Meeting the Mental Health Needs of Young Low-Income Children Via Medicaid Funding

Our Current Challenge: Washington lacks a state-wide approach to addressing the mental health of its neediest young children birth to five. As a result, where a child's family lives can determine whether or not the child's serious mental health needs are ever assessed or addressed. Obtaining support is a particular challenge for families with infants and toddlers given a limited understanding of, and the dearth of mental health clinicians with specialty training in, Infant & Early Childhood Mental Health (IECMH).

Key Players:

- Health Care Authority – Oversees All Medicaid and SCHIP (Apple Health) Billing
  - Apple Health – Contracts Mental Health Services for Less Serious MH Needs
- Division of Behavioral Health and Recovery in DSHS –
  - Oversees Inpatient Substance Use Providers, Community Outpatient Substance Use Providers and Regional Support Networks (RSN's)
    - RSN's Oversee Community Mental Health Providers Serving Low-Income Individuals with Serious Mental Health/Behavioral Health Needs
      - RSNs use Managed Care (King) or Fee For Service (FFS) (Snohomish) systems.
      - RSNs require a child to meet Access to Care Standards (ACS) including having a covered diagnosis (off a limited list) and meeting standards for severity.

Key Transitions:

- US 2015 – MH Providers shifted from using the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) to the DSM-V. Version V is less developmentally appropriate for young children than IV.
  - The V eliminated the scale (Children's Global Assessment Scale/CGAS) that providers were using to rate the severity of MH disorders in order to determine the intensity of services needed.
- US 2015 – Health and MH providers were required to change from the ICD-9 (International Classification of Diseases) to the ICD-10. ICD codes are required for billing purposes.
  - DSM diagnoses (identified by clinician) are automatically linked in electronic data management systems to ICD codes determined by the state.
- WA 2015 – The Access to Care Standards (ACS) were modified to accommodate these changes.
- WA 2016 – RSN's are being eliminated and Chemical Dependency and Mental Health services will be integrated going forward under single integrated entities "Behavioral Health Organizations" (BHOs).

Key Issues:

- **Getting Children Into Services – Developmentally Appropriate Diagnosing**
  - Few providers use an age appropriate diagnostic structure like the Diagnostic Classification of Mental Health & Developmental Disorders of Infancy & Early Childhood Rev. (DC03-R).
    - Discussion of the DC03-R was removed from the ACS during revision.
  - Those who were using the DC03-R used a 'crosswalk' to the DSM-IV developed in King County. A 'crosswalk' to the DSM-V is clinically problematic.
    - The DSM-V eliminated the diagnostic code being used in the 'crosswalk' for when a significantly disordered caregiver-child relationship is present.
  - The covered diagnosis list in the ACS revision did not include several ICD-10 codes most appropriate for characterizing young children's mental health challenges.
  - The revised ACS did not specify what scale should be used to replace the CGAS. Many RSN's are moving to the CALOCUS – designed for children 6-17.

- **Getting Children the Right Services – Treating in the Context of Relationship**
    - The revised ACS do not fully articulate what a 'severe' MH challenge looks like in a very young child. In a managed care setting, like King County, providers are paid a fixed amount based on the level of severity (King: B rates are ~3-4 times A rates). When young children do qualify for RSN services they often do so only at the lower rate even if they require more intensive services (such as children involved with child welfare).
    - More often young children are deemed unable to meet ACS and are referred to Apple Health. Reimbursement rates for Apple Health are significantly lower. (Snohomish $130/hr vs $45).
    - Both the ACS and HCA policy are focused primarily on the child with limitations in:
        - Treating the family or seeing a parent without the client being present.
        - Providing prevention oriented treatment based on parental mental health challenges.
    - Home Based Services are best practice in IECMH in most cases. However, whether or not providers are compensated for this approach varies by RSN.
        - Snohomish FFS model currently pays $130/clinical hour in office and $185 in home.
        - King County rates are based on severity level (A/B), not where services are delivered

Potential Solutions:

- **Getting Children Into Services**
    - Revise the ACS to set the expectation that a developmentally appropriate diagnostic approach like the DC03 will be used when seeing young children.
        - MI State's policy has excellent language in this regard.
        - Language to this effect is contained in Strategy 8 in the WA State ELP from early versions of HB 1373 (2009) www.del.wa.gov/publications/elac-qris/docs/ELP.pdf .
    - Revise the ACS to include all appropriate ICD-10 codes and encourage providers to 'crosswalk' directly from the DC03R to ICD-10, bypassing the DSM entirely (e.g. FL).
    - Revise the ACS to include a developmentally appropriate tool for determining the Level of Care needed by young children for statewide use to ensure equity. (ex: MI State's policy)
- **Getting the Right Services**
    - Revise ACS and HCA policy as needed to clearly delineate what substantive mental health challenges look like in a young child AND remove limitations on *family* treatment
        - Examples for descriptive language: MI State, NM State, & King County
    - Review existing Medicaid waiver, clarify policies, and standardize billing for home-based services so that providers are able to implement best practices.
    - Explore replication of innovative prevention strategies that address parental mental health such as Ohio's Maternal Depression Screening and Response Program (required in all OH home visiting).

System Activities Needed:

- **Immediately** convene a statewide group of IECMH experts to work with DBHR and HCA to address revisions to the ACS and identify needed HCA policy shifts (Examples: WI, MN, MI, FL).
- Ensure BHO contracts contain clear direction regarding meeting the MH needs of children 0-5 and ensuring contracted providers have the skills needed to both diagnose and treat this population.
- Provide standardized training around the state on using the DC03R and the DC05 (coming Dec 2016).
- Address workforce development by utilizing the WA-AIMH Endorsement® system to ensure providers have the necessary skills to serve this population as some other states have done.
- Develop an ongoing IECMH taskforce or other interdisciplinary body to focus long-term on: improving awareness of IECMH including; system development; and exploring innovative potential funding strategies (EX: NM State's use of SAMHSA Diagnostic Impression of Imminent Risk codes).
    - **Immediate First Steps** --Include IECMH and DBHR into existing integration and collaboration conversations with DEL (QRIS), Thrive (HV), ESIT, Children's Administration and the HCA.