

MEMORANDUM

TO: Gavin Cooley

FROM: Research support (Cowork)

DATE: June 22, 2026

RE: How much behavioral-health money Spokane County actually *controls* — and what that means for homelessness response

Bottom line. The behavioral-health dollars Spokane County genuinely controls are far smaller than the headline totals suggest, because most treatment money passes *through* the county (restricted) or *around* it (Medicaid). The county's truly discretionary behavioral-health money is roughly **\$20–25 million a year** — the 1/10 of 1% behavioral-health sales tax plus opioid-settlement funds. On top of that it *administers* a larger, state-directed crisis system as the regional BH-ASO, and it does **not** control the largest pot, Medicaid behavioral-health treatment, which flows through managed-care organizations.

Summary Table — Behavioral-Health & Related Funding by Control Level

1/10 of 1% behavioral-health sales tax	~\$15–22M / yr (proceeds; \$15M+ allocated in 2025, plus ~\$7M to crisis-center expansion)	Discretionary — Commissioners direct	Mental health court, Initiative for Student Wellness, behavioral-health transitional housing, regional stabilization/crisis center. The county's primary local lever.
Opioid settlement funds	~a few \$M / yr (e.g., \$5M to stabilization center; tens of \$M over the full multi-year settlement)	Discretionary (restricted to opioid abatement)	Treatment, recovery, and crisis infrastructure tied to addiction — central to homelessness root causes.
BH-ASO / Spokane County Regional Behavioral Health (SCRBH) state crisis funds	Larger pass-through (exact contract total not yet pulled)	Administers — state-directed, restricted	Crisis line, mobile crisis, ITA/involuntary treatment, crisis stabilization — provided regardless of insurance or ability to pay. Control is administrative, not budgetary.
Medicaid behavioral health (Apple Health / managed-care orgs)	Largest pot (not a county appropriation)	Indirect only — county is the ASO, <i>not</i> the MCO	Bulk of treatment dollars; held by the five Apple Health MCOs, not the county. MCOs must, however, contract with the county BH-ASO for crisis services (see “BH-ASO, not MCO” below). Often mistaken for county money in aggregate “behavioral health” totals.
County 2026 “community support” (housing + addiction + MH, blended)	>\$80M across various funds (within the \$983M total 2026 county budget)	Mixed (discretionary + pass-through + restricted)	Includes \$15M toward the Spokane Regional Stabilization Center. Useful headline, but overstates freely-redirectable money.

Homelessness / housing grants (state Consolidated Homeless Grant, document-recording fees, federal Continuum of Care)	Separate ledger (not in BH accounts)	Mostly City of Spokane + state	This is the "Tier 1" funding now being squeezed by new federal rules (cap cut from 90% to 30%). Distinct from county BH money.
Genuinely discretionary BH money the county can move	≈ \$20-25M / yr	Discretionary	Sales tax + opioid settlement, sitting atop a much larger restricted/pass-through system.

Dollar figures marked "~" are estimates inferred from published allocation decisions, not from a confirmed gross-revenue budget line. See "Data caveats" below.

The Distinction That Matters

For a homelessness-response conversation, the politically important point is not the size of the behavioral-health system but how much of it the county board can actually *redirect*. Three tiers:

1. Controls (discretionary). The 1/10 of 1% behavioral-health sales tax is the real lever — Commissioners decide, year to year, where the proceeds go. In 2025 that meant \$15M+ for mental health court, student wellness, and behavioral-health transitional housing, with roughly \$7M steered to the regional stabilization/crisis center. Opioid-settlement dollars add a few million more, restricted to abatement but locally directed.

2. Administers (restricted, state-directed). As the Administrative Services Organization for the Spokane Regional Service Area, the county contracts and disburses state crisis funds — crisis line, mobile crisis, involuntary treatment, crisis stabilization — regardless of a person's insurance. This is a larger flow, but it is restricted to crisis services and shaped by the state, so it is "control" in an administrative sense, not a budget-priorities sense.

3. Does not control. The largest behavioral-health treatment dollars run through Medicaid managed-care organizations (Apple Health), not the county. Large aggregate "behavioral health" figures mostly reflect this pass-through, which is why the >\$80M "community support" line in the 2026 budget overstates what is freely redirectable.

BH-ASO, Not MCO — and the Leverage That Remains

A common shorthand is that the county "is the MCO." It isn't, and the correction matters. Spokane County is the **Behavioral Health Administrative Services Organization (BH-ASO)** for the six-county Spokane Regional Service Area (Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens). The **MCOs** are the five Apple Health managed-care insurers. They are different roles holding different money.

What changed in 2019. Until integrated managed care, the county-run entity — first the Regional Support Network, then the Behavioral Health Organization (BHO) — *did* hold and manage the full Medicaid behavioral-health budget for the region. When the Spokane region integrated in 2019, that Medicaid responsibility, and the dollars, moved to the MCOs. The county was left with the BH-ASO function. In short, the county already gave up direct control of the Medicaid behavioral-health pot; it no longer holds the capitation.

So how much control does the county have over Medicaid dollars today? Directly, essentially none — but it keeps real *indirect* leverage:

- **It owns the crisis system the MCOs are required to buy into.** By law, the integrated MCOs must contract with the BH-ASO for crisis services for their Medicaid enrollees. The county designs and holds those crisis contracts — mobile crisis, the crisis line, involuntary treatment (ITA), stabilization — for everyone in the region regardless of insurance. That is genuine system-shaping power even though the underlying treatment dollars belong to the MCOs.
- **It controls the non-Medicaid slice.** Of the state general-fund appropriation for behavioral-health rate

enhancement in each region, 20% flows to the BH-ASO (non-Medicaid) while the remaining 80% plus all federal funds go to the MCOs (Medicaid). The county directs that non-Medicaid 20%, along with state crisis appropriations and services for the uninsured.

- **It holds regional convening and oversight roles** — the behavioral-health advisory board and the ombudsman — which set regional priorities and surface gaps even without controlling the Medicaid budget.
- **Its discretionary dollars are the flex.** The sales-tax and opioid-settlement money (the ~\$20–25M in the table) is exactly what the county can deploy to fill gaps Medicaid and the MCOs won't cover — transitional housing, court diversion, stabilization infrastructure. This is where county influence over the *shape* of the homelessness/behavioral-health response is most real.

Net: the county does not control Medicaid dollars the way an MCO does — it influences the system as the regional crisis administrator and gap-filler. The lever it can pull on its own remains the ~\$20–25M discretionary base, amplified by its statutory power to set crisis-system terms the MCOs must accept.

How the County Exercises “Voice” Over Dollars It Doesn't Own

Even without holding the Medicaid capitation, the county has several concrete channels of influence over how regional behavioral-health dollars — Medicaid and otherwise — actually get spent. This is where the practical answer to “how much say does the county have?” lives.

- 1. The county governs the regional crisis administrator.** BH-ASOs in Washington are county bodies, and the governance model is itself a lever: some regions are governed by multiple counties (Greater Columbia's ASO by nine counties; Thurston-Mason's by two). In the Spokane Regional Service Area, Spokane County Community Services is the BH-ASO (SCRBH) for all six counties. The county doesn't merely participate in the crisis system — it governs it, sets its priorities, and holds its provider contracts.
- 2. MCOs are legally tethered to the county's crisis system.** Integrated MCOs must contract with the BH-ASO for crisis services for their Medicaid members, and those contracts carry coordination and data-sharing requirements. That gives the county a permanent seat at the table on how Medicaid enrollees move through crisis care, hand-offs, and follow-up — the exact points where homelessness and behavioral health intersect.
- 3. “Braiding” — the county's real strategic power.** The county's discretionary local dollars are small next to Medicaid, but they buy outsized influence because they fund the gaps Medicaid won't and set priorities the larger system then has to coordinate around. The 1/10 of 1% sales tax (RCW 82.14.460) carries five statutory funding priorities and is routinely used to fill exactly these gaps — housing for people with behavioral-health needs, criminal-justice-involved clients, and prevention/early intervention. The recognized statewide model is to *braid* these local dollars with the federal block grant, the HCA crisis contract, and Medicaid into a single service (King County, for example, braids its MIDD 0.1% sales tax with the block grant, HCA contract, and Medicaid to run its children's crisis system). When the county puts its dollars on the table first, it effectively designs the service the MCOs and state then plug into.
- 4. It administers state crisis revenue.** The statewide 988 crisis-line tax flows to BH-ASOs to fund required regional crisis services, and the non-Medicaid state general-fund slice (the 20% noted above) is the county's to direct. These are not Medicaid dollars, but they fund the regional backbone — mobile crisis, the 988/crisis line, stabilization — that Medicaid care depends on.
- 5. Formal coordination and advisory channels.** The transition to integrated care created standing cross-sector steering committees that include MCOs, the state, county representatives, providers, and criminal-justice partners; regionally, the behavioral-health advisory board and ombudsman give the county structured input. And because HCA — not the MCOs — writes the MCO contracts, county advocacy to HCA is a real (if indirect) route to shaping what MCOs are required to do.

The honest limit. None of this is control of the Medicaid capitation. The MCOs still set network, rates, and utilization for the bulk of treatment dollars. The county's voice is strongest where it (a) governs the crisis system MCOs must use, (b) braids its own discretionary dollars to set service design, and (c) advocates to HCA on contract

terms. It is weakest on the core Medicaid treatment spend, where the county is a coordinator and influencer — not the payer.

Why This Frames the Homelessness Question

"Mental-health dollars" and "homelessness-response dollars" are overlapping but separate ledgers. Much homelessness and housing funding — the state Consolidated Homeless Grant, document-recording fees, and the federal Continuum of Care — runs primarily through the City of Spokane and the state, not the county's behavioral-health accounts. That distinction is sharpened right now by new federal guidance cutting Tier 1 renewal funding from 90% to 30% as the administration moves away from Housing First. The county's discretionary behavioral-health money becomes more strategically important precisely as the housing-side grant base tightens.

Data Caveats

The dollar ranges above are drawn from public reporting on the county's *allocation* decisions, not from a single confirmed gross-revenue line for the 1/10% tax or a published SCRBH ASO contract total. The estimates are sound for order-of-magnitude and strategy discussion, but should be replaced with exact figures before any public statement.

Recommended Next Step

Pull two exact numbers from the county's adopted 2026 budget and the SCRBH ASO contract: (1) gross annual revenue of the 1/10 of 1% behavioral-health sales tax, and (2) the total state crisis-services contract the county administers as BH-ASO. Those two figures convert this from a defensible estimate into a citable, podium-ready fact base. I can do that pull on request.

Sources: Spokesman-Review, "Spokane County Commission passes \$983 million 2026 budget" (Dec. 1, 2025); KHQ, "Spokane County breaks ground on \$21M center for mental health, substance use care" (2026); The Center Square, "Spokane County OKs sales-tax money for mental health clinic"; Spokane County BH-ASO and Mental Health Treatment Services pages (spokanecounty.gov); The Center Square, "Spokane braces for homelessness funding cuts ahead of new federal funding rules" (June 2026). Figures marked as estimates are inferred from reported allocations.

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