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Funding, Oversight, and Administration of Washington's Prenatal Through Age 25 Behavioral Health Services

Written By
Liz Arjun, Principal
Megan Beers, Senior Consultant
Hugh Ewart, Adduna Health Partners

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INTRODUCTION

In response to a growing and persistent behavioral health crisis among children, youth, caregivers, and families, in 2022 the Washington Legislature authorized the Children and Youth Behavioral Health Work Group (CYBHWG) to "convene an advisory group for the purpose of developing a draft strategic plan" to improve the behavioral health system of supports and services available to children, youth, young adults and their parents and caregivers in Washington State.[1] The legislation was updated in 2024 to extend the timeline for submitting the draft strategic plan to the Governor and the Legislature by November 1, 2025.[2] The effort to develop a statewide Prenatal through Age 25 Behavioral Health Strategic Plan (P−25 Strategic Plan) is now referred to as "Washington Thriving" and will bring a draft strategic plan to the CYBHWG in August 2025. The legislation calls for a comprehensive landscape including:

1. An overview of current structures providing funding to, oversight and administration of the behavioral health services currently available to the Prenatal through Age 25 (P−25) population.
2. A stakeholder engagement process about what children, youth, their families and caregivers want from a behavioral health system for the P−25 population and the experiences of the children, youth, parents/caregivers, and families who use and/or may need services and supports as well as system partners and providers who administer and deliver services and supports.
3. A gap analysis estimating the need across the different age groups within the P−25 population, (perinatal, school-age children, youth transitioning into adulthood, and the families and caregivers of those children and youth), across different parts of the behavioral health services continuum, and the costs of providing those services.

This report fulfills Part 1 of the comprehensive landscape and aims to provide a foundation for the next phases of work and follows work throughout 2024 to develop a proposed vision for the P−25 behavioral health system.

Washington Thriving's vision and principles articulate that behavioral health services should be available to meet the broad range of needs of the P−25 population in state ranging from health promotion and education at a population wide level to prevention and early intervention through intensive residential services at an individual level. The vision statement indicates that these services should be provided in culturally responsive ways and in the settings that best serve infants, children, youth, and their parents/caregivers and families. These settings may include homes, schools, other community settings, providers' offices, and inpatient and residential care settings. The complete range of these services is often referred to as a continuum of care. Most importantly, the vision statement articulates that the behavioral health services must be available to all children, youth, their families and caregivers, regardless of what type of and whether or not they have health care coverage.

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[1] 67th Legislature 2022 Regular Session. Chapter 76, Laws of 2022 Second Substitute House Bill 1890: Children and Youth Behavioral Health Work Group—Modification. Effective Date: June 9, 2022. Available at: https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1890-S2.SL.pdf?q=20241025101943

[2] 68th Legislature 2024 Regular Session Chapter 372, Laws of 2024 Engrossed Substitute House Bill 2256: Children and Youth Behavioral Health Work Group—Modification Effective Date: June 6, 2024. Available at: https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/House/2256-S.SL.pdf?q=20241025102640.

Development of the infrastructure to support the vision will require bringing together several sources of funding that support the current array of behavioral health services and supports and leveraging them to create a comprehensive continuum of care.

The current landscape of behavioral health services for the P–25 population in Washington consists of multiple entities that are accountable for funding, administering, delivering, and overseeing the full array of behavioral health services for children and young adults.

This report outlines the state of funding, oversight and administration of the current array of behavioral health services and identifies key areas of focus necessary to transform this fragmented array of services into a more comprehensive system of care.

HEALTH INSURANCE COVERAGE

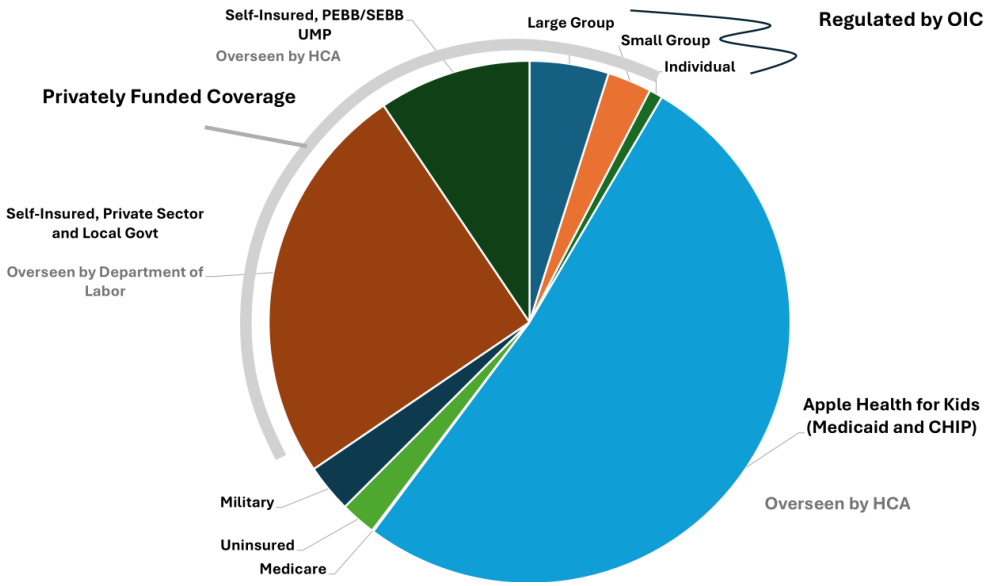
Before the Affordable Care Act (ACA) and mental health parity laws were enacted, behavioral health services were largely developed and funded locally based on the types of services and the level of need in the community and the resources available. Simultaneously, Medicaid was a growing funding source for behavioral health services, but were limited to certain categories of populations, and limited in the scope and funding of available services. Both local programs and often Medicaid behavioral health services were delivered separately from the general healthcare system. The ACA, state and federal mental health parity laws, combined with other state efforts to integrate financing for behavioral and physical health care has promoted whole-person care, but seamless access to programs and services remains a challenge. However, as a result of these changes over time, today, the primary source of funding for behavioral health services for the P−25 population is determined by the child, youth, or young adult's healthcare insurance and the behavioral health benefits and scope of services their plan covers.

Broadly, the two main sources of health coverage in Washington are publicly and privately funded insurance. Publicly funded sources of health coverage include Medicaid; the Children's Health Insurance Program (CHIP), known as Apple Health for Kids in Washington; state-funded programs for children/youth who are ineligible for CHIP because of their families' federal immigration status; and Military Health System (MHS) coverage for children/youth with parents who are serving in the armed forces. Private health insurance coverage includes employer-sponsored and self-funded large, small group, and individually purchased health plans.

Figure 1 shows the source of health coverage for Washington's P−25 population according to these categories. About half of these individual rely on publicly funded health coverage, while nearly 40 percent rely on privately funded health coverage. A small percentage of children are covered through their parents' MHS plan, and less than 3 percent are uninsured.[3]

[3] Yen W. Medicaid Increase Created All-Time Low for Washington's Uninsured Rate, but a Reversal Is Emerging. OFM Health Care Research Center Research Brief No. 114. February 2024. Available at: https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief114.pdf.

Figure 1. Sources of Healthcare Coverage for Washington's P–25 Population



The benefits and services available through these sources of coverage vary because of the different laws that created them and the requirements that govern them as explained later in this report. As a result, children, children, youth, young adults, parents/caregivers, and families have access to different services based on their healthcare coverage.

Publicly Funded Coverage

Medicaid and CHIP, authorized under Titles XIX and XXI of the Social Security Act, funded by the federal and state governments. In Washington, these programs are called Apple Health and Apple Health for Kids, respectively. Both Medicaid and CHIP include minimal standards for the benefits and services that states must provide and the populations they must cover in order to receive federal matching funds. States may offer more than the minimal standards required by the federal government and cover additional services or treatment modalities. The benefit package provided under Apple Health for Kids is established in state law and includes many categories that provide services that comprise the ideal behavioral services array needed to create a continuum of care for the P–25 population (see Table 1).[4]

[4] Washington State Legislature. Washington Administrative Code 182-501-0060: Health Care Coverage—Program Benefit Packages—Scope of Service Categories. Available at: https://app.leg.wa.gov/wac/default.aspx?cite=182-501-0060.

Table 1. Benefits Available to Apple Health for Kids Enrollees

Benefit Service Categories in Apple Health for Kids[5]
Ambulance (ground and air)
Applied behavior analysis (ABA)
Behavioral health services*
Blood/blood products/related services
Dental services
Diagnostic services (lab and X-ray)
Early and periodic screening, diagnosis, and treatment (EPSDT) services*
Enteral nutrition program
Habilitative services
Healthcare professional services
Health homes
Hearing evaluations
Hearing aids
Home health services
Home infusion therapy/parenteral nutrition program
Hospice services
Hospital services Inpatient/outpatient
Intermediate care facility/services for persons with intellectual disabilities
Maternity care and delivery services
Medical equipment, supplies, and appliances
Medical nutrition therapy
Nursing facility services

[5] Ibid.

Benefit Service Categories in Apple Health for Kids[5]
Organ transplants
Orthodontic services*
Out-of-state services
Outpatient rehabilitation services (occupational therapy, physical therapy, surgical therapy)
Personal care services
Prescription drugs
Private duty nursing
Prosthetic/orthotic devices
Reproductive health services
Respiratory care (oxygen)
School-based medical services
Vision care exams, refractions, and fittings
Vision hardware (frames and lenses)*

**Indicates a benefit category that is only available to children and youth through age 19.*

The first category is behavioral health services, which in statute includes a variety of specific services, including "psychiatric physician-related services and other professional mental health services."[6]

In addition to the scope of services available under the behavioral health service category required by Washington's Medicaid program, early and periodic screening, diagnostic, and treatment (EPSDT) services are required benefits as stipulated in the federal laws governing Medicaid. EPSDT for P−19 enrollees is focused on ensuring that children and youth receive medically necessary healthcare services so that health problems are avoided or identified and treated as soon as possible. EPSDT services include well child visits, behavioral and developmental screenings and services, as well as dental, vision, and hearing care. The EPSDT requirement provides access to the most comprehensive set of behavioral health services for children and youth.[7]

[6] Ibid.

[7] Centers for Medicare & Medicaid Services. State Health Official Letter #24-005 RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements. September 26, 2024. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

Washington State continues to enhance the behavioral health benefits and services available to the P−25 population with Apple Health coverage to address gaps in the service array. For example, two new treatment services, intensive outpatient and partial hospitalization, were recently added as reimbursable services under Apple Health for Kids. In addition, the federal government recently approved community health worker (CHW) services as part of the state's Medicaid plan, and that benefit is now being implemented.[8,9]

The Centers for Medicare & Medicaid Services and the Washington State Health Care Authority (HCA) oversee Apple Health—both Medicaid and CHIP. Apple Health for Kids offers state-funded coverage to non-federally qualified children and youth under the aegis of the HCA. Oversight of these programs includes monitoring and ensuring that access and quality standards comply with state and federal laws. HCA contracts with five Medicaid managed care organizations (MCOs) to administer the benefits, and MCOs contract with a network of providers and facilities to deliver the services.

Privately Funded Coverage

As noted previously, a little less than half of the P−25 population in Washington has privately funded health insurance coverage, either through employer-based (large and small group) or individual plans. Two types of large employer-based plans are available: fully insured and self-funded. Fully insured employer plans are those that organizations purchase from an insurer, whereas with self-funded plans, employers pay claims directly through their own funds. In this arrangement, employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator, or they can be self-administered. This is an important distinction because self-funded health plans are governed by a federal law called the Employee Retirement Income Security Act (ERISA),[10] as opposed to any state-mandated benefits or additional laws that Washington may have adopted. Moreover, oversight of these plans lies with the federal Department of Labor, not the Washington Office of the Insurance Commissioner, which has regulatory authority over the other types of private coverage.

In Washington, about one-quarter of the child population has coverage through self-funded health plans. which means that for a significant portion of the P−25 population the State has no authority to mandate benefits and no role in ensuring access to care and compliance with quality standards for the services those plans cover. Therefore, it will be critical that the strategic plan include a concerted effort to work with large self-funded employers to align and strengthen the behavioral health services and benefits available to the P−25 population.

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[8] Washington State Health Care Authority. 2SSB 5736: Intensive Outpatient and Partial Hospitalization. September 2023. Available at: https://www.hca.wa.gov/assets/program/iop-ph-faq-20230915.pdf.

[9] Centers for Medicare & Medicaid Services. State Health Official Letter #24-005 RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements. September 26, 2024. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

[10] US Department of Labor. Health Plans and Benefits. Available at: https://www.dol.gov/general/topic/health-plans.

Essential Health Benefits

For the rest of the P−25 population who rely on privately funded coverage, the ACA established a new benchmark for the benefits and services that all health plans are required to offer through the Essential Health Benefits (EHBs). Behavioral health services, however, do not fit exclusively into one of these benefit categories. For example, one of the required benefits, mental health and substance use disorder services, defines behavioral health treatment as psychotherapy and counseling, mental and behavioral health inpatient services, and substance use disorder (SUD) treatment services.[11] Another required category in the EHBs, preventive health services, includes behavioral health services that focus on the promotion, prevention, and early intervention of behavioral health conditions, such as autism screening for children at 18 and 24 months, depression screening for adolescents beginning routinely at age 12, developmental screening for infants and toddlers ages three and younger, and well-baby and well-child check-ups and behavioral assessments for children.[12]

Washington's EHBs are established in statue and include the federally required categories and provide more details about required services and their scope to be compliant with state law. Comprehensive sections of the statute focus on behavioral health benefits and services, as well preventive health services for the P−25 population. These mandates establish a strong foundation for delivering a comprehensive array of behavioral health services spanning the continuum. One area of note in the section focused on preventive health provides a foundation for offering prevention services that are comparable to those included in the Medicaid EPSDT benefit, including the "services, tests and screening contained in the U.S. Health Resources and Services Administration ("HRSA") Bright Futures guidelines as set forth by the American Academy of Pediatricians."[13] Many members of the pediatric community consider Bright Futures to be the gold standard for delivering health promotion services driven by best practices.[14]

All plans in the **small group and individual markets** and those that are **fully insured in the large group market** must provide the EHBs as they are established in state law. Publicly funded coverage, healthcare services and benefits for in privately funded health coverage is provided through health plans that **administer** the benefits. Health plans then contract with networks of providers and facilities to **deliver** the healthcare services.

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[11] HealthCare.gov. Benefits & Coverage. Available at: https://www.healthcare.gov/coverage/what-marketplace-plans-cover/.

[12] HealthCare.gov. Preventive Care Benefits for Children. Available at: https://www.healthcare.gov/preventive-care-children/.

[13] Washington State Legislature. Washington Administrative Code 284-43-5642: Essential Health Benefits. Available at: https://app.leg.wa.gov/WAC/default.aspx?cite=284-43-5642.

https://app.leg.wa.gov/WAC/default.aspx?cite=284-43-5642

[14] American Academy of Pediatrics. Bright Futures. 2025. Available at: https://www.aap.org/en/practice-management/bright-futures?srsltid=AfmBOooEKXn6ScCybYyppoxuvopipQuBruHw39RPySsbxKp3icDEtcRI.

DISCUSSION: GAPS AND DISPARITIES IN HEALTH COVERAGE

The scope of the behavioral health services that publicly and privately funded plans sources differs considerably. This variance is because, until mental health parity laws were enacted—more specifically the Mental Health Parity and Equity Addiction Act (MHPAEA) of 2008—many private insurers either did not offer behavioral health benefits or applied more stringent limitations on coverage for these services.[15] Until these parity laws and the ACA EHB requirements were set in motion, access to behavioral health services was primarily available through publicly funded sources of health coverage, including Medicaid, CHIP, and community-funded programs. **Because the Medicaid program has been the traditional payer of this comprehensive set of behavioral health services, including evidence-based treatments and approaches, it continues to be the largest funder of behavioral health services both nationally and in the State of Washington.**[16,17]

And, though Washington statute outlines the EHBs clearly, the scope of the services that are available is less comprehensive than what Medicaid and CHIP have established. Furthermore, statutory requirements to improve parity between public and private coverage can only achieve so much. Recent efforts to implement Engrossed 2nd Substitute House Bill (E2SHB 1688), Behavioral Health Crisis Services, have demonstrated the challenges associated with efforts to better align the benefits and services available in privately funded coverage with those that Apple Health provides.[18] Implementation of this state law has required significant coordination between state agencies, payers, providers, and advocates to realize the goals of the legislation, which remains an ongoing challenge.[19]

Adopting new benefits and services in privately funded coverage based on the publicly funded structures will need to be coupled with significant training and support for all parties involved including providers and health plans.

Adopting new benefits and services in privately funded coverage based on the publicly funded structures will need to be coupled with significant training and support for all parties involved including providers and health plans.

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[15] Centers for Medicare & Medicaid Services. The Mental Health Parity and Addiction Equity Act (MHPAEA). Modified September 10, 2024. Available at: https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity.

[16] Guth M, Saunders H, Corallo B, Moreno S. Medicaid Coverage of Behavioral Health Services in 2022: Findings from a Survey of State Medicaid Programs. Kaiser Family Foundation. March 17, 2023. Available at: https://www.kff.org/medicaid/issue- brief/medicaid-coverage-of-behavioral-health-services-in-2022-findings-from-a-survey-of-state-medicaid-programs/:~:text=Medicaid%20plays%20a%20key%20role,disorder%20(SUD)%20in%202020.

[17] Centers for Medicare & Medicaid Services. Behavioral Health Services. Available at: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html.

[18] 67th Washington State Legislature. Engrossed Second Substitute House Bill 1688: Out-of-Network Health Care Services—Balance Billing—Various Provisions. Effective March 31, 2022. Available at: https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1688-S2.SL.pdf?q=20230309162951.

[19] Washington State Office of the Insurance Commissioner. About 1688 Behavioral Health Crisis Services. Available at: https://www.insurance.wa.gov/about-1688-behavioral-health-crisis-services.

Even with the most comprehensive behavioral health benefit package—regardless of whether it is privately or publicly funded coverage—there is still no guarantee of access to behavioral health services.

Gaps in access to care occur for a number of reasons, most of which have to do with payment rates. Medicaid historically has provided low reimbursement rates for Medicaid when compared with other insurers (i.e., Medicare and commercial insurance), and all sources of health coverage, public and private, have traditionally offered lower reimbursement rates for behavioral health services. This concern is evident in a recent study that Health Management Associates conducted for Washington's Office of the Insurance Commissioner (OIC), which focused on healthcare affordability. Using the Washington All-Payer Claims Database, which includes data on commercial payers that are exempt from ERISA mandates in Washington, found that the average reimbursement rate for behavioral health services is 88 percent of the Medicare reimbursement rate. Meanwhile, several other categories of services are reimbursed at significantly more than 100 percent of Medicare's payment amounts.[20] The gap analysis part of the landscape will provide some additional insights into how payment for services in both public and privately funded coverage may be contributing to a lack of access to care.

Addressing the gap in reimbursement for behavioral health services will be an important focus of building the road map to achieve the Washington Thriving Vision and will require a variety of strategies that touch different sources of health coverage.

Another consideration in addressing the role of health insurance is that, though coverage for a comprehensive service array and access to services is a bedrock of achieving the P−25 Vision, Washington will need to place an emphasis on incentivizing quality and outcomes of behavioral health services.

The necessity of this shift is evident, considering that Washington has achieved near universal care coverage for the P−25 population because of a concerted effort over the past 20 years to expand health insurance coverage for these individuals;[21] however, Mental Health America ranks Washington 48th of the 50 states on several indicators for youth behavioral health.[22]

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[20] Health Management Associates. WA OIC Final Report on Health Care Affordability. July 29, 2024. Available at: https://www.insurance.wa.gov/sites/default/files/documents/Health-care-cost-afford-rprt-Nov-5.pdf.

[21] Yen W. Medicaid Increase Created All-Time Low for Washington's Uninsured Rate, but a Reversal Is Emerging. *OFM Health Care Research Center Research Brief No. 114*. February 2024. Available at: https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief114.pdf.

[22] Mental Health America. Youth Ranking 2024. Available at: https://mhanational.org/issues/2024/mental- health-america-youth-data.

Ensuring that health plans and providers that deliver services are aligned in these efforts and that training is available and incentives are in place to support implementation of evidence- based practices and programs that result in improved outcomes will be another important focus area in the Washington Thriving road map.

Several states that have undertaken reform efforts to improve behavioral health outcomes for children and youth through system reform have articulated the need for demonstrated attention to this concern.[23]

Finally, it is worth noting that CMS has approved Washington's application for its Medicaid 1115 waiver, which will allow the State to provide five years of continuous eligibility for children enrolled in Apple Health for Kids. As a result, children enrolled in Apple Health will retain Apple Health coverage through their sixth birthday, regardless of a change in household income.[24] Continuous eligibility (previously set at only one year) has been shown to improve health outcomes and lower costs because children and youth are more likely to receive the full array of preventive health services. The guaranteed enrollment of children from birth to six years old through a Medicaid MCO presents an opportunity for the state to leverage contracting and oversight and further engage health plans and providers in collective efforts to support access to high-quality care and prioritize opportunities to improve health outcomes.[25]

In addition to publicly and privately funded health coverage, other key sources of funding for behavioral health services include federal block grants, state general funds, and local funds.

[23] National Academy for State Health Policy. Behavioral Health System Modernization: Comprehensive Approaches and Cross-Cutting Tools. March 22, 2024. Available at: https://nashp.org/behavioral-health-system-modernization-comprehensive-approaches-and-cross-cutting-tools/#quality.

[24] Washington Health Care Authority. Apple Health Continuous Eligibility. Updated July 2023. Available at: https://www.hca.wa.gov/assets/free-or-low-cost/apple-health-for-kids-continuous-eligibility.pdf.

[25] Urban Institute. Multiyear Continuous Eligibility in Medicaid and CHIP: Five Keys to Maximizing Positive Benefits for Children and Their Families. October 2024. Available at: https://www.urban.org/sites/default/files/2024-10/Multiyear-Continuous-Eligibility-in-Medicaid-and-CHIP.pdf.

OTHER SOURCES OF FUNDING FOR BEHAVIORAL HEALTH SERVICES

Federal Block Grants

The federal block grants come from the Substance Abuse and Mental Services Health Administration and include the Community Mental Health Services Block Grant (MHBG) and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRBG). The MHBGs provide funding to: 1) support comprehensive, community-based mental health services for adults with serious mental illness and children with serious emotional disturbance, and 2) monitor progress in implementing a comprehensive, community-based mental health system. The SUPTRBGs provide funding to plan, implement, and evaluate activities that prevent and treat substance use and promote public health. The total value of the block grants awarded to Washington in 2023 was $59,082,968, and the state has up to two years to spend these funds. The block grants are **overseen and administered** by the Division of Behavioral Health and Recovery within the HCA.[26,27]

State General Funds

The state general funds in Washington serve as the main source of revenue for behavioral health crisis services provided to everyone living in the state and for behavioral health services provided to people who are ineligible for Medicaid or are uninsured. The HCA's Division of Behavioral Health and Recovery (DBHR) has oversight authority over these funds, which are then disbursed to the behavioral health services organizations in 10 regions across the state.[28]

Local Government Funds

Local governments are also important sources of funding for behavioral health services. A Washington State law passed in 2005 allows counties that have populations of more than 800,000 residents to opt in to a 0.1 percent sales tax increase to fund behavioral health services.[29] These funds are used for expenses related to the operation or delivery of new or expanded chemical dependency or mental health treatment programs and services as defined in statute, including modifications to existing facilities. Any county that imposes the sales tax is also required to establish and operate a therapeutic court component for drug dependency proceedings. As of 2022, 28 of Washington's 39 counties have passed laws to levy a sales tax for behavioral health services in their communities.[30] These local funds are **overseen by the counties and cities from where they are collected. The administration and delivery of the services** supported by these funds varies across the state**.**

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[26] Washington State Health Care Authority. Community Mental Health Block Grants (MHBG). November 2024. Available at: https://www.hca.wa.gov/assets/program/fact-sheet-community-mental-health-block-grant.pdf.

[27] Washington State Health Care Authority. Substance Use, Prevention, Treatment and Recovery Services (SUPTRS) Block Grant. November 2024. Available at: https://www.hca.wa.gov/assets/program/fact-sheet-suptrs-block-grant.pdf.

[28] Washington State Health Care Authority. Behavioral Health − Administrative Service Organizations. November 2023. Available at: https://www.hca.wa.gov/assets/program/bhaso-fact-sheet.pdf.

[29] 59th Washington State Legislature. Engrossed Second Substitute Senate Bill 5763. Chapter 504, Laws of 2005: Mental and Substance Abuse Disorders. Effective July 1, 2005. Available at: https://lawfilesext.leg.wa.gov/biennium/2005-06/Pdf/Bills/Session%20Laws/Senate/5763-S2.SL.pdf?q=20241114145212.

[30] Washington State Department of Revenue. Local Sales & Use Tax Change Notices. 2022. Available at: https://dor.wa.gov/taxes-rates/sales-use-tax-rates/local-sales-use-tax-change-notices.

Some counties and cities **administer** them directly through city and county staff, while other **administer** them through the regional BH-ASO. Some BH-ASOs provide services directly while others contract with providers and facilities.

Other State and Federal Funds

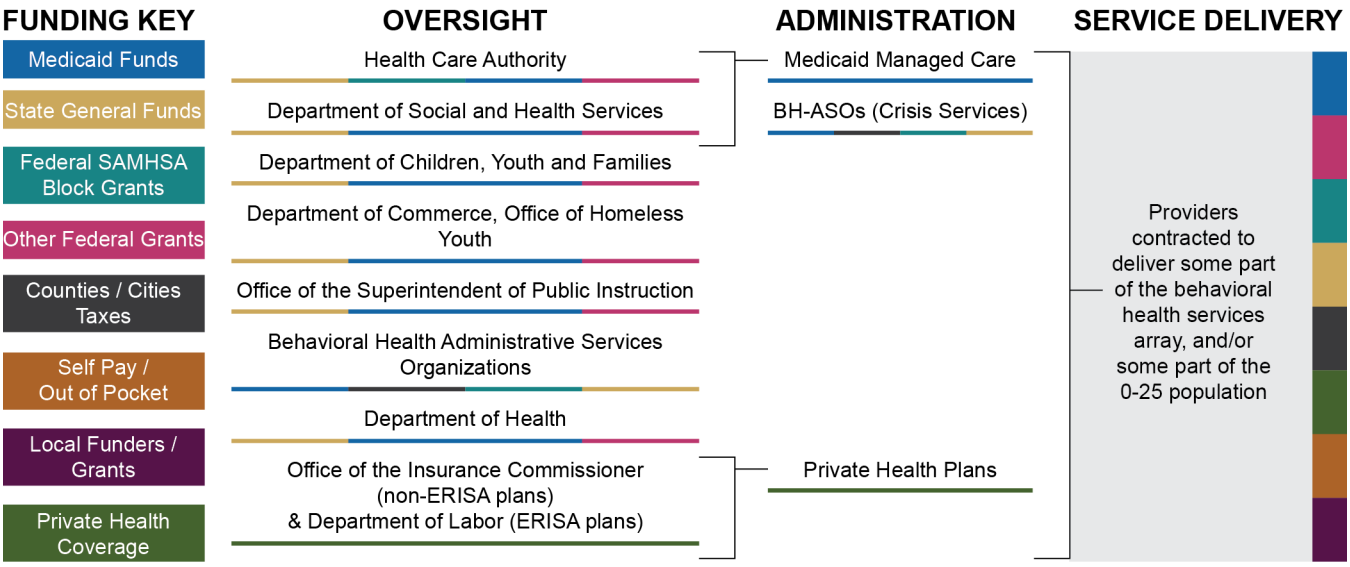
Finally, state and federal dollars are flowing through various agencies that fund additional key behavioral supports for young people Washingtonians. Examples include the funding for prenatal to age five home visiting programs and mental health support in early childcare education, both critical prevention and mental health promotion efforts for young children and their families who come through the Department of Children, Youth and Families (DCYF) and the Department of Health (DOH).

Similarly, child welfare dollars support a variety of prevention and intervention-oriented behavioral health supports that are not traditionally delivered through the healthcare and behavioral health system. These services are listed in the Catalogue of Behavioral Health Services below. Coordinating these efforts with other behavioral health services is a critical next step in developing a road map for a future system that is more comprehensive and accessible.

STATE AND COUNTY OVERSIGHT AND ADMINISTRATION

Multiple state agencies and local entities oversee and administer programs that are related to behavioral health across the P−25 continuum and receive funding from the sources described above. The following section identifies these agencies and their scope of responsibility in funding, managing, and administering behavioral health services for the P−25 population. **Figure 2** offers a high-level overview of this system.

Figure 2. Entities Involved in Funding, Managing, and Delivering Behavioral Health Services for Focus Population



Washington State Health Care Authority

HCA is the largest purchaser of healthcare in the Washington and has oversight authority for the state's Medicaid and CHIP programs. Apple Health for Kids covers a range of behavioral health services for enrollees, from outpatient to intensive outpatient and partial hospitalization, to long-term residential care such as the Children's Long-Term Inpatient Program (CLIP).

HCA administers the program primarily through contracts with five Medicaid MCOs, which, in turn, contract with a network of providers to deliver benefits to enrollees, including behavioral health services. As the administrator of Apple Health for Kids, HCA is responsible for ensuring access to and the quality of behavioral health services that MCOs deliver. HCA also administers the Community MHBG and the SUPTRBG and oversees the distribution of the funding and reporting requirements. The HCA administers programs that support workforce development; formal networks or groups of people with similar experiences, such as Family Youth System Partner Roundtables; surveys such as the Washington State Healthy Youth Survey; and digital or technological tools such as Smart Health and Smart Tiles apps, which focus on well-being. In short, HCA programs support the well-being across the entire P−25 service array.

HCA also administers and oversees healthcare benefits for public employees through the Public Employee Benefits Board (PEBB) and school employees through the School Employees Benefits Board (SEBB). PEBB and SEBB contract with health plans and a third-party administrator (TPA), which then contracts with a network of providers to deliver healthcare services (including the behavioral health benefits required under state law). As part of administering the PEBB and SEBB programs, HCA is responsible for overseeing the quality of and access to these services.

Department of Social and Health Services

The Department of Social and Health Services (DSHS) is responsible for administering and overseeing a variety of Medicaid-funded behavioral health programs, and the Behavioral Health Administration and Developmental Disabilities Administration administers and monitors behavioral health services for individuals with a developmental or intellectual disability. These divisions are responsible for a variety of specialized behavioral health services for distinct populations including services for youth with intellectual and developmental disabilities, with autism spectrum disorder, and children and youth who receive services at the Child Study and Treatment Center. DSHS contracts directly with providers to deliver these services and is responsible for overseeing the access to and quality of the services deliver received.

Department of Children, Youth, and Families

The Department of Children, Youth, and Families (DCYF) is responsible for overseeing and administering a range of programs, including early learning, early childhood home evidence-based home visiting, juvenile rehabilitation, and child welfare programs and services, including foster care. Behavioral health supports of varying types and intensity are embedded within many of these programs. For example, mental health consultation services are offered through DCYF's Early Childhood Education and Assistance (ECEAP) program and Behavioral Rehabilitation Services and in home therapeutic services are offered through the child welfare division. DCYF is responsible for ensuring the quality of and access to these services for eligible young people who are eligible.

Department of Health

The Department of Health (DOH) is the state's public health agency. DOH plays several roles in supporting the state's behavioral health system. First, it oversees and administers multiple services and/or initiatives focused on public health campaigns to promote the importance of behavioral health in overall well-being and reduce stigma. Additionally, DOH collects, analyzes and reports data on the overall health of the state's population, including behavioral health outcomes. Finally, it is the state agency responsible for overseeing licensure of behavioral health providers and facilities.

Department of Commerce Office of Homeless Youth

The Department of Commerce Office of Homeless Youth (OHY) leads statewide efforts to reduce and prevent homelessness among adolescents ages 12−17 and young adults ages 18−24 through partnerships with community programs to establish ongoing and future funding, policies, and best practices. OHY authorizes and administers grants to develop housing options for these people and organizations that connect youth with needed behavioral health services. Funding comes from Medicaid, state general funds and other federal grants.

Office of Superintendent of Public Instruction

The Office of Superintendent of Public Instruction (OSPI) is the state's public K−12 education agency. It oversees 295 school districts, eight state-Tribal education compact schools, and 12 additional jurisdictions, including Bates Technical College, educational service districts, the Office of the Governor, and the Washington Center for Childhood Deafness and Hearing Loss, educating 1,100,059 children and youth across the state. Working with the state's 295 public school districts and six state-Tribal education compact schools, OSPI allocates funding and provides tools, resources, and technical assistance so every student in Washington can experience high-quality public education.

As part of that effort, school districts and Educational Service Districts (ESDs) also contract with Medicaid to provide behavioral health services in school settings. A large network of school-based health centers operated by federally qualified health centers (FQHCs) provide behavioral health services in school-based settings. Looking forward, the State will need to collaborate with OSPI, ESDs, school-based health centers and FQHCs to identify how to maximize access to behavioral health services, regardless of the source of health coverage a child or youth may have. For example, California has recently undertaken an effort to develop a statewide multi-payer fee schedule for school-linked behavioral health services under its Children and Youth Behavioral Health Initiative (CYBHI), which requires publicly and privately funded health plans to accept set rates for local education agencies and school-affiliated providers in service of this goal.[31]

[31] State of California. Children and Youth Behavioral Health Initiative. Statewide Multi-Payer Fee Schedule for School-Linked Behavioral Health Services. 2025. https://cybhi.chhs.ca.gov/workstream/statewide-multi-payer-fee-schedule-for-school-linked-behavioral-health-services/.

Office of the Insurance Commissioner

The Office of the Insurance Commissioner (OIC) regulates privately funded non-ERISA health insurance plans, including the large and small group employer plans and individual plans in the state. These plans provide health insurance to a significant portion of the Washington's P−25 population. OIC ensures that benefits comply with state requirements, enforces parity laws, ensures access to mandated services, and annually reviews rates proposed by insurers to ensure they are actuarially sound. Plans then contract with a network of providers to deliver these services, including those for behavioral health needs. OIC's access standards differ from Medicaid's in that its role as an overseer/regulator does not include detailed review of the quality of the services received. As noted in Figure 1 and discussed in the section focused on privately funded coverage, OIC does not have regulatory authority over the employer-sponsored plans that fall under ERISA.

Behavioral Health-Administrative Service Organizations

Behavioral Health-Administrative Services Organizations (BH-ASOs) are responsible for overseeing and administering a portion of regional behavioral health services. Specifically, Medicaid MCOs and the Health Care Authority (HCA) contract with 10 BH-ASOs to provide crisis services (i.e., regional crisis hotline services, mobile crisis outreach, short-term SUD crisis services for certain populations, and mental health evaluation and treatment services for individuals who are involuntarily detained) for the people who live in that region.[32] These services are largely funded through state general funds and state and federal block grants. Some BH-ASOs also administer and oversee behavioral health services that are funded by the local sales tax collected by the counties in their region are often supplemental or complementary to the services that individuals may be receiving through their health coverage or for individuals who lack access to behavioral services. Examples include services to help individuals navigate through mental health or substance use disorder (SUD) treatment services. BH-ASOs may contract with providers and or provide behavioral health services directly. The BH-ASOs are responsible for the quality of and the access to the services that they fund.

Counties

County governments throughout across the state have opted to use their taxing authority to support and enhance the behavioral health services in their communities. Counties are responsible for overseeing the services available because of these funds, and some are also responsible for administering these funds as they serve as the region's behavioral health services organization and contract with providers to offer behavioral health services. Others are part of regional BH-ASOs that comprise multiple counties and either contract with providers or deliver these services directly. Resources, structures, and offerings vary substantially across each county. Some examples of regional programs that counties have funded to support the behavioral health needs of the P−25 population include King County's Best Starts for Kids and the Teen Text line, which serves several counties in Eastern Washington through Spokane County.

[32] Washington Apple Health. Behavioral Health-Administrative Services Organizations (BH-ASO). November 2023. Available at: https://www.hca.wa.gov/assets/free-or-low-cost/19-0040-bh-aso-map.pdf.

In developing the strategic plan road map, it will be important to articulate a clear picture of how county funds can complement a statewide vision and strategies for supporting shared local priorities.

Another view of the current behavioral health system is one that looks at the different categories of services that comprise the current behavioral health system. This approach provides an organizing framework to understand the behavioral health services provided outside of those funded through public and private payers and to develop a gap analysis about access to and funding for these various service categories. **Figure 3** outlines the different categories of these services that have been identified as essential to the behavioral health continuum that Washington Thriving envisions and offers a high-level overview of the different entities that are involved in each category of the behavioral health service array described earlier.

Figure 3. Entities Involved in Washington's Array of Behavioral Health Services

Entities Involved	Behavioral Health Activity / Service
BH-ASOs, Counties, DCYF, DOH, HCA, OSPI	Health Promotion & Education
BH-ASOs, Counties, DCYF, DOH, HCA, OSPI, PHC	Prevention & Early Intervention
HCA, OSPI, PHC	Outpatient & Integrated Care
BH-ASOs, HCA, DSHS, PHC	Intensive Home & Community Services
BH-ASOs, DOH, HCA, PHC	Comprehensive Crisis Care
BH-ASOs, HCA, PHC	Inpatient Care
BH-ASOs, Counties, DCYF, DSHS, HCA, PHC	Residential Treatment
HCA, BH-ASOs, DSHS	Tiered Service Coordination
BH-ASOs, Counties, DCYF, DSHS, DoC, HCA	Recovery Supports
BH-ASOs, Counties, DCYF, DoC, DSHS, HCA	Community Services

BH-ASOs = Behavioral Health Administrative Services Organizations
DCYF = Department of Children, Youth and Families
DoC = Department of Commerce
DOH = Department of Health
DSHS = Department of Social and Health Services
HCA = Health Care Authority
PHC = Private Health Coverage

Notably, Washington is not alone in trying to address this complexity. The impacts of expanded coverage through the ACA and mental health parity laws have brought significant new funding possibilities to the table that could be leveraged to support a more robust system, and many other states are in the process of efforts to achieve this goal. Organizations such as the National Academy for State Health Policy have developed toolkits and technical assistance for states grappling with these issues.[33] Finally, federal leaders from the multitude of agencies that comprise the U.S. Department of Health and Human Services co-authored a brief in *Health Affairs* that speaks to the need for a collective effort to organize and address the nation's behavioral health crisis and how they were prepared to engage in this work.[34]

These primary sources are accompanied by other smaller sources of funding and support, some of which are described in the catalogue of behavioral health services described next.

CATALOGUE OF BEHAVIORAL HEALTH SERVICES

As noted previously, the primary source of funding for behavioral health services for the P−25 population is determined by the child, youth, or young adult's source of health coverage and the behavioral health benefits and scope of the service that coverage includes. Many entities are involved in the funding, administration, oversight, and delivery of different services within the system. Alignment across these players is critical to achieving the proposed vision of Washington Thriving.

Complementary to, and at the same time complicating, this arrangement, is a range of limited scope programs and services, behavioral health collaborations, pilot programs, and outreach activities that some of these entities provide to the P−25 population. These programs can provide insights, information and enhancements as part of the Washington Thriving Strategic Planning effort.

To help the public and policymakers understand the universe of what is happening in the state, HCA developed a catalogue of existing behavioral health services the state's P−25 population. Washington Thriving staff worked informally with state agency staff and completed desk research to create an index of behavioral health services that are currently available to some or all the P−25 population.

The P−25 catalogue of services is designed to capture the current state of interventions in this state that address behavioral health for any/some/every part of the P−25 continuum. It is a snapshot in time, summer/autumn 2024, that is informed almost exclusively by the input of key stakeholders. Multiple key stakeholder interviews were conducted with state agency experts, county leaders, public health professionals, health sector association staff, commercial carriers, and other interested parties. Some key stakeholders supplied written documentation to supplement or in lieu of their verbal input. Because it captures a specific point in time, what is true today will likely look different a few months, let alone a year or more, from now.

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[33] National Academy for State Health Policy. Modernizing Behavioral Health Systems: A Resource for States. March 22, 2024. Available at: https://nashp.org/modernizing-behavioral-health-systems-a-resource- for-states/.

[34] Becerra X, Palm A, Haffajee RL, et al. Addressing the Nation's Behavioral Health Crisis: An HHS Roadmap to Integrate Behavioral Health. *Health Affairs*. December 2, 2022. Available at: https://www.healthaffairs.org/content/forefront/addressing-nations-behavioral-health-crisis-hhs-roadmap-integrate-behavioral-health.

Given the nature of all of this input, the catalogue is broken into different categories to reflect the type of intervention as follows:

- Programs and services
- Consultation lines and services
- Funding source or financing mechanism
- Workforce
- Coalitions, networks, workgroups, and systems improvements
- Public education, health promotion, campaigns and app-based
- Curriculum or training
- Surveys, studies, and data collection
- Care setting

State agencies administer most of the interventions listed in the catalogue. It offers little in the way of input from commercial insurers, Accountable Communities of Health and Counties, although efforts to include those sectors were made and feedback was limited. The interventions are further broken out based on the following criteria:

- Care continuum
- Age of recipient
- Accountable and/or administering agency
- System specialty
- Subspecialized focus area
- Funding source

The catalogue is a key tool in describing the current landscape of mental and behavioral health for prenatal to age 25 people in the State of Washington, but, again, it is a snapshot in time and the healthcare sector is not static. It is subject to change in the future based on any changes in workforce, reimbursement, or public policies affecting coverage and other factors that influence supply and access.

A robust continuum of care offers services and supports that address the full scope of an individual's behavioral health and co-occurring needs in the settings that work best for the member, families, and caregivers. For the purposes of this catalogue, service types have been sorted into service categories. Each service description includes the identified age range to which the service is available. Though the categories may be the same across the age groups, the services appropriate for young children (birth−5 years old) differ greatly from those appropriate for school-aged children (6−12 years old), teens (13−17), and young adults (18−25). Some overarching service categories offer supports to all or some of the age ranges rather than just one age classification. Moreover, the sources of funding, the oversight and accountability often differ across the age ranges.

Prevention and Early Intervention Services

Primary prevention services must be delivered regularly and consistently to the entire P−25 population and throughout all ages and stages of development. These interventions include behavioral and developmental screenings that occur in all settings where the P−25 population can be reached, including primary care practices, schools, and early care and education. Primary prevention activities are closely linked with early intervention services (also known as secondary prevention services) and both reside at the lowest end of the acuity continuum and should be available to all. These services play a crucial part in either preventing more serious and costly care altogether or with early detection that will reduce the severity of symptoms and hardship.

Though these services are a required benefit in the publicly and privately funded health plans available to most of the P−25 population, more can be done to ensure that more resources are allocated to these activities to promote access and the use of best practices in screening tools and early intervention services. **Multiple state agencies are responsible for funding and administering myriad interventions and programs outside of health coverage within this part of the service array, creating confusion, overlap, duplication, and lack of collaboration and coordination across agencies. Washingtonians are confused about how and where to seek and receive appropriate prevention and early intervention services. A single access point for all could help address this confusion and better meet the needs of residents of this state**. At present, services offered and the responsible agency include:

- **DCYF provides home visiting services** to infants and young children up to age five and their families/guardians. These voluntary, family-focused services center on supporting the physical, social, and emotional health of young children and their caregivers.
- **DCYF's Plan of Safe Care (POSC)** serves children birth to five years old and their families. This family-centered prevention plan is designed to promote the safety and well-being of birthing parents and their infants with prenatal substance exposure. The purpose of the POSC is to ensure the parent and infant remain safe and healthy, work with families to identify their needs, and connect them to resources in the community and follow up over time to ensure those needs are met.
- **DCYF's Early Childhood Education and Assistance Program (ECEAP)** serves children from birth to age five and their families, providing free early learning to support a child's development and learning. It features family support and parent involvement, child health coordination and nutrition, mental health consultation, and services responsive and appropriate to each child's and family's heritage and experience. Eligibility is based on family income.

PREVENTION AND EARLY INTERVENTION ***(Secondary Prevention)*** Examples of Programs & Initiatives

- Home visiting services, P-5
- Parent Child Assistance Program, P-5
- Early Childhood Education and Assistance Program (ECEAP), 0-5
- Plan of Safe Care, 0-5
- Early Childhood Intervention and Prevention Services (ECLIPSE), 0-5
- Problem gambling treatment, 13-25
- Clubhouse and Peer-Run Organization Programs, 18-25
- Law Enforcement Arrest Diversion (LEAD), 13-25
- Projects for assistance in transition from homelessness (PATH), 18-25
- Supported employment, 13-25
- Reentry community services program, 18-25
- Sources of Strength, 12-25
- Pediatric Mental Health Care Access Initiative (PMHCA), 12-18
- Recovery Based Housing, 18-25
- Trueblood diversion, including Forensic HARPS, Forensic PATH, and Outpatient Competency Restoration (OCRP), 18-25
- Preventing Opioids Through Supported Transition (POST), 13-25
- Community assisted care, 13-17 and 18-25

- **DCFY's Early Childhood Intervention and Prevention Services (ECLIPSE)** program serves infants and children up to age five and their families. It offers healing-centered, trauma-specific, person-centered intervention and treatment services to people who have experienced substantial stress and/or complex trauma. Services included therapeutic interventions. Children and families who have interacted with or are interacting with the DCYF child welfare system are categorically eligible for these services, and children can become eligible based on their behavioral or emotional needs.
- **DCYF's Preventing Opioids through Supported Transition (POST)** serves young people ages 13-25. Summary Unavailable
- **DCYF community assisted care** is available to individuals ages 13−17 and 18−25. Summary unavailable.
- **DOH's Sources of Strength** serves people ages 12−18 and is a best practice youth mental health promotion and suicide prevention program designed to harness the power of peer social networks to create healthy norms and culture, ultimately preventing suicide, violence, bullying, and substance misuse. The goal of Sources of Strength is to prevent adverse outcomes among youth by improving their well-being, willingness to seek help, resiliency, healthy coping skills, and sense of belonging. Sources of Strength moves beyond a singular focus on risk factors by applying an upstream approach for youth suicide prevention. This upstream model strengthens multiple sources of support or protective factors for young people so that when times get hard, they can rise to the challenge. A total of 18 to 20 state-funded middle schools, high schools, and other youth-serving entities offer the program annually.
- **DOH's Action Alliance for Suicide Prevention (AASP)** uses strategy, momentum, and input to guide policy, financial, legislative, and programmatic change in accordance with Gov. Jay Inslee's January 2016 Executive Order (EO 16-02) and the Washington State Suicide Prevention Plan. Members share their multidisciplinary expertise, perspectives, and networks to improve suicide prevention implementation efforts across Washington State. The AASP supports and assists with the update to the Washington State Suicide Prevention Plan. Community engagement has been a cornerstone of the process and includes in-person workshops, focused listening sessions, subject matter expert interviews, focused workgroups, and public review. Input and feedback have been solicited from all residents to ensure the plan is informed by the people and represents the concerns of all Washingtonians.

- **DOH's Pediatric Mental Health Care Access Initiative (PMHCA)** serves children and teens aged 12−18 with funding from the Health Resources & Services Administration (HRSA) PMHCA grant. DOH's Children and Youth with Special Health Care Needs (CYSHCN) team is working in partnership with Seattle Children's and Frontier Behavioral Health in Spokane to increase mental health care access for youth in 10 primarily rural and frontier communities in Eastern Washington (Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanagan, Pend Oreille, Spokane, and Stevens). The PMHCA initiative addresses limitations in youth behavioral health workforce capacity in rural areas by connecting pediatric primary care providers to psychiatric specialty support through Seattle Children's Psychiatry Access Line (PAL) and increases availability of a brief crisis intervention model, Supporting Adolescents and Families Experiencing Suicidality (SAFES), for youth and their families. Other projects connected to the PMHCA initiative include:
    - A Seattle Children's Mental Health Consultation for Emergency Departments project to improve the availability of child psychiatry consultation to providers working in emergency departments
    - A collaboration with Reclaiming Futures (via Portland State University) to provide licensure, training, and ongoing support to a school-based health center in Walla Walla to implement an innovative school-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) program for uncovering and addressing youth behavioral health concerns in two schools
- **HCA has a parent-child assistance program (PCAP)** that serves infants and children ages 0−5 and their birthing parents. It is an evidence-informed program that provides intensive case management and support services to pregnant and parenting women with substance use disorders and their young children. Services include:
    - Referral, support, and advocacy for SUD treatment and continuing care
    - Assistance with accessing and using local resources such as family planning, safe housing, healthcare, domestic violence services, parent skills training, child welfare, childcare, transportation and legal services
    - Linkages to healthcare and appropriate therapeutic interventions for children
    - Timely advocacy based on client needs.
- **HCA offers problem gambling treatment** to youth and young adults ages 13−25 and provides gap treatment reimbursement funding for eligible individuals and family members who are seeking clinical treatment for problem gambling and gambling disorder (DSM-5). The program funds certified gambling counselors and other clinicians and supports prevention, awareness, outreach, and education activities statewide.

- **HCA Clubhouse and Peer-Run Organization Programs** serve young adults ages 18−25 and benefits both individuals and peer communities working toward recovery. These programs provide a restorative environment for people with behavioral health challenges and whose lives have been severely disrupted because of these challenges and who need the support of others in recovery. Clubhouses and peer-run organizations help members locate employment and educational opportunities, find community-based housing, and participate in health and wellness activities—all of which are intended to reduce hospitalizations and involvement with the criminal justice system, as well as improve social relationships, satisfaction, and quality of life.
- **HCA's Law Enforcement Arrest Diversion (LEAD)** program serves youth and young adults ages 13−25 is a model framework that supports community-based alternatives to jail and prosecution for people who have engaged in unlawful behavior because of unmanaged substance use, mental health challenges, or extreme poverty. LEAD provides care coordination for these individuals, who tend to have complex, ongoing unmet behavioral health needs and/or income instability and may lack shelter/housing, income, food, healthcare, and social networks. The program starts by diverting people with behavioral health needs away from jail and prosecution and into collaborative community-based systems of response and care.
- **HCA's Projects for Assistance in Transition from Homelessness (PATH)** serves young adults ages 18−25 and is designed to assist eligible individuals with accessing supportive services, basic needs resources, and healthcare. Services include housing, systems and benefits advocacy, mental health care, SUD treatment, disability support, and other services to enable enrollees to move toward goals. Eligibility criteria include having a serious mental illness (SMI) or co-occurring disorders (COD) and experiencing homelessness or being at imminent risk of homelessness.
- **HCA offers supported employment services** to youth ages 13−25 and helps individuals with significant barriers to finding and maintaining a stable job, including young people with multiple diagnoses. Employment is associated with a range of improved quality of life indicators including overall well-being, self-esteem, management of mental health symptoms, and financial stability. This program serves individuals who are eligible for the Housing and Essential Needs (HEN) or Aged, Blind, and Disabled (ABD) programs; those experiencing significant mental illness and/or SUD; long-term care recipients with complex needs; and vulnerable teenagers and young adults with behavioral health challenges.
- **HCA's reentry community services program** serves young adults ages 18−25 and promotes successful reentry, public safety, and recovery for eligible individuals who are exiting a Department of Corrections (DOC) facility and who DOC has identified as high risk and having a diagnosed mental health disorder. Specific services provided include prerelease engagement, intensive case management, specialized treatment services, housing assistance, basic living expenses, transportation assistance, educational and vocational services, employment services, unfunded medical expenses and other non-medical treatment supports that increase capacity to live in the community.

- **HCA's recovery-based housing** supports serve young adults ages 19−25 and includes supportive housing through Housing First and harm reduction programs that focus on a variety of assist people who unhoused or unstably housed with behavioral health diagnoses. The supportive housing program is a component of the state 1115 Medicaid transformation project waiver and is designed to assist eligible individuals with housing and employment by delivering coaching, advocacy, information and referrals, linking and coordinating, and ongoing supports. The Housing First program in tandem with the harm reduction model to deliver housing stabilization services to low-income unhoused and unstable young adults with diagnosed behavioral health conditions.
- **HCA's Trueblood diversion**, serves people ages 18−25. It includes the Forensic Housing and Recovery through Peer Supports (HARPS), Forensic Projects for Assistance in Transition from Homelessness (PATH), and Outpatient Competency Restoration Program (OCRP). Summary unavailable.

Outpatient and Integrated Care

Both publicly and privately funded health plans cover outpatient and integrated care. Nonetheless, the experience of Washingtonians seeking these services is generally disappointing because wait times are too long due to a combination of low reimbursement and the administrative burden providers would face in dealing with multiple payers. In addition, some specific services have medical necessity requirements. Washington has been a national leader in pioneering integrated care through the Collaborative Care Model, but this best practice has yet to be deployed to the full extent possible for the P−25 population.

For several years the mental health referral assistance service described below has tracked the availability of appropriate accessible outpatient services for children and teens up to age 17 and shows the short supply of these services and lengthy wait times associated with receiving them. The experience for youth seeking integrated care is similar.

- **HCA provides mental health referral assistance services for children and teens** ages 17 and younger and connects families with mental health providers in the family's community who accept new patients. The service also works with insurance and fit to meet the child's or teen's needs.
- **HCA is charged with ensuring collaborative care is available to all Medicaid enrollees**. Collaborative care is a type of integrated care in which medical providers and behavioral health providers partner to address behavioral health conditions, including mental health and substance use disorders. It includes care management support for patients receiving behavioral health treatment and regular psychiatric consultation with the primary care team.

OUTPATIENT & INTEGRATED CARE
Examples of Programs & Initiatives

- Mental health referral assistance service for children and teens, 0-17
- Collaborative Care, All
- Ancillary therapeutic services, 13-17
- Intensive outpatient and partial hospitalization services, 13-25

- **HCA provides intensive outpatient and partial hospitalization services** for a variety of diagnoses, including anxiety and obsessive-compulsive disorder and school refusal for ages 13−25. These programs provide multiple-hour intensive therapeutic services delivered by clinicians with specialized training that allows families to return home in evenings to practice implementation of tools and skills gained to facilitate a full transition home.
- **OHY's ancillary therapeutic services** serve youth ages 13−17 and provides a variety of behavioral health supports to people engaged in agency programs. Services include screening and referral, diagnosis by a licensed mental health provider, brief behavioral health treatment, counseling, substance misuse prevention, harm reduction, care coordination, and more.

Intensive Home and Community Based Supports

These services are covered by publicly and privately funded health coverage, but the supply is inadequate supply to meet all of the needs of the population. The reasons for this challenge vary by service somewhat, with insufficient funding for Apple Health reimbursement and a lack of properly trained workforce as the primary factors.

HCA's Wraparound with Intensive Services (WISe) program is intended to serve all children and youth with complex needs. The reality, however, is that WISe has a long wait list, and the program unable to meet the needs of the highly complex youth population because too few professionals receive the necessary specialized training.

- **DCYF's combined in-home services** serves children and youth within the child welfare system and their families through a variety of evidence-based models (e.g., parent-child interaction therapy, intensive family preservation services, Triple P, promoting first relationships, and others). Services are designed both for the prevention of out-of-home placement and to support successful family reunification.
- **DCYF's behavioral rehabilitation services** serves youth ages 13−17 who are in the child welfare system, whose support needs are greater than what WISe alone can provide.
- **HCA's WISe** serves children and youth from birth to age 18 and provides intensive mental health services in home and community settings for eligible children and youth with complex, cross-system needs. Services include crisis planning and face-to-face interventions. WISe uses a wraparound approach and is strengths-based, relying heavily on youth and family voice and choice through all phases.

INTENSIVE HOME & COMMUNITY BASED SERVICES
Examples of Programs & Initiatives

- Wraparound with intensive services (WISE)
- New journeys first episode psychosis, 13-25
- Combined in-home services
- Behavioral rehabilitation services, 13-17

- **HCA's New Journeys, an Early Intervention Program for First Episode Psychosis** serves youth and young adults ages 13−25 and delivers early screening, evidence-based interventions, and improved quality of life for individuals experiencing first episode psychosis (FEP). The program provides access to services as symptoms emerge rather than waiting for the individual to become severely, chronically ill. It involves a multidisciplinary team providing a spectrum of person-centered, community-based services that account for the person's natural supports. New Journeys also includes public education and outreach to hasten identification and rapid referral of young people experiencing FEP.

Comprehensive Crisis Care

Comprehensive crisis care supports the needs of children and youth with needs that are more acute than outpatient settings can meet but are not yet serious enough to require hospitalization. Comprehensive crisis care is less widely available than are outpatient services. Some comprehensive crisis care offerings serves a population with multiple complexities and needs. Other services are focused on populations with a specific and relatively common mental health diagnosis. In a fully functioning system, comprehensive crisis care can catch children and youth before their mental health needs escalate and require more intensive interventions such as emergency mental health services. Washington is implementing a number of changes to its crisis system including requiring private health plans to contract with crisis providers, which offers important lessons for aligning different funders of health coverage to support a more robust set of services.

COMPREHENSIVE CRISIS CARE
Examples of Programs & Initiatives

- Youth residential crisis stabilization program (RCSP)
- Tribal crisis services

- **HCA's youth residential crisis stabilization program (RCSP)** serves children and youth ages 5−17 and provides 24/7 intake, treatment, and supervision in a safe and therapeutic environment. The service is for children and youth who do not meet the acute inpatient or free-standing psychiatric hospitalization criteria yet still need intensive intervention. It serves young people experiencing a behavioral health crisis who require emotional or behavioral intervention, stabilization, and support. The RCSP treats children and youth with co-occurring mental health, substance use, intellectual, and developmental conditions who need immediate, short-term crisis stabilization.
- Information regarding **Tribal crisis services** for ages 13−25 is unavailable.

Inpatient Services

Inpatient services are a required benefit in both publicly and privately funded health coverage for individuals who meet the criteria for admission. Many children, youth, and young adults who require inpatient care either never receive it or receive it after an unacceptably lengthy wait. The overall number of inpatient beds serving the child and youth Apple Health population has declined in recent years in Washington largely due to inadequate funding.

- **HCA supports pregnant people who use substances** and are ages 18−25 qualify for inpatient services for up to 26 days to improve the health of the pregnant individual and the fetus, including: immediate access to care, withdrawal management, medical stabilization and treatment, and SUD treatment.
- **HCA authorizes services provided under the Involuntary Treatment Act (ITA)** that are available to youth and young adults ages 13−25 whose symptoms are so acute that they may require involuntary admission to an evaluation and treatment (E&T) facility or a secure withdrawal management and stabilization (SWMS) facility. Individuals are typically referred under the ITA by family members, first responders, caregivers, or other medical providers. Individuals undergo an evaluation to determine whether they are at risk of serious harm and/or grave disability. If a high level of risk is present, they are referred to an E&T or SWMS facility for up to 120 hours of treatment and stabilization that could be extended if they are still at risk.

INPATIENT SERVICES
Examples of Programs & Initiatives

- Substance using pregnant women, 18-25
- Services under the Involuntary Treatment Act (ITA), 13-25

Residential Services

Residential services for children, youth and young adults are also a required benefit in both publicly and privately funded health plans for individuals who meet the criteria for admission. Still, due to inadequate funding and workforce and increasing demand, residential services are in short supply and unable to meet the needs of this population. Although the state has expanded the number of beds authorized to serve children and youth in recent years, the number of available beds lags behind the number of people authorized.

- **DCYF funds mental health treatment in carceral settings** for youth and young adults ages 13−25. A summary is unavailable.
- **HCA's Children's Long-Term Inpatient Program (CLIP)** serves children and youth ages 6−17 and is the only publicly funded, long-term inpatient program for youth. CLIP serves young people diagnosed with serious psychiatric illnesses who typically have been served by multiple systems and have complex needs such as suicidal/self-injurious behavior, intense aggression or sexualized behavior, medical needs, co-occurring SUDs, complex family and legal issues, and co-occurring developmental disabilities.

RESIDENTIAL SERVICES
Examples of Programs & Initiatives

- Children's Long-Term Inpatient Program (CLIP), 6-17
- Long-term civil commitments (90- and 180-day beds), 18-25
- Forensic mental health, 18-25
- Mental health treatment in carceral settings, 13-25

- **HCA's Long-term civil commitments (90 and 180 days of institutional care) programs** for people ages 18−25 provides people with long-term civil commitments to receive services in a variety of community hospitals across the state (not just state hospitals).
- HCA's **forensic mental health** service are available to young adults ages 18−25, but a summary is not available.

Recovery Supports

- **HCA funds peer supports** for youth and young adults ages 12−25. Peer support services pair individuals in recovery from mental health and SUD treatment with certified peer counselors (CPCs) who have had shared life experiences. CPCs inspire peers to find hope and make progress toward recovery through shared understanding, rapport, and empowerment.
- **HCA's Recovery Navigator Program** serves youth and young adults ages 13−25 and provides behavioral health services to individuals who are justice involved because of drug possession or other alleged criminal activity and who have SUD, are using drugs in a problematic way, or have co-occurring disorders. The program provides community-based outreach, intake, assessment, and connection to services referred through pre-booking diversion and community referral. The program is modeled on core components of LEAD. Program staff facilitate and make connections to a broad range of resources including treatment and recovery support services.
- **HCA** offers **discharge and housing supports for youth and emerging adults including recovery residences** for young adults ages 17−25. Recovery residences are safe, healthy, family-like, substance-free living environments that support individuals in recovery from SUD. These residences are centered on peer support from others in recovery and connections to services that promote long-term recovery.
- **HCA's Peer Bridger, Pathfinder, and Respite programs are designed for people ages 18−25.**
    - **The Peer Bridger Program** delivers peer support services to people in state hospitals prior to discharge and after returning to the community. Peer Bridger staff develop trusting relationships with clients and can play various supportive roles including role model, mentor, teacher, and ally. Peer Bridgers promote culture change to promote the expectation that recovery is possible.

RECOVERY SUPPORTS
Examples of Programs & Initiatives

- Peer supports, 12-25
- Recovery Navigator Program,13-25
- Discharge and housing supports for youth and emerging adults, including recovery residences, 17-25
- Peer Bridgers, 18-25
- Peer Pathfinders, 18-25
- Peer Respite, 18-25

- **Peer Pathfinder Project** builds on the PATH program to provide SUD peer recovery support in emergency departments and homeless encampments. It links people with treatment options, helping them navigate and obtain other services to address barriers to independence and recovery including housing, financial resources, transportation, habilitation and rehabilitation, and prevocational and vocational services.
- **Peer Respite** facilities offer voluntary, short-term (up to 7 days), 24-hour services in home-like settings. Clients may receive peer services from CPCs in these facilities, which are designed to aid in their wellness and recovery and to avoid more intensive levels of service.

Care Coordination

- **HCA's The Bridge** is a statewide collaboration that between community-based housing providers, behavioral health discharge planners, other community-based professionals, and young people with lived experience that serve people ages 16−25. The group focuses on facilitating unaccompanied young people's return to the community with safe housing and services upon exiting an inpatient behavioral health setting. The Bridge provides cross-system coordination and training, return to community customized planning, and goal setting for future education and system change.
- **DCYF/HCA/OHY/DSHS(DDA), collaborated to provide the Youth and Young Adult Housing Response Team**, which offers resource referral and navigation for youth and young adults ages 12−24 who are exiting a publicly funded system of care and are at risk of homelessness. The goal is for any unaccompanied youth discharged from a publicly funded system of care be discharged into safe and stable housing. The team assist participants with finding stable housing.
- **HCA's Youth Behavioral Health Navigators (Kids Mental Health Washington) program** serves children up to 17 years old and is designed to support each region with communitywide teams that convene to support children, youth and families, building an access portal for individuals concerned about a child or youth to reach out requesting support, and convene a multidisciplinary team from the communitywide team to support the child, youth, or family with accessing the services they need and develop a plan to meet their needs.

CARE COORDINATION
Examples of Programs & Initiatives

- The Bridge
- Youth and Adult Housing Response Team
- Youth Behavioral Health Navigators (Kids Mental Health Washington)

Community Services

- **HCA's Foundational Community Supports (FCS)** resources provide supportive housing and other resources for youth and young adults serving ages 18−25. The FCS program funds services at approximately $6,300 per person in supportive housing annually. It pays to help applicants obtain documentation and complete paperwork necessary to move into housing and, once housed, the benefit includes funding to assist tenants with: planning to meet treatment and service needs; working with property managers; life skills training, budgeting, accessing treatment and benefits; and eviction prevention.

COMMUNITY SUPPORTS
Examples of Programs & Initiatives

- Foundational Community Supports

SUMMARY AND NEXT STEPS

Washington's behavioral health services are funded, overseen and administered by several different entities. Each has different accountabilities and requirements that guide both their oversight and how they ultimately contract with providers to deliver behavioral health services. Moreover, no single entity is responsible for ensuring and monitoring the quality of and access to the behavioral health services that are being delivered to the P−25 population across these different entities. This results in a fragmented system of care in which behavioral health providers experience high levels of administrative burden to comply with multiple contract requirements and where monitoring and measuring the access to and quality of the services is challenging. Ultimately, this burden is underscored by the need to combine or leverage these different sources of funding in a way that results in services that are coordinated and patient-centered. Combined with the poor reimbursement rates for behavioral health services both in publicly and privately funded coverage, it is unsurprising that the experience of children, youth, families, and caregivers is one that reflects poor access, a lack of coordination, and unnecessary suffering as the result of having to repeatedly interface with different providers, programs and services.

Further complicating this and as reflected in **Figure 3 and the catalogue of services,** different entities are involved in providing different behavioral health services for different portions of the population (often varied by age, by setting or by involvement with child welfare). During a a meeting of the System Partners and Providers Discussion Group of the Washington Thriving Advisory Group in December of 2024 members expressed their appreciation for the catalogue, especially the effort to reflect a comprehensive compendium of the state's programs and initiatives. Participants offered some insights in how to organize and capture additional information for strategic plan development, which included:

1. Bring together agency leadership to agree on the categories of behavioral health services for the P–25 population and develop common definitions of what each category of services means.
2. Confirm information and programs identified to ensure that this catalogue is comprehensive and accurate and that different programs are categorized correctly according to the agreed-upon definitions.
3. Share information with the System Partners and Providers Discussion Group participants so they can better understand the content of the catalogue and offer input.

At the same time, statewide agreement on how different behavioral health services are defined and categorized can provide an organizing framework for the information that is collected and gathered in the quantitative gap analysis about access to the services, cost of and payment rates for services and quality of the services across publicly and privately funded sources of health coverage. This framework can then be used to identify and build out more specificity and guidance for providers about the types of programs, treatments and interventions that fit within each service category, and identified and reimbursable best practices within each category. Finally, this framework can be used collectively with state agency leaders, providers and payers to align training, contracting, payment rate increase to ensure access to and improve the quality of the services that comprise the P−25 behavioral health continuum.