Washington State Health Care Authority

Report to the Legislature

Behavioral health outcomes

2021-22 Integrated Managed Care Data

Engrossed Substitute Senate Bill 5187; Section 215(35); Chapter 475; Laws of 2023

December 30, 2023

Behavioral health outcomes

Acknowledgements

Generating HCA's first submission of the legislatively mandated behavioral heatlh outcomes report has revealed numerous opportunities for HCA to continuously improve data acquisition and analysis regarding behavioral health outcomes for Integrated Managed Care (IMC). Many thanks to HCA's partners for helping produce this report. Their guidance regarding the report's contents will be vital as efforts to develop and improve behavioral health outcome metrics and data acquisition for IMC and beyond continue to evolve at HCA.

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Executive summary

The Health Care Authority (HCA) is submitting this report in response to ESSB 5187; Section 215(35); Chapter 475; Laws of 2023:

> The authority shall seek input from representatives of the managed care organizations (MCOs), licensed community behavioral health agencies, and behavioral health administrative service organizations (BH-ASOs) to develop specific metrics related to behavioral health outcomes under integrated managed care (IMC). These metrics must include, but are not limited to:
>
> a) Revenues and expenditures for community behavioral health programs, including Medicaid and non-Medicaid funding;
> b) access to services, service denials, and utilization by state plan modality;
> c) claims denials and record of timely payment to providers;
> d) client demographics; and
> e) social and recovery measures and managed care organization performance measures.
>
> The authority must work with managed care organizations and behavioral health administrative service organizations to integrate these metrics into an annual reporting structure designed to evaluate the performance of the behavioral health system in the state over time. The authority must submit a report to the office of financial management and the appropriate committees of the legislature, before December 30th of each year during the fiscal biennium, that details the implemented metrics and relevant performance outcomes for the prior calendar year.

This report contains metrics in accordance with the legislative directive for the calendar years 2021 and 2022. This report represents the first version in which data is being reported. Based on feedback from the stakeholder efforts, all data presented in this report was acquired from existing sources and reports throughout the agency.

Drawing connections and trends based on this version of the report – the first submission containing data – remains challenging. HCA has attempted to provide some analysis for each metric while offering insight into the performance of managed care programs and managed behavioral health care services via Comagine Health's Comparative Analysis report.

As a baseline is established, the agency will continue to evaluate and refine the data reporting metrics over time, based on stakeholder feedback. Within this report, you will see clear evidence that there is continued system improvement needed, acknowledging this first reporting period represents the unprecedented time of a public health emergency and behavioral health workforce crisis. HCA staff will continue to act as appropriate through program oversight to address concerns and work toward meaningful system design improvements.

Additionally, the years incorporated in this report were heavily impacted by system disruptions, workforce shortages, and societal unease during the COVID-19 public health emergency. These impacts further complicate any conclusions that might be drawn from this report.

Background

Legislative History

During the 2021-22 biennium, a proviso was added to the Community Behavioral Health section of the HCA budget. That proviso outlined requirements for HCA to develop a legislative report addressing revenues and expenditures for community behavioral health programs, including data on social and recovery measures and MCO performance measures. After the submission of HCA's initial response, Washington's Legislature clarified their directive in a subsequent proviso which stated HCA must collaborate with MCOs, BH-ASOs, and licensed community behavioral health agencies to develop specific metrics related to behavioral health outcomes. The following metrics must be included in the report:

- Revenues and expenditures for community behavioral health programs, including Medicaid and non-Medicaid funding.
- Access to services, service denials, and utilization by state plan modality.
- Claims denials and record of timely payment to providers.
- Client demographics; and
- Social and recovery measures and managed care organization performance measures.

HCA was also directed to work with MCOs and BH-ASOs to integrate these metrics into an annual reporting structure designed to evaluate the performance of the behavioral health system in the state over time.

First report submission in June 2023

Partnerships

HCA collaborated internally and consulted behavioral health providers, MCOs, Tribal leaders, and other external partners before producing the first legislatively mandated report: Behavioral Health Outcomes: An Overview of Metrics for Future Reporting. While feedback from HCA's partners regarding the proposed reporting format and metrics was primarily positive, provider and MCO representatives stressed that implementing new metrics would not be welcome due to the current administrative burden they experience when obtaining and submitting behavioral health outcome data.

Feedback from Tribes and HCA's Office of Tribal Affairs (OTA) also initiated considerations for including fee-for-service (FFS) data in the new legislatively mandated report. HCA plans to expand the scope of the behavioral health outcomes report to include FFS data in future iterations of the annual report with the aim of strengthening the agency's work to develop inclusive, holistic services for everyone. Moving forward, HCA plans to internally map the architecture of FFS data to ensure gaps in data acquisition are addressed. This process will include identifying areas where HCA can support the improvement of FFS data systems and reporting mechanisms.

Reporting metrics

HCA's initial report offered the Legislature an overview of the reporting format and metrics that HCA currently acquires from existing sources, such as revenue and expenditure reports, service encounter data submitted by MCOs and BH-ASOs, and performance measure data reported by DSHS Research and Data Analysis (RDA). To review a map of reporting metrics, including the origin of data presented in this report, see Appendix A.

While no new behavioral health outcome metrics were implemented for the first data report, HCA is committed to generating an annual report that offers the Legislature and the agency's external partners insightful behavioral health outcome data. HCA also aims to continue improving the acquisition of utilization, service access, social and recovery measures, MCO performance measures, and others. HCA staff will continue collaborating with MCOs, BH-ASOs, Tribes, and licensed community providers to improve HCA's annual behavioral health outcomes report so that it offers a holistic view of behavioral health outcomes across all Apple Health enrollees.

Findings

This report will contain metrics per the legislative directive for the calendar years 2021 and 2022. The data presented in this report originates from existing sources. To review the origin of each metric below, see Appendix A.

Behavioral health service providers have up to a year from the date of service to submit claims, thus the most recent calendar year reported – 2022 – may not be fully mature. As this report evolves, metrics will be annualized once matured for inclusion in subsequent reporting.

Revenues and expenditures for community behavioral health programs

See Appendix B for data on revenues and expenditures relating to community behavioral health programs.

Medicaid

The Milliman Index is a financial data resource that uses Managed Care encounter data to help identify and set service reimbursement rates. Actuarial services and data provided by Milliman help HCA develop actuarially sound capitation rates for Apple Health Managed Care programs. Revenue, expenditure, and behavioral health service utilization metrics are provided in Milliman's data book and appendices.

When HCA reports Medicaid revenue and expenditure data, utilization data is also provided for mental health and substance use disorder (SUD) inpatient admits per 1,000 males ages 19 – 64 and 1,000 females ages 19 – 64; ultimately, offering readers insight into amounts spent and earned in relation to where services are being used.

MCOs contract with the Medicaid State Agency (HCA) to provide covered services to Medicaid beneficiaries. The contractual agreement includes premiums paid on a per member per month basis. Then, MCOs contract with providers who serve their enrolled individuals. The data reflected in this report are the compilation of the payments to contractors, which incorporates the date of service and expenditures related to those services. This same data is also used to calculate admits per 1,000 and utilization per 1,000 along with Member Months (MMs). MMs are the number of individuals participating in the plan each month and are useful in developing budgets.

BH-ASO non-Medicaid

Washington is broken up into ten health care purchasing regions. HCA contracts with a Behavioral Health Administrative Service Organization (BH-ASO) in each region. The BH-ASO then contracts with providers for crisis and other services to anyone within the region who is experiencing a mental health or substance use disorder (SUD) challenge, regardless of income or insurance. BH-ASOs also provide some services to low-income, uninsured, and or individuals not eligible for Apple Health, within available resources. The expenditures related to these contracts were used to aggregate the data provided in the tables. BH-ASOs also manage block grants, the Criminal Justice Treatment Account (CJTA), and the Dedicated Cannabis Account (DCA). These non-Medicaid services are reported to HCA through quarterly reports listing revenue and expenditures.

Access to services

Finding comprehensive, non-burdensome ways of measuring timely access to services continues to be an area of challenge for HCA, contractors, and providers alike. HCA has held focus groups, researched processes used by other states, and sought technical assistance to find better approaches.

Per section 6.9.4 of the IMC contract, non-urgent, symptomatic (i.e., routine care) office visits shall be available from the Enrollee's Primary Care Provider (PCP) or another provider within ten (10) calendar days, including behavioral health services from a behavioral health provider. A non-urgent, symptomatic visit is associated with the presentation of medical signs not requiring immediate attention. For more information, visit HCA's model managed care contracts page. Per HCA's IMC contract with MCOs (section 1.156), intake evaluations or assessments for routine behavioral health (non-crisis) services should be initiated within ten (10) business days of a request for services. Intake evaluations are used to determine the best course of treatment and shall be completed within thirty (30) business days.

No clear strategies have been identified that create parity between administrative data collection requirements for physical health and behavioral health providers, nor any methodology that can be systematically applied across provider types and facility types.

While it does not provide a holistic perspective of access, HCA's Service Encounter Reporting Instructions (SERI), it does require outpatient behavioral health providers to submit "request for service" encounters when an individual who is not currently receiving services seeks non-crisis services. Using this request for service data point, HCA can measure median and average wait times it takes for an individual to get their first intake appointment. Although data accuracy and completeness are ongoing areas for improvement, HCA can show average and median wait times, when data is available. Note that when a request for service encounter is missing, HCA is not able to include this in the reporting.

HCA continues to partner with MCOs and providers on strategies to improve reliable acquisition of access to service data. Outside of what is collected for new individuals requesting behavioral health services, HCA relies on survey results, administered by the MCO-collective, to understand behavioral health access across the state. HCA also uses complaints, grievances, and anecdotal information as a primary method for monitoring access concerns.

See Appendix C for data relating to access to services.

Service denials

MCOs

For MCOs, a service may only be denied, or determined to be an adverse benefit (42 C.F.R. § 438.400(b)), if the MCO or HCA has determined that the service does not meet medical necessity per clinical criteria or is not a covered benefit. At the time of any adverse determination, an individual, provider, and facility seeking services must be notified of the adverse benefit determination in writing. If the service is non-contracted, but covered by HCA, directions for obtaining services through HCA must be provided by an MCO to an individual so they can coordinate and receive those services. Service authorization determinations are to be made and notices provided as expeditiously as the enrollee's health condition requires.

MCOs must decide to approve, deny, or request additional information from a service provider within five calendar days of the original receipt of the request. If additional information is required and requested, MCOs must give the provider five calendar days to submit the information and then approve or deny the

request within four calendar days of the receipt of the additional information. Under certain circumstances, 14 additional calendar days but no more than 28 is allowed (42 C.F.R. § 438.210(d)). For service authorization decisions not reached during this amount of time, Notices of Adverse Benefit Determinations must be provided no later than the date that the timeframes expire.

The MCOs provide education and ongoing guidance and training to individuals and providers about its Utilization Management (UM) protocols and UM criteria, including the American Society of Addiction Medicine Criteria for Substance Use Disorder services for admission, continued stay, and discharge criteria. The MCOs must have in effect mechanisms to ensure consistent application of UM review criteria for authorization decisions. The MCOs must have mechanisms for at least an annual assessment of interrater reliability of all clinical professionals and non-clinical staff involved in UM determinations. The MCOs must consult with the requesting provider when appropriate, prior to issuing an authorization determination.

MCOs submit quarterly reports to HCA, which display data on grievances, adverse determinations, and appeals for Medicaid and non-Medicaid (GFS) services.

MCO service denial data is acquired from quarterly submissions of the Grievance, Appeals, and Independent Review Report, which identifies service denials as adverse benefit determinations.

HCA reviews this information as part of its MCO monitoring. It is also utilized by the External Quality Review Organization.

See Appendix D for data relating to service denials.

Utilization by state plan modality

This report includes several different sources of utilization data.

The Milliman Index is a financial data resource using Managed Care encounter data to help identify and set service reimbursement rates. Actuarial services and data provided by Milliman help HCA develop actuarially sound capitation rates for Apple Health Managed Care programs. Revenue, expenditure, and behavioral health service utilization metrics are provided in Milliman's data book and appendices. Please review the Revenues and Expenditures section of this report, including Appendix B.

HCA collaborates with DSHS/RDA to implement community behavioral health service data into the existing Executive Management Information System (EMIS). For the EMIS, DSHS uses the One Department Data Repository (1DDR) – a centralized, automated, and highly structured repository system for aggregate performance measure data. 1DDR was built primarily to support the EMIS reports, which include regularly reported budget, caseload, and utilization data. The goal is reliable, easily accessible, consistently reported and thoroughly documented data. Because of 1DDR's success in meeting these goals, it has expanded to include other data sets that require similar easy data access, custom reporting, and consistent documentation.

The system currently houses time series data for 8,017 measures, dating back as far as July 1979. These measures include performance indicators, targets, projections, and sub-program or geographic drilldowns for hundreds of DSHS program areas. To review the EMIS platform and create annual reports, click here.

Data presented in Appendix E was acquired via Washington's Behavioral Health Data System (BHDS). Driven by state law and implemented under federal rules, Washington required integration of both mental health (MH) and substance use disorder (SUD) into a behavioral healthcare model. This behavioral

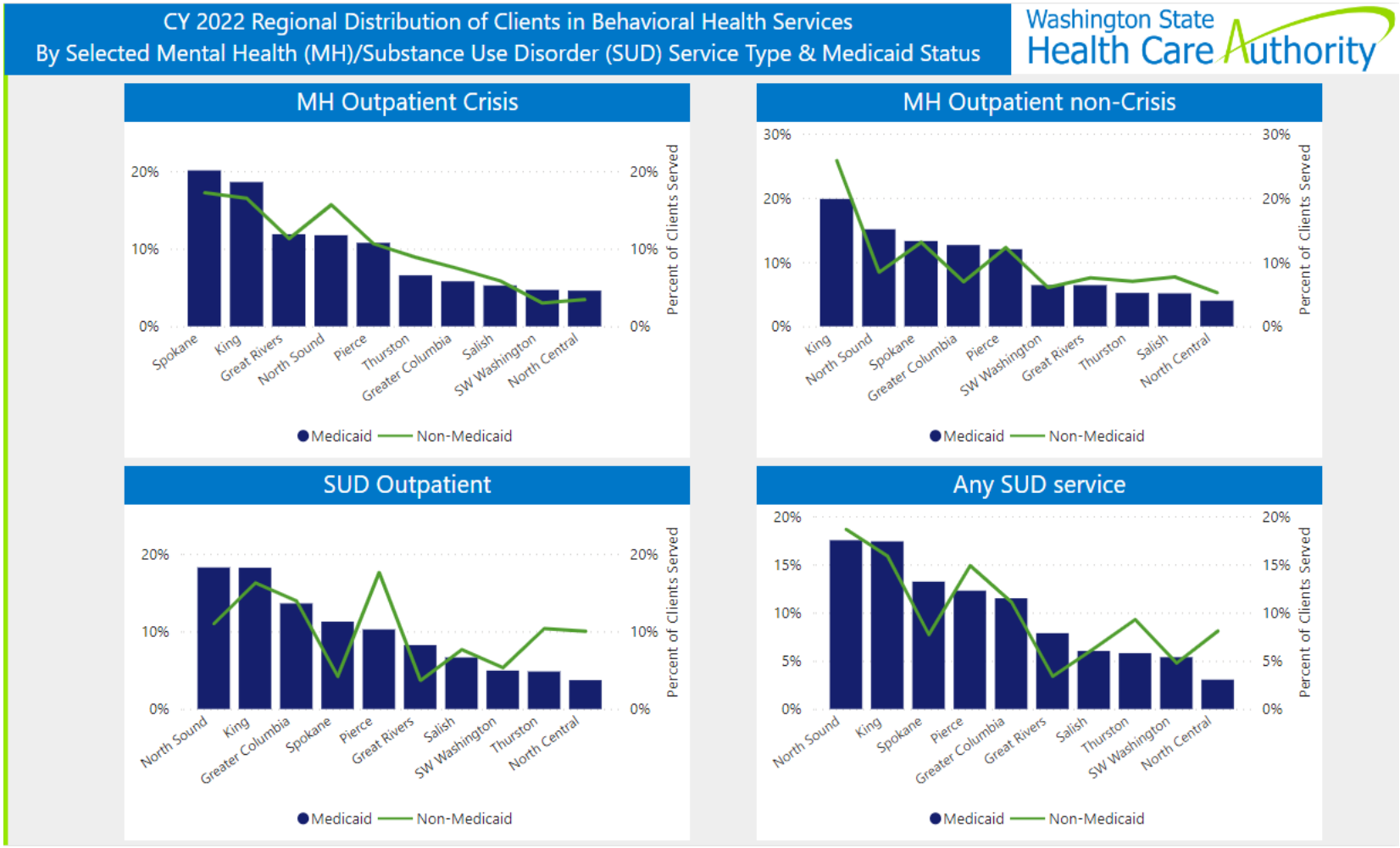
healthcare model was a first step toward a larger integration of behavioral health services with physical healthcare by January 1, 2020, known as Integrated Managed Care (IMC). These innovative changes have also given rise to a change from a fee-for-service to a managed care model for SUD treatment services. The Behavioral Health Data Consolidation (BHDC) project developed and implemented a combined behavioral healthcare model, ultimately incorporating integrated behavioral health data collection, storage, and supporting reporting functions and substance abuse data collection into a database called BHDS. Organizations submitting data to DBHR via BHDS are MCOs and BH-ASOs.

See Appendix E for data relating to utilization by state plan modality.

The graphs on the following page show regional distribution of clients served in behavioral health services by selected MH or SUD service type and client's Medicaid status in calendar year 2022. Overall, varying patterns of regional distribution of clients with Medicaid (blue bar) and non-Medicaid (green line) for most frequently used mental health (MH) and substance use disorder (SUD) services are seen.

- **MH Outpatient Crisis Services:** Among Medicaid clients, Spokane region had the highest share, about 20 percent, followed by King region, Great Rivers and North Sound. However, North Sound region had a much higher share among non-Medicaid clients receiving MH outpatient crisis services along with Spokane and King regions.
- **MH Outpatient Non-Crisis Services:** Among Medicaid clients who received MH outpatient non-crisis services, King region had the highest share, followed by North Sound, and Spokane. Among non-Medicaid clients, King region had the highest share, followed by Spokane and Pierce.
- **SUD Outpatient Services:** North Sound and King Regions had the highest share among Medicaid clients, while Pierce had the highest share of non-Medicaid clients who received SUD outpatient services.
- **Any SUD Service:** North Sound and King Regions each served about 17 percent of Medicaid clients followed by Spokane, while Spokane has a much lower share (about 7 percent) among non-Medicaid clients.

Graph 1: Type of BH services received among Medicaid clients by region



Claims denials and record of timely payment to providers

MCOs submit quarterly claims denial analysis reports to HCA to demonstrate compliance with federal and state claims payment standards.

MCOs must pay or deny, and must require subcontractors to pay or deny, 95 percent of clean claims within thirty (30) calendar days of receipt, 95 percent of all claims within sixty (60) calendar days of receipt and 99 percent of clean claims within ninety (90) calendar days of receipt. The MCO and its providers may agree to a different payment requirement in writing on an individual claim.

Upon submission of a claim, it is determined to be clean, rejected, or denied. A clean claim can result in a paid claim based on the information submitted, or it can be denied after adjudication.

- A "clean claim" is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.
- A "rejected claim" is a claim that was rejected by a payor or clearinghouse due to an incomplete submission.
- A "denied claim" is a claim initially accepted as clean, adjudicated, then payment was denied due to missing or incorrect information, no prior authorization, duplicate claims submission, or other considerations.

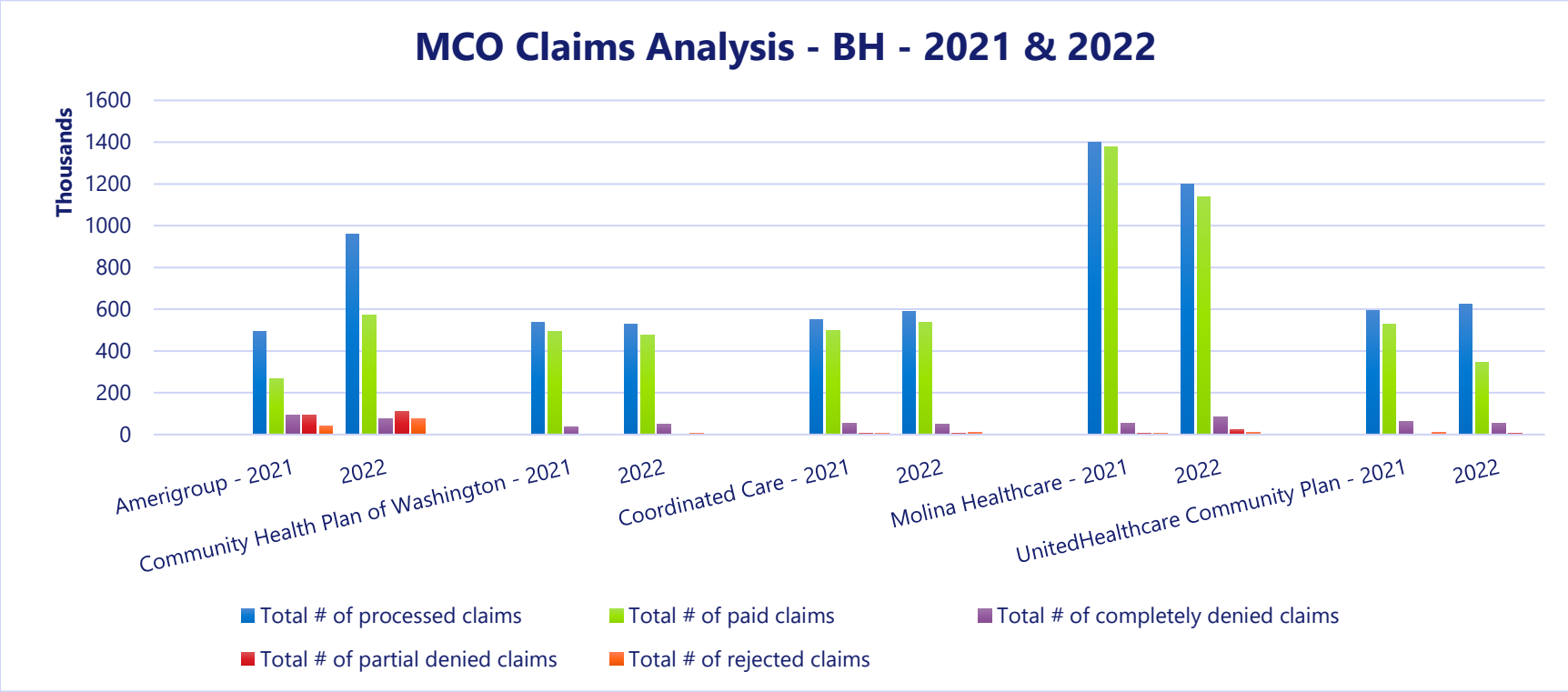
When a BH provider experiences a high percentage of claim rejections or denials, it can be disruptive to a practice as it leads to loss of cash flow and revenue. If this occurs, the MCOs are required to provide training and support to BH providers to resolve encounters or claims not approved in initial submission and identify and resolve repeated errors in encounter submissions and provider billing systems before they become significant and impact additional providers or delay payments for services. In addition to this, the MCOs are to proactively address any other billing issues discovered during the first 180 calendar days of when a BH provider first joins the plan's network or until the denial rate for any affected BH provider is below 10 percent for three consecutive months.

HCA provides oversight and may intervene when a provider's denial rate remains above 10 percent for a period of three months or longer. HCA may require a corrective action plan to address a pattern of incorrectly denied or delayed provider payments when a pattern has been determined to exist.

HCA does not obtain claims denial information from BH-ASOs; therefore, only denials relating to Medicaid Managed Care are displayed below.

Medicaid

Graph 2: 2021 and 2022 BH claims analysis by MCO



Client demographics

The inclusion of client demographics offers HCA an opportunity to perform a variety of disparity analyses concerning behavioral health service outcomes. HCA continues to refine utilization data acquisition and reporting and plans to incorporate utilization data from the BHDS Tableau Dashboard and Executive Management Information System (EMIS) that can be paired with demographic information in future iterations of the behavioral health outcomes report. Until then, ProviderOne encounter data will be used to report demographic data.

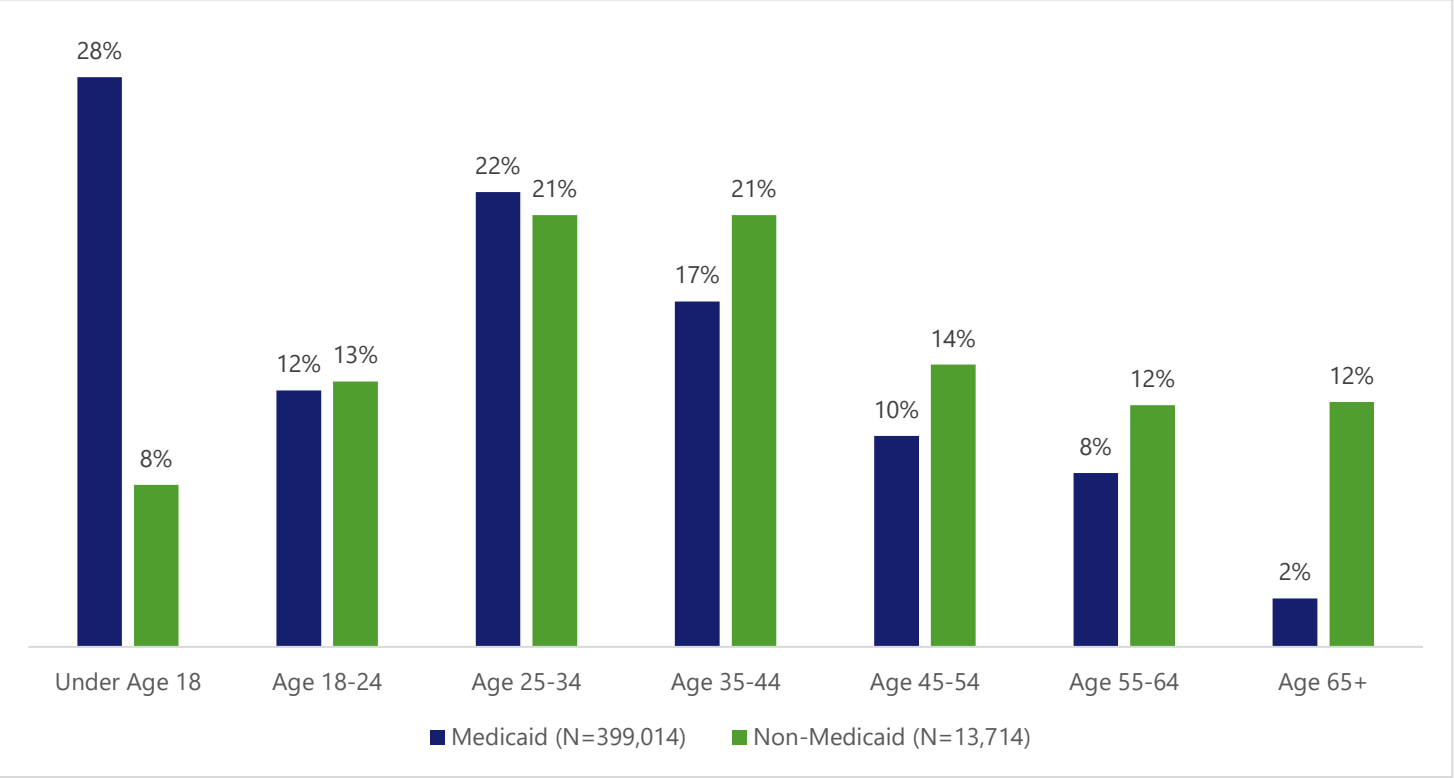
To review current and historical demographic data on Apple Health enrollees, visit HCA's Apple Health Client Dashboard.

See Appendix F to review demographic data acquired via BHDS.

Age

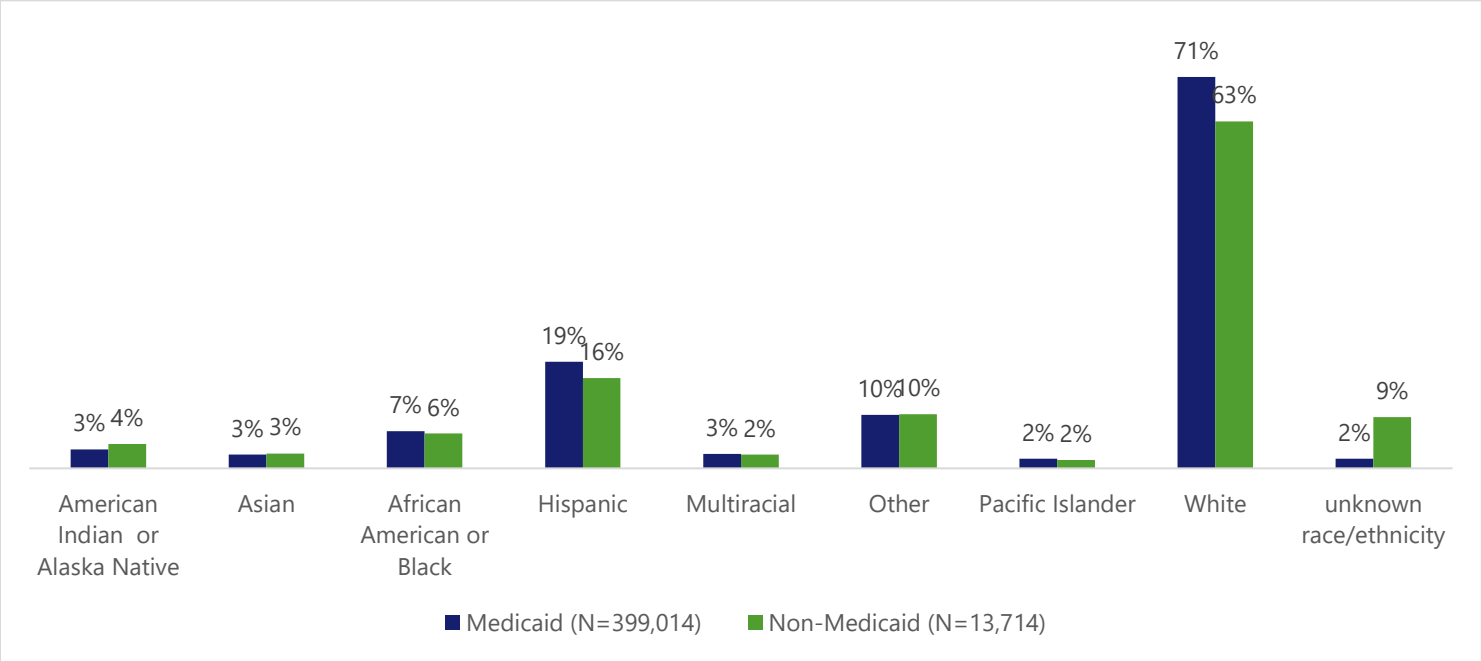
The majority of clients who received Behavioral Health (BH) services in CY 2022 were between age 25-64 regardless of Medicaid status. For Medicaid, 40 percent were under age 25 and 2 percent age 65 or older whereas for the non-Medicaid clients, only 21 percent were under age 25 and 12 percent were age 65 and older.

Graph 3: Age distribution of clients with BH services by Medicaid status, CY 2022



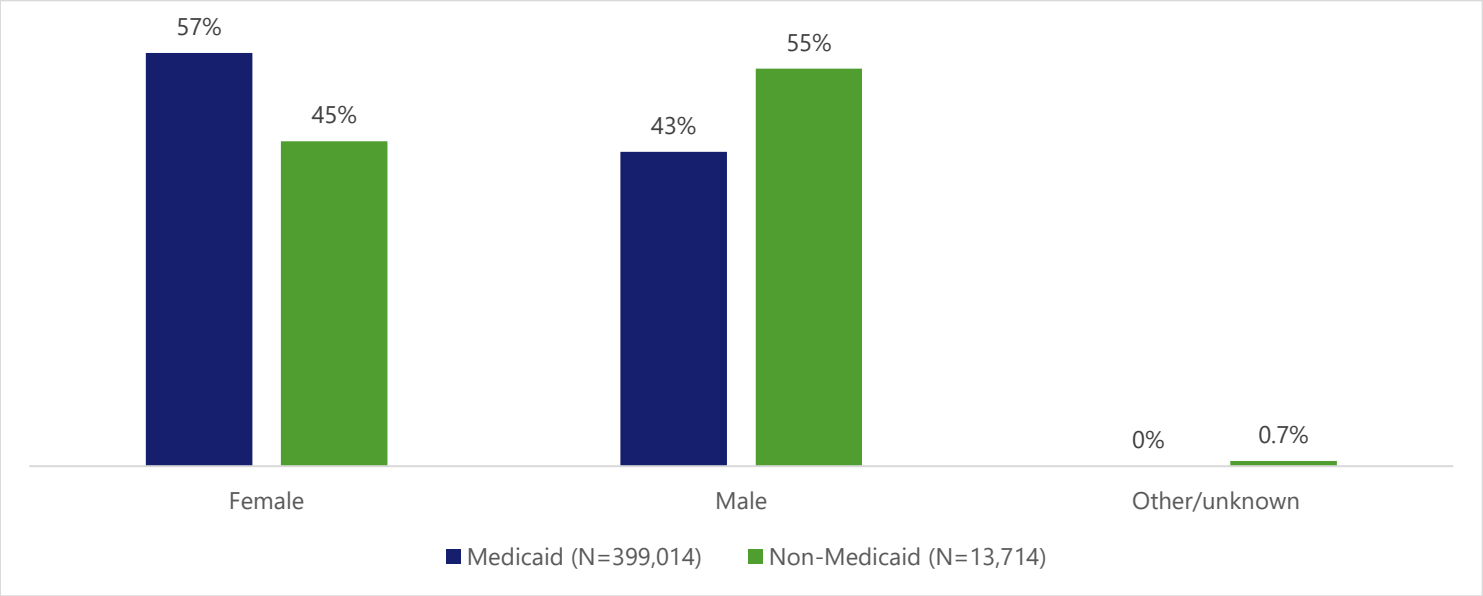
Race and ethnicity

Graph 4: Race/ethnicity of clients with BH services by Medicaid status, CY 2022



Gender

Graph 5: Gender of clients with BH services by Medicaid status, CY 2022



Performance measures

Social and recovery metrics

The Substance Abuse and Mental Health Service Administration (SAMHSA) definition of recovery from behavioral health conditions is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." SAMHSA identifies the following attributes of recovery:

- Health: Overcoming or managing one's disease(s) or symptoms,
- Home: A stable and safe place to live,
- Purpose: Meaningful daily activities, and
- Community: Relationships and social networks.

HCA has a broad data-sharing agreement with DSHS/RDA, which allows HCA to access reports concerning certain social determinants of health (SDOH) and recovery. Some SDOH and aspects of recovery can be directly or indirectly measured with RDA's current set of metrics concerning employment, arrest, homelessness, client satisfaction, measures of treatment adherence, and use of preventative vs. acute and long-term services.

Click links to review metrics:

- Employment Statuses of Washington Apple Health (Medicaid) Clients and Non-Client Individuals with Dependents Who Are Apple Health Clients (calendar year 2021)
- Employment Statuses of Washington Apple Health (Medicaid) Clients and Non-Client Individuals with Dependents Who Are Apple Health Clients (calendar year 2022)
- Living arrangement (homeless broad (HOME-B); homeless narrow (HOME-N), which is Included in the most recent Comparative Analysis report

MCO performance measures

Comagine Health's Comparative Analysis report presents 3-year trends on MCO performance measures, as well as health equity analyses by race/ethnicity, gender, spoken language, and an urban vs. rural comparison. To review Comagine Health's Comparative Analysis report, visit HCA's External Quality Review (EQR) comparative and regional reports page for 2021 and 2022 data. Note: health equity analyses being on page 43 of the report.

Excerpts from the 2022 Comparative and Regional Analysis Report:

> "As of January 1, 2020, the majority of services for Apple Health clients were provided through the MCOs.
>
> Many access measures show a strong shift of improvement, as well as a few of the behavioral health measures. These statistically significant improvements are notable, especially in the context of COVID-19.
>
> - There were two years of statistically significant improvement (between MY2019 and MY2020 and between MY2020 and MY2021) for the following measures:
>
> - Antidepressant Medication Management (AMM) Acute and Continuation Phase measures

- Use of Opioids at High Dosage (HDO)

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: 13-17 Years

While there were measures that showed improvements, there were also measures that demonstrated statistically significant declines. The following measures have declined for the last two years:

- Mental Health Service Rate, Broad Definition (MH-B), 6-64 Years
- Pharmacotherapy for Opioid Use Disorder (POD): 16-64 Years
- Use of Opioids at High Dosage (HDO) (note that a lower rate is better for this measure)

There were measures that showed improvements between MY2019 and MY2020, but then demonstrated a statistically significant decline between MY2020 and MY2021:

- Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total
- Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, 18-64 Years
- Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total
- Substance Use Disorder (SUD) Treatment Rate, 12-64 Years
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Engagement of AOD Treatment: Total"

Comagine Health offered five recommendation areas for Washington to focus in their 2022 Comparative and Regional Analysis Report, including:

1. Sustain improvement in clinically meaningful areas,
2. Continue to leverage Value Based Payment incentives,
3. Address behavioral health declines,
4. Focus on access and preventive care, and
5. Continue to prioritize health equity.

Comagine Health also provided the following insight in the 2022 Comparative and Regional Analysis Report:

"Several behavioral health measures saw significant improvement between MY2019 and MY2020; however, between MY2020 and MY2021 most of these measures either saw no significant change or performance declined significantly. In addition, the statewide Mental Health Service Rate Broad version (MH-B) and the Pharmacotherapy

> for Opioid Use Disorder (POD) measures have declined significantly for the last two years (MY2019 to MY2020 and MY2020 to MY2021). The decline in statewide rates may be due to restrictions put in place at the beginning of the COVID-19 pandemic that limited in-person visits.
>
> Behavioral health metrics show the most variation between the MCOs, both in terms of year-over-year improvements and when compared to benchmarks. This suggests there is the potential for MCOs to improve performance through coordination of care efforts and through adopting best practices. MCOs can also work with providers to leverage telehealth appointments where clinically appropriate. Focused efforts to ensure individuals receive mental health treatment must be a priority for all MCOs."

Comagine Health's 2022 Comparative and Regional Analysis Report suggests there is the potential for MCOs to improve performance through coordination of care efforts and through adopting best practices. MCOs can also work with providers to leverage telehealth appointments where clinically appropriate. Focused efforts to ensure individuals receive mental health treatment must be a priority for all MCOs.

Future metric considerations

As HCA works to improve acquisition and monitoring of behavioral health outcome data, the contents of this report will evolve. The following highlights areas where HCA plans to focus its efforts to improve behavioral health data acquisition and reporting.

Access to services

HCA continues to refine the acquisition and reporting of access to service data. HCA anticipates using bed tracking software to support providers and others with identifying available beds on behalf of persons experiencing crises.[1] Use of this software could support the creation of a variety of metrics (e.g., available capacity by specific behavioral health provider type(s) across regions of the state). Until HCA launches this tracking system, HCA is unable to identify service access metrics for these services.

HCA continues to enhance reporting on access to services. HCA plans to present these metrics in an upcoming submission of the behavioral health outcomes report, once HCA's new Behavioral Health Data Set (BHDS) Tableau Dashboard has been authorized. HCA's BHDS Tableau dashboard is slated for implementation during CY 2025 at the earliest. For information about BHDS, visit the *Utilization by state plan modality section* of this report.

Utilization and client demographics

HCA's BHDS Tableau dashboard will provide insight into client demographic data and will supply behavioral health service utilization data for persons receiving mental health and substance use disorder services. Once implemented, HCA plans to use the BHDS Tableau dashboard for future reporting on behavioral health service utilization and client demographics.

Social and recovery measures and MCO performance metrics

Substitute Senate Bill 5157 (2021) directs the Performance Measures Coordinating Committee (PMCC) to establish performance measures to be integrated into the Washington State Common Measure Set (WSCMS) that track rates of criminal justice system involvement among Washington Apple Health (Medicaid) clients with an identified behavioral health need including, but not limited to, rates of arrest and incarceration. Second Substitute Senate Bill 1860 (2SHB 1860 (2022)) also directs the PMCC to establish performance measures to bed into the WSCMS for tracking rates of homelessness and housing instability among Apple Health clients. These data are anticipated to be included in the December 2024 Comparative Analysis report and January 2025 EQR report, with both being posted to the HCA's managed care reports page when available.

Medicaid Transformation Project 2.0 investments may provide an opportunity to explore new social and recovery measures. If funded, the proposed Community Information Exchange will be a data source for new insights on screening and referrals to social and health services, such as housing, employment, food, and transportation.

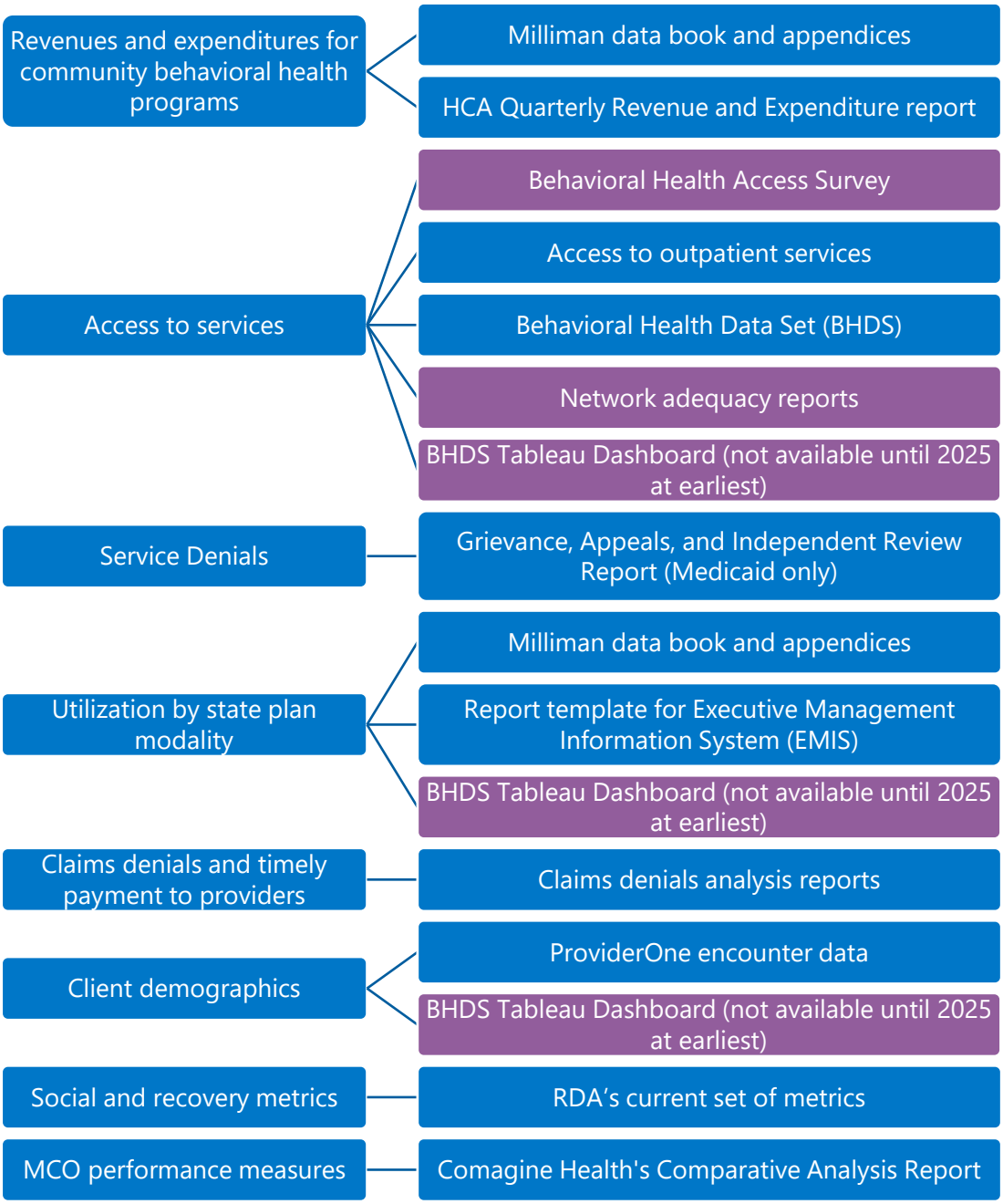
[1] For more information on the 988 system's upcoming bed tracking system, please review HCA's Final Technical and Operational Plan: https://www.hca.wa.gov/assets/program/final-technical-and-operational-plan-988.pdf

Conclusion

HCA's first submission of the legislatively mandated behavioral health outcomes report contains data collected from numerous reports submitted to HCA by MCOs, BH-ASOs, and licensed community behavioral health providers. While no new behavioral health outcome metrics were implemented during the creation of this report, HCA is committed to generating an annual report offering the Legislature and the agency's external partners insightful behavioral health outcome data.

HCA continues to generate strategies for improving acquisition of data concerning service access, utilization, social and recovery measures, MCO performance measures, and others with aim of offering a holistic view of behavioral health outcomes across all Apple Health enrollees. HCA staff will continue to partner with stakeholders to make strategic system improvements and act as appropriate through program oversight.

Appendix A: Metric map



Note: Metric sources highlighted in purple will be considered for future behavioral health outcome reporting.

Appendix B: Revenues and expenditures (calendar years 2021 & 2022)

Medicaid

Table 1: Medicaid revenues and expenditures for community behavioral health programs

CY		Total	Great Rivers	Greater Columbia	King County	North Central	North Sound	Pierce	Salish	Southwest Washington	Spokane	Thurston-Mason
2021	Revenue	1,377,518,688	85,419,593	120,516,486	360,228,258	43,293,436	189,527,619	179,741,553	62,058,715	92,282,307	189,312,390	55,138,330
	Expenses	1,082,844,101	86,388,675	110,500,210	225,560,262	41,214,414	151,703,072	117,207,506	67,389,346	59,828,062	157,609,029	65,443,525
2022	Revenue	1,614,146,867	121,428,599	160,396,168	391,512,234	57,006,245	227,922,261	181,794,954	74,332,650	92,446,855	224,414,085	82,892,816
	Expenses	1,150,271,925	90,310,487	123,118,044	239,547,299	46,613,292	166,732,141	118,635,078	75,742,793	59,658,475	159,402,077	70,512,239

Inpatient Admit per 1,000		Average	Great Rivers	Greater Columbia	King County	North Central	North Sound	Pierce	Salish	Southwest Washington	Spokane	Thurston-Mason
Female 2021 MH		11.8	10.7	9.2	12.3	6.4	11.9	13.5	8.4	14.1	14.8	16.2
Female 2021 SUD		2.3	3.7	0.5	1.3	1.0	2.8	1.4	2.3	6.7	0.5	2.5
Male 2021 MH		16.5	14.5	13.5	18.3	8.4	17.6	20.2	11.5	19.5	20.3	21.1
Male 2021 SUD		4.9	6.1	1.4	2.6	1.2	5.0	2.8	3.1	17.6	0.9	8.3

Inpatient Admit per 1,000		Average	Great Rivers	Greater Columbia	King County	North Central	North Sound	Pierce	Salish	Southwest Washington	Spokane	Thurston-Mason
Female 2022 MH		11.9	13.1	8.3	12.7	6.1	12.0	12.0	9.8	15.0	14.2	15.5
Female 2022 SUD		3.1	5.8	0.6	1.6	1.5	2.7	2.8	3.0	6.4	0.7	6.3
Male 2022 MH		15.7	15.5	11.2	18.1	9.3	14.7	16.5	12.1	18.9	17.8	22.7
Male 2022 SUD		5.3	6.1	7.9	1.2	3.4	1.1	6.1	6.1	5.4	14.8	0.8

Utilizations per 1,000		Average	Great Rivers	Greater Columbia	King County	North Central	North Sound	Pierce	Salish	Southwest Washington	Spokane	Thurston-Mason
Female 2021		345.8	328.3	336.5	232.5	272.1	401.8	344.9	388.6	350.6	423.0	379.9
Female 2022		317.2	305.9	306.4	210.1	247.4	367.1	315.9	362.2	318.1	389.9	349.7

Utilizations per 1,000		Average	Great Rivers	Greater Columbia	King County	North Central	North Sound	Pierce	Salish	Southwest Washington	Spokane	Thurston-Mason
Male 2021		612.5	581.1	572.3	467.6	389.2	727.4	765.1	726.3	577.9	694.9	622.7
Male 2022		553.0	533.3	509.9	417.3	345.5	655.4	691.7	663.5	515.2	632.9	565.9

Age range for both genders is 19-64
Date range is Calendar Year (CY)

Table 1 data note: Managed Care Organization (MCO) Revenue is premiums paid to MCOs at the date of service. MCO expenditures are filtered through the Milliman Databook which reflects ProviderOne (P1) data to meet the criteria of this report. Case rates are removed to reflect expenditures associated with the premium payments collected in the revenue portion of the table. Inpatient admissions per 1,000 is split between mental health (MH) and substance use disorder (SUD) by gender. This information is also collected from the Databook and filtered to meet the needs of this report. Admits are collected,

divided by MMs and multiplied by 12,000. To calculate the utilization per 1,000 members in a calendar year, utilization is divided by MMs, then multiplied by 12,000 (12 months * 1,000 members). Inpatient admittances per 1,000 are also split among genders. This information is collected from the Databook and filtered to meet the needs of this report. Admits are collected, divided by MMs and multiplied by 12,000. This information does not include data regarding youth served through the integrated foster care contract. The age range is listed at 19-64. A small number of 35–99-year-olds couldn't be verified, and counts wouldn't change the calculations; therefore, these were left in the data.

Non-Medicaid

Table 2: BHASO non-Medicaid revenues and expenditures for community behavioral health programs

CY	BH-ASO Non-Medicaid	Total	Great Rivers	Greater Columbia	King County	North Central	North Sound	Pierce	Salish	Southwest Washington	Spokane	Thurston-Mason
2021	Revenue	155,149,675	7,782,724	16,338,344	37,925,191	7,494,482	23,081,227	17,543,932	8,260,513	12,939,237	16,133,229	7,650,796
	Expenses	108,307,774	3,751,069	11,952,706	33,242,017	3,116,082	21,700,975	12,993,062	2,868,507	5,096,755	8,459,923	5,126,677
2022	Revenue	157,794,474	7,767,959	16,286,908	43,918,596	7,526,332	22,129,893	19,233,830	8,218,343	9,600,697	15,552,106	7,559,810
	Expenses	138,483,809	7,299,244	15,058,830	41,280,554	5,765,591	19,135,291	17,404,477	4,934,280	8,131,693	10,483,799	8,990,050

Combination of General Fund State and Proviso

CY	DCA & CJTA	Total	Great Rivers	Greater Columbia	King County	North Central	North Sound	Pierce	Salish	Southwest Washington	Spokane	Thurston-Mason
2021	Revenue	9,533,619	140,112	1,463,255	3,077,139	150,340	581,292	1,730,817	898,295	278,292	1,053,097	160,980
	Expenses	9,158,768	120,301	1,471,692	2,826,777	180,550	571,578	1,900,356	594,378	632,512	698,863	161,763
2022	Revenue	8,291,629	140,112	1,454,819	2,962,079	(1,132,371)	581,292	1,594,504	920,114	242,199	1,367,901	160,980
	Expenses	8,307,761	106,674	1,446,382	2,578,425	106,721	470,766	1,247,631	770,981	229,847	878,021	472,312

CY	Block Grant	Total	Great Rivers	Greater Columbia	King County	North Central	North Sound	Pierce	Salish	Southwest Washington	Spokane	Thurston-Mason
2021	Revenue	51,519,275	2,578,036	5,012,153	12,362,200	1,971,642	8,610,346	5,912,513	3,232,483	3,850,051	5,116,121	2,873,730
	Expenses	25,942,520	1,464,328	3,403,798	6,147,866	783,169	4,904,434	3,276,976	1,250,669	1,911,523	1,453,551	1,346,207
2022	Revenue	51,009,276	2,503,036	5,017,153	12,367,200	1,896,642	8,535,346	5,837,514	3,157,483	3,775,051	5,041,121	2,878,730
	Expenses	29,896,923	1,351,235	3,312,258	4,016,947	1,210,517	6,862,190	4,437,840	2,107,168	2,567,413	1,825,036	2,206,320

Please note block Grant funds must be expensed. Revenue represents available to spend, an underspend does not establish a balance.

Table 2 data note: BH-ASO Non-Medicaid Revenue is an aggregate of General Fund State and Provisos funding per contracts. BH-ASO Non-Medicaid Expenditures are recorded from submitted Revenue and Expenditures reports. There is no age filter or gender breakout. BH-ASO DCA & CJTA Revenue is funding totals per contracts. BH-ASO DCA & CJTA Expenditures are recorded from submitted Revenue and Expenditures reports. There is no age filter or gender breakout. BH-ASO block grant revenue is funding totals per contracts. Since block grant revenue is first expensed, then reimbursed via invoice, the amounts displayed are available amounts that must be expensed. An underspend does not establish a balance. BH-ASO Block Grant Expenditures are recorded from submitted Revenue and Expenditures reports. There is no age filter or gender breakout.

Appendix C: Access to services (calendar years 2021 & 2022)

Table 3: Wait times for MH treatment by region

Regional service area	MH Treatment – Average wait time in days		MH Treatment– Median wait time in days	
	2021	2022	2021	2022
Great Rivers	15	18	11	14
Greater Columbia	19	25	14	24
King County	11	12	3	5
North Central	15	14	12	8
North Sound	14	17	10	13
Pierce	10	14	7	12
Salish	10	12	6	8
Southwest Washington	16	18	14	14
Spokane	16	13	12	9
Thurston-Mason	11	14	6	9

Table 4: Wait times for SUD treatment by region

Regional service area	SUD Treatment – Average wait time in days		SUD Treatment– Median wait time in days	
	2021	2022	2021	2022
Great Rivers	9	11	5	6
Greater Columbia	7	6	0	0
King County	5	5	0	0
North Central	13	16	11	13
North Sound	5	6	0	0
Pierce	5	8	0	4
Salish	15	13	9	7
Southwest Washington	12	8	7	0
Spokane	11	13	5	9
Thurston-Mason	7	8	3	5

Appendix D: Service denials – (calendar years 2021 & 2022)

Table 5: Adverse benefit determinations by MCO

Managed Care Organization	# of adverse behavioral health benefit determinations		# of adverse behavioral health benefit determinations related to GF-S service	
	2021	2022	2021	2022
Amerigroup	239	264	0	0
Community Health Plan of Washington	521	485	31	4
Coordinated Care of Washington	187	919	93	227
Molina Healthcare of Washington	2,309	4,494	0	0
UnitedHealthcare Community Plan	322	754	0	0

Table 6: Adverse benefit determinations by MCO

Managed Care Organization	# of adverse MH IP benefit determinations		# of adverse MH OP benefit determinations		# of adverse SUD IP benefit determinations		# of adverse SUD OP benefit determinations	
	2021	2022	2021	2022	2021	2022	2021	2022
Amerigroup	125	176	54	33	60	52	0	3
Community Health Plan of Washington	0	1	175	353	1	1	345	130
Coordinated Care of Washington	79	122	95	758	7	38	6	1
Molina Healthcare of Washington	202	145	2,101	4,349	0	0	6	0
UnitedHealthcare Community Plan	58	77	241	648	15	14	8	15

Appendix E: Utilization by state plan modality – (calendar years 2021 & 2022

Medicaid

Table 7-10 data note: Reports the unduplicated number of persons receiving service during CY by age, gender, race/ethnicity, service type, and regional service area (RSA). Regional Service Area assigned based on the county of a client's residence in the month of service. Data includes treatment services provided by a behavioral health agency, in compliance with the Service Encounter Reporting Instructions (SERI) guide. Age is calculated as of June 30th of the calendar year. MH Residential includes Child Long-term Inpatient Program, Evaluation and Treatment facilities, and Community Hospital. SUD Residential includes Intensive Inpatient Residential Services, Long-Term Care Residential Services, and Recovery House Residential Services.

Table 7: Medicaid service utilization – statewide and regional service area – 2021

Behavioral Health Service type	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
Mental Health (MH) service - any	363,471	24,206	45,274	73,986	14,712	56,359	45,455	19,175	23,765	51,141	20,034
MH OP Crisis	26,692	3,361	1,470	3,636	1,089	3,093	2,977	1,600	1,286	6,824	1,958
MH OP Stabilization Services	4,096	208	378	755	136	566	737	352	296	478	290
MH OP non-Crisis	355,935	23,378	44,882	72,754	14,555	55,353	44,608	18,711	23,554	48,895	19,393
MH Inpatient	6,397	362	545	1,560	86	854	614	575	111	1,417	531
MH Involuntary Treatment Act Investigation	9,217	667	241	2,155	247	1,625	1,031	533	338	1,916	678
Substance Use Disorder (SUD) service - any	50,116	3,993	6,041	9,491	1,459	9,516	6,596	3,065	2,797	6,661	2,914
SUD OP	37,297	3,181	5,128	7,138	1,283	7,045	4,542	2,397	2,113	4,125	1,817
SUD Residential	9,498	627	1,500	770	281	1,721	1,317	674	294	2,070	658
Opiate Substitution Treatment	14,942	1,087	617	3,883	59	3,259	2,353	782	816	1,842	941
Withdrawal Management	4,458	280	629	391	80	1,093	611	288	67	908	186

Table 8: Medicaid service utilization data – statewide and regional service area - 2022

Behavioral Health Service type	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
Mental Health (MH) service - any	380,138	25,335	48,712	77,517	15,477	58,851	46,667	20,013	24,779	52,494	20,493
MH OP Crisis	28,136	3,412	1,666	5,344	1,320	3,373	3,093	1,514	1,347	5,774	1,887
MH OP Stabilization Services	3,889	193	326	645	134	598	769	369	257	477	217
MH OP non-Crisis	371,942	24,452	48,294	75,693	15,254	57,656	45,795	19,569	24,493	50,642	19,814
MH Inpatient	5,688	355	509	1,530	78	471	629	523	105	1,202	494
MH Involuntary Treatment Act Investigation	9,113	699	223	2,208	155	1,747	916	604	276	1,784	684
Substance Use Disorder (SUD) service - any	48,168	3,973	5,803	8,781	1,533	8,846	6,198	3,043	2,716	6,673	2,927
SUD OP	35,281	3,025	4,998	6,691	1,363	6,701	3,768	2,440	1,817	4,134	1,776
SUD Residential	8,470	495	1,270	715	266	1,719	1,157	605	253	1,825	571
Opiate Substitution Treatment	15,524	1,271	740	3,811	60	3,437	2,304	796	957	1,854	990
Withdrawal Management	4,362	277	624	417	106	1,047	506	322	84	935	128

Non-Medicaid

Table 9: Non-Medicaid service utilization data – statewide and regional service area - 2021

Behavioral Health Service type	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
Mental Health (MH) service - any	11,966	1,220	459	2,379	272	1,641	1,156	858	464	2,603	1,062
MH OP Crisis	7,931	1,033	245	707	166	1,239	758	578	239	2,266	764
MH OP Stabilization Services	278	<11	<11	21	<11	108	16	22	<11	82	<11
MH OP non-Crisis	3,330	224	218	956	157	242	398	248	244	442	260
MH Inpatient	812	36	22	274	<11	89	73	63	23	159	79
MH Involuntary Treatment Act Investigation	3,657	207	80	1,103	49	718	289	233	99	539	361
Substance Use Disorder (SUD) service - any	1,648	64	86	356	70	368	243	100	113	141	133
SUD OP	1,220	58	81	289	62	172	222	96	96	54	108
SUD Residential	40	<11	<11	<11	<11	<11	<11	0	<11	<11	<11
Opiate Substitution Treatment	495	<11	<11	171	0	230	16	<11	<11	42	20
Withdrawal Management	90	0	<11	<11	<11	19	<11	0	<11	43	<11

Table 10: Non-Medicaid service utilization data – statewide and regional service area – 2022

Behavioral Health Service type	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
Mental Health (MH) service - any	12,355	1,189	888	2,850	412	1,794	1,282	798	442	1,818	1,028
MH OP Crisis	8,380	956	629	1,394	291	1,325	900	495	253	1,455	752
MH OP Stabilization Services	251	<11	<11	25	<11	111	26	23	<11	35	14
MH OP non-Crisis	3,428	262	241	897	182	293	427	267	210	455	244
MH Inpatient	760	34	43	254	<11	87	93	56	22	104	74
MH Involuntary Treatment Act Investigation	3,800	224	144	1,157	56	724	374	204	133	465	333
Substance Use Disorder (SUD) service - any	1,784	61	200	286	146	336	268	113	86	139	167
SUD OP	1,394	52	196	229	141	155	248	108	75	59	146
SUD Residential	50	<11	<11	<11	<11	11	11	<11	<11	<11	<11
Opiate Substitution Treatment	446	<11	<11	126	<11	207	14	<11	<11	54	20
Withdrawal Management	39	0	0	<11	<11	0	<11	0	<11	23	<11

Appendix F: Client demographics – (calendar years 2021 & 2022)

Medicaid

Table 11: Medicaid clients receiving behavioral health services by age - 2021

Age group	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
< 17	103,673	7,592	15,082	16,384	5,476	15,063	13,789	4,794	7,493	14,830	5,769
18-24	48,182	2,956	7,106	8,745	2,211	7,634	5,716	2,434	3,321	7,084	2,604
25-34	86,285	5,378	10,217	18,219	3,011	14,324	10,851	4,879	5,448	12,311	5,095
35-44	63,085	4,339	6,987	13,053	1,971	10,651	8,057	3,683	3,874	9,060	3,735
45-54	39,402	2,844	3,970	9,171	1,288	6,307	4,708	2,312	2,492	5,251	2,226
55-64	32,985	2,173	3,262	8,468	998	5,355	3,975	1,906	1,883	4,090	1,584
65+	8,891	448	639	3,774	194	1,248	936	333	355	847	282
age missing	0	0	0	0	0	0	0	0	0	0	0

Table 12: Medicaid clients receiving behavioral health services by age - 2022

Age group	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
< 17	110,317	8,263	16,697	16,802	5,832	16,234	14,627	5,057	7,505	15,641	6,125
18-24	49,706	3,021	7,534	9,109	2,369	7,748	5,819	2,519	3,385	7,085	2,646
25-34	88,106	5,408	10,764	18,953	3,035	14,421	10,791	4,920	5,700	12,364	5,033
35-44	66,929	4,596	7,452	13,848	2,140	11,179	8,337	3,998	4,275	9,486	3,840
45-54	40,895	2,863	4,337	9,619	1,306	6,382	4,861	2,353	2,627	5,452	2,238
55-64	33,651	2,255	3,335	8,783	1,054	5,405	4,016	1,936	1,954	4,058	1,610
65+	9,410	503	696	3,992	190	1,314	975	365	378	846	327
age missing	0	0	0	0	0	0	0	0	0	0	0

Non-Medicaid

Table 13: Non-Medicaid clients receiving behavioral health services by age – 2021

Age group	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
< 17	974	110	42	293	18	116	75	93	21	139	77
18-24	1,629	139	80	333	55	227	160	101	75	320	162
25-34	2,938	231	146	616	81	411	368	176	92	586	273
35-44	2,826	241	124	553	63	429	315	197	130	580	240
45-54	1,768	197	56	335	35	252	157	128	85	372	166
55-64	1,652	171	53	304	32	288	153	125	61	360	131
65+	1,466	175	36	225	22	270	116	126	49	342	116
age missing	<11	<11	0	0	0	0	0	0	0	0	0

Table 14: Non-Medicaid clients receiving behavioral health services by age – 2022

Age group	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
< 17	1,080	109	97	240	51	148	117	71	25	118	108
18-24	1,760	123	159	390	74	276	187	123	62	229	152
25-34	2,884	242	273	692	105	406	349	190	81	327	251
35-44	2,884	224	235	669	99	446	341	178	111	382	246
45-54	1,870	180	141	410	53	312	197	119	73	257	150
55-64	1,606	164	93	347	38	251	147	114	60	292	120
65+	1,629	188	74	325	41	268	134	103	61	314	141
age missing	<11	0	0	0	0	<11	0	0	0	0	0

Race/ethnicity

Medicaid

Table 15: Medicaid clients receiving behavioral health services by race/ethnicity - 2021

Race/Ethnicity*	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
American Indian or Alaska Native	12,948	1,037	1,179	2,364	299	2,674	1,422	794	628	2,206	871
Asian	9,600	122	350	5,400	71	1,358	1,270	183	335	365	311
African American or Black	25,846	476	1,091	11,929	242	2,290	6,025	716	1,079	2,022	881
Hispanic	71,720	3,424	18,452	13,079	5,965	9,653	7,717	2,214	3,931	6,379	2,839
Multiracial	9,324	511	721	2,279	193	1,338	1,737	591	551	1,150	620
Other	35,672	1,161	9,728	7,756	2,710	5,048	3,784	844	1,701	2,533	1,176
Pacific Islander	6,410	179	274	2,366	66	883	1,302	412	378	422	311
White	276,732	22,021	33,314	44,315	11,277	45,843	31,718	16,533	19,801	44,143	16,851
unknown race/ethnicity	5,971	223	606	1,405	291	1,148	774	268	393	632	274

*Client may be represented in more than one category

Table 16: Medicaid clients receiving behavioral health services by race/ethnicity - 2022

*Client may be represented in more than one category

Race/Ethnicity*	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
American Indian or Alaska Native	698	60	18	131	<11	179	53	47	13	136	63
Asian	317	12	<11	169	<11	37	34	<11	<11	22	24
African American or Black	930	17	15	356	<11	78	212	50	24	142	52
Hispanic	1,869	112	202	418	114	266	182	97	66	218	219
Multiracial	307	28	<11	68	<11	38	38	31	12	57	31
Other	1,017	58	122	250	67	130	96	46	32	108	126
Pacific Islander	184	<11	<11	69	0	14	33	16	<11	19	17
White	8,700	989	346	1,431	211	1,304	760	687	374	1,951	755
unknown race/ethnicity	1,101	91	25	185	12	213	118	59	46	264	97

Non-Medicaid

Table 17: Non-Medicaid clients receiving behavioral health services by race/ethnicity - 2021

Race/Ethnicity*	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
American Indian or Alaska Native	13,825	1,157	1,267	2,526	320	2,772	1,517	876	660	2,312	964
Asian	10,077	152	392	5,703	76	1,440	1,235	200	334	378	323
African American or Black	27,069	501	1,124	12,666	222	2,447	6,146	721	1,133	2,033	964
Hispanic	77,525	3,724	20,580	13,760	6,585	10,316	8,250	2,370	4,083	6,748	2,965
Multiracial	10,511	544	811	2,617	217	1,544	1,974	618	631	1,241	668
Other	38,812	1,250	11,031	8,258	2,993	5,380	4,066	910	1,793	2,614	1,252
Pacific Islander	6,923	192	319	2,531	68	980	1,414	432	388	489	293
White	284,813	22,822	35,150	45,082	11,706	46,777	32,184	17,083	20,472	45,150	17,069
unknown race/ethnicity	6,984	291	721	1,723	324	1,343	890	308	413	715	286

Table 18: Non-Medicaid clients receiving behavioral health services by race/ethnicity – 2022

Race/Ethnicity*	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
American Indian or Alaska Native	610	43	47	111	12	156	54	49	<11	90	49
Asian	371	<11	<11	208	<11	40	52	12	12	15	22
African American or Black	890	26	32	412	<11	90	178	43	16	49	48
Hispanic	2,239	110	414	489	177	325	233	98	53	162	207
Multiracial	343	30	13	94	<11	43	44	32	<11	39	37
Other	1,327	53	270	291	101	209	120	43	40	88	129
Pacific Islander	210	<11	<11	75	<11	25	47	21	<11	11	14
White	8,677	953	632	1,678	315	1,312	828	645	325	1,362	734
unknown race/ethnicity	1,286	111	68	204	18	233	149	53	55	265	135

Gender

Medicaid

Table 19: Medicaid clients receiving behavioral health services by gender - 2021

Gender	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
Female	216,917	14,340	26,782	42,833	8,765	34,846	27,822	11,454	14,609	29,908	11,970
Male	165,586	11,390	20,481	34,981	6,384	25,736	20,210	8,887	10,257	23,565	9,325
Other	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0

Table 20: Medicaid clients receiving behavioral health services by gender - 2022

Gender	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
Female	226,716	15,122	28,753	44,839	9,186	36,039	28,766	11,961	15,325	30,634	12,238
Male	172,298	11,787	22,062	36,267	6,740	26,644	20,660	9,187	10,499	24,298	9,581
Other	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0

Non-Medicaid

Table 21: Non-Medicaid clients receiving behavioral health services by gender – 2021

Gender	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
Female	5,602	528	209	1,166	123	903	488	423	242	1,101	476
Male	7,575	713	324	1,481	181	1,082	847	519	268	1,596	679
Other	<11	0	0	<11	0	0	0	0	0	0	<11
unknown	46	22	<11	<11	<11	<11	<11	<11	<11	0	<11

Table 22: Non-Medicaid clients receiving behavioral health services by gender – 2022

Gender	All	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	SW Washington	Spokane	Thurston
Female	6,097	516	443	1,428	224	978	574	345	235	910	507
Male	7,509	668	617	1,631	237	1,124	893	546	234	1,007	649
Other	<11	<11	0	<11	0	0	0	0	0	0	0
unknown	76	43	<11	<11	0	<11	<11	<11	<11	0	<11