26-39 years	56%	15,320	27,508
40-64 years	59%	2,135	3,594
RACE/ETHNICITY			
American Indian/Alaska Native	66%	1,497	2,272
Asian	43%	748	1,726
Black/African American	52%	2,504	4,776
Hispanic or Latino	53%	7,753	14,507
Native Hawaiian/Pacific Islander	40%	953	2,392
White alone, Non-Hispanic	63%	12,355	19,751
Unknown	46%	1,020	2,206

Table 12: Apple Health-enrolled pregnant individuals who had an identified need for substance use disorder (SUD) treatment in 2023, by age and race/ethnicity

Category	% with a need for SUD treatment	# with a need for SUD treatment	# of all Apple Health clients
All pregnant individuals	17%	8,045	46,413
AGE			
10-17 years	17%	167	956
18-25 years	15%	2,206	14,355
26-39 years	17%	4,790	27,508
40-64 years	25%	882	3,594
RACE/ETHNICITY			
American Indian/Alaska Native	34%	780	2,271
Asian	7%	118	1,725
Black/African American	18%	849	4,773
Hispanic or Latino	10%	1,393	14,495
Native Hawaiian/Pacific Islander	8%	199	2,390
White alone, non-Hispanic	24%	4,778	19,737
Unknown	8%	171	2,205

Table 13: Mental health (MH) treatment rate for Apple Health-enrolled pregnant individuals in 2023, by age and race/ethnicity

Category	% with a need for MH treatment, who received any MH treatment	# with a need for MH treatment, who received any MH treatment	# who needed MH treatment
All pregnant individuals	57%	14,991	26,155
AGE			
10-17 years	67%	411	612
18-25 years	57%	4,578	8,088
26-39 years	58%	8,818	15,320
40-64 years	56%	1,184	2,135
RACE			
American Indian / Alaska Native	56%	838	1,497
Asian	53%	393	748
Black / African American	54%	1,351	2,504
Hispanic or Latino	60%	4,660	7,753
Native Hawaiian/Pacific Islander	52%	497	953
White alone, non-Hispanic	57%	7,053	12,355
Unknown	56%	569	1,020

Table 14: Substance use disorder (SUD) treatment rate for Apple Health-enrolled pregnant individuals in 2023, by age and race/ethnicity

Category	% with a need for SUD treatment, who received any SUD treatment	# with a need for SUD treatment, who received any SUD treatment	# who needed SUD treatment
All pregnant individuals	33%	2,673	8,045
AGE			
10-17 years	19%	31	167
18-25 years	17%	371	2,206
26-39 years	41%	1,943	4,790
40-64 years	37%	328	882
RACE/ETHNICITY			
American Indian / Alaska Native	42%	325	780
Asian	20%	24	118
Black / African American	23%	199	849
Hispanic or Latino	27%	369	1,393
Native Hawaiian/Pacific Islander	20%	39	199
White alone, non-Hispanic	36%	1,736	4,778
Unknown	27%	46	171