PDG B-5 TA CENTER

Medicaid Partnerships in Washington State Contributing to a Continuum of Infant and Early Childhood Mental Health Supports and Services

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This brief consists of a case study informed by the perspectives of partners across sectors in Washington State who have engaged in innovative ways to build the infrastructure and field capacity to finance infant and early childhood mental health screening, assessment, diagnosis, and treatment. Specific examples from Washington State will help other national and state program leaders understand 1) ways state administrators across agencies can partner with advocates and policymakers to raise awareness about infant and early childhood mental health; 2) approaches for collaborating with colleagues in state Medicaid offices on specific financing strategies; and 3) strategies for advocating for and implementing reform in the assessment and diagnosis of mental health issues in infants, toddlers, and young children that drive service delivery and billing.

Introduction

In the past two decades, the visibility of infant and early childhood mental health (IECMH) has been increasing, as have considerations about the societal cost of failing to intervene early to support children's social-emotional development and address concerns in ways that are developmentally appropriate and based on an emerging body of evidence. While the early childhood years are a time of tremendous possibility, young children who live in family and community contexts in which they experience parental loss, substance misuse, mental illness, or other early adversities are at greater risk for poorer behavioral and physical health outcomes (Felitti et al., 1998; Perigee Fund, 2021a; Zero to Three, 2017, 2019). Recently, the **National Scientific Council on the Developing Child** (2020) described how to disrupt stress and adversity by intervening across systems to support the early foundations of physical and mental health.

What is infant and early childhood mental health (IECMH)?

According to **Zero to Three** (2017), IECMH is "the developing capacity of a young child from birth to five years to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; explore the environment and learn—all in the context of family, community, and culture" (p. 1).

Many states, territories, and tribes have been working on financing a continuum of IECMH supports and services through Medicaid and our health care system. This continuum aims to promote healthy social-emotional development; prevent more extensive mental health issues; and provide treatment for those

young children and their families who may need skilled interventions and support to develop nurturing, responsive relationships that undergird child development and growth. However, despite a growing evidence base, scaling and sustaining IECMH supports and services has been challenging, and there is a continued need to address inequities and underfunding of our systems of care to support IECMH (Perigee Fund, 2021b). Washington is among several states that received **Preschool Development Grant Birth through Five (PDG B-5)**[1] awards with goals to advance IECMH supports and services. This brief focuses on the perspectives of Washington state leaders, as reflected in key informant discussions, local and national reports, legislative recommendations, and presentations.

On Washington State's efforts to center equity and trauma-informed approaches in early care and education systems

"We need help addressing behavioral and emotional challenges in our early learning classrooms and with our families. Now we are seeing as a result of the last 2 years of the pandemic that there are unmet behavioral health needs for all the adults in children's lives—including the providers and the families caring for children, and the children themselves. Everyone is in need of trauma-informed approaches and behavioral health access. It was always something that we were really intentional about in our approach to the needs assessment and strategic planning even before the pandemic. We really wanted to continue to drill down with that particular focus and intentionality around what the experience is for traditionally marginalized early childhood populations, because we know that for them, there is the potential for a whole other level of adversity if they don't have access to supports."

—Washington state program leader

Building an Equitable Policy and Systems Infrastructure for the IECMH Continuum in Washington State

Several activities associated with the PDG B-5 award are helping Washington state leaders create a coordinated approach to IECMH that can further financing efforts. The Washington State Department of Children, Youth, and Families (DCYF) is the lead agency for the PDG B-5 initial (2018) and renewal (2019) awards. As part of PDG B-5 activities, DCYF undertook a collaborative effort to compose the state's **Early Learning Needs Assessment** (2020) and **Early Learning Coordination Plan** (2021). These strategic activities highlighted the need to support the social-emotional health of infants, toddlers, and young children in equitable and trauma-informed ways.

[1] PDG B-5 federal grants were first awarded in fiscal year 2019 and fiscal year 2020 to support states in building, enhancing, and expanding birth through five mixed delivery systems and high-quality birth through five programs and services. These awards differ significantly from previous federal **Preschool Development Grants** as well as **Race to the Top – Early Learning Challenge** grants. Several states have leveraged multiple federal, state, and philanthropic funding opportunities to build the infrastructure for a statewide IECMH system.

Adding to this work, DCYF is currently in the process of creating a clarified vision for IECMH work that aims to address fragmented IECMH services and funding administered by a range of state systems serving children and families. This work is unfolding in DCYF in ways that intersect with finance reform undertaken by the Washington State Health Care Authority (HCA), the state's Medicaid office. Although some of the broader, systems-building PDG B-5 work is not directly related to IECMH financing, several state leaders shared that the community-driven process and methods used to engage partners for the work sparked interest in how to "build on tables we've already convened through the work of PDG B-5."

Who are the appointed members of Washington State's Children and Youth Behavioral Health Work Group?

- State legislators
- State administrators across agencies
- Representatives from Tribal Councils
- Public and private health care organizations
- Private insurers
- University research and evaluation partners
- Advocacy organizations
- Parents and foster parents (a seat for a parent of a child under age 6 was added in 2020)
- Youth who have received services
- Representatives from the **Washington Association for Infant Mental Health**

Advocating for Targeted Legislative Changes in Support of IECMH

In 2016, Washington State passed House Bill 2439, which established a Children's Mental Health Work Group, later renamed the **Children and Youth Behavioral Health Work Group (CYBHWG)**. This work group is charged with focusing on children prenatal to age 25 as well as identifying barriers to the access of mental health services for children and families. There have been a few legislatively mandated iterations of the CYBHWG, which is currently authorized through 2026 (H.B. 2737, 2020).

Since 2016, the CYBHWG has prioritized and supported systems-focused recommendations for young children to the legislature in advance of each legislative session. The CYBHWG has **five advisory groups**, including one focusing on Prenatal to Age Five Relational Health, which came together in more recent years and is co-chaired by a state legislator and a leader from the Washington Association of Infant Mental Health. This advisory group consists of 100 partners that include behavioral health and professional clinicians, and it is facilitated by an advocate with significant experience lobbying the state legislature. The CYBHWG has issued recommendations related to financing IECMH and workforce development, and, as a result, the legislature enacted a series of bills and budgetary appropriations (see Appendix A).

Implementing Developmentally Appropriate Assessment and Diagnosis for Washington State's Infants, Toddlers, and Young Children

DC:0-5 implementation in Washington State

"I think that the DC:0-5 is now one of our most tangible policy-to-program innovations that represents the multiyear arc from a policy idea, to a policy study, to a legislative advocacy campaign, to passage, to provider and community implementation. What we're excited about with DC:0-5 is that that's a little bit ahead of some of the other wonderful things we are trying to do in Washington in the prenatal to five space, including mental health."

—IECMH funder and thought partner in Washington State

In 2016, the CYBHWG recommended standardized mental health assessment, outcome, and diagnostic tools for infants, toddlers, and young children birth through five, which is consistent with a growing national consensus (Cohen & Andujar, 2021; Smith et al., 2018). The work group specified that the tools 1) be culturally and developmentally appropriate, 2) support access to services, and 3) clearly describe what mental health challenges look like in early childhood. Several state leaders interviewed for this brief supported using a comprehensive diagnostic tool for early childhood assessments that reflects the relational nature of IECMH, and such a clinical tool exists. Sponsored and led by Zero to Three (2021), researchers and advocates developed the **Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)**. Using this tool is recognized as a best practice for thinking through cases and the diagnosis of children birth through five.

In 2018, a small team from across agencies in Washington State began participating in a learning collaborative on IECMH financing policy facilitated by Zero to Three. Many of these team members also participated in the CYBHWG Prenatal to Age Five Relational Health advisory group. State leaders who participated in this Zero to Three technical assistance reported those two opportunities were the first to address the difference in frameworks and perspectives between HCA team members and IECMH program leaders about state billing and other best practices for the assessment and treatment of infants, toddlers, and young children.

In 2020, based on CYBHWG recommendations, the legislature appropriated funds for an actuarial analysis. The purpose of this analysis was to describe the costs of 1) allowing reimbursement for three to five sessions of intake and assessment for children birth through five, instead of the then-standard one session; 2) enabling reimbursement for assessments in home and community settings, including clinician travel time; and 3) requiring use of DC:0-5 rather than the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; S.B. 6168, 2020). Based on Medicaid claims data, the analysis highlighted several unsustainable billing patterns. Noteworthy were practices such as billing for the one allowable assessment and intake session for young children, and then using replacement codes for individual or family treatment to bill for additional assessment sessions by transdisciplinary clinicians,

which were necessary to observe children across settings and caregivers and consult with a range of relevant adults at home and in other settings (HCA, 2020).

According to multiple state leaders, the cost analysis was instrumental in building the momentum to pass landmark legislation supporting IECMH in April 2021 (H.B. 1325). This legislation requires providers to use DC:0-5 for assessment and diagnosis and enables reimbursement for up to five sessions—the demonstrated best practice that matched imputed Washington State billing practices. To support implementation in January 2022, HCA published an **Interim DC:0-5 Crosswalk** with DSM-5 and International Classification of Diseases diagnostic codes, which was adapted from crosswalks provided by Zero to Three. Free trainings on DC:0-5 assessment and billing for any Washington State provider supporting young children and families began in March 2022. According to HCA staff, the trainings are modeled on work that unfolded in several other states,[2] and they include content on the policy issues associated with Medicaid financing structures and advocacy required at the community mental health agency level to implement billing reform associated with DC:0-5 and other changes to practice.

Leveraging a Public–Private Partnership to Drive Reform in Washington State's Health Care Authority

Another innovation in Washington State to advance reform in IECMH financing is a public–private partnership between HCA and a local philanthropic organization—**Perigee Fund**. Perigee Fund makes select national investments in advocacy and field capacity, but has funded deeply in Washington State. A leader from Perigee Fund described the approach as embedding "early relational health in and across HCA." Early relational health acknowledges that healthy child development occurs optimally in the context of warm, responsive early adult–child relationships that flourish in safe and connected communities (Willis, 2019). Health and behavioral health services and supports that are mindful of an early relational health framework consider the nested contexts in which development unfolds. For example, the health and well-being of caregivers in considered and treated when intervening with children and families.

The innovative relationship between HCA and Perigee Fund is supported by a renewable, 3-year grant that funds a small team of HCA staff members to work on reform. Team members are all infant mental health champions with backgrounds that cut across clinical, research, and evaluation expertise related to infant and parent mental health, birthing outcomes, and the perinatal period.

The overall goal of this public–private partnership is to improve birthing outcomes and perinatal to three physical and mental health, centering dyadic relationships in which the health of the parent is improved

[2] HCA staff reported learning from discussions about how to develop training opportunities with colleagues from Alabama, Arkansas, Colorado, Idaho, Illinois, Massachusetts, Michigan, Minnesota, Nevada, New York, Oregon, and South Carolina.

in ways that enhance the health and development of the infant. A priority of this partnership includes addressing the mental health of the birthing parent, a leading cause of Washington State's pregnancy-related deaths, and a factor in early childhood outcomes. Areas of focus for the partnership include:

- *DC:0-5 implementation* as the primary diagnostic tool for assessing infants, toddlers, and young children in developmentally appropriate and family-friendly ways.
- *Postpartum Medicaid expansion* beyond 60 days of care to improve the quality of care for new birthing parents.
- *Maternity bundle*[3] that centers the dyad through behavioral health screening and intervention, adult psychosocial functioning, the adjustment to parenting, and coordination between obstetricians and pediatric providers that care for infants.

On translating Medicaid practices for providers

"A lot of our focus has been on demystifying Medicaid for people who work in community mental health agencies, because Medicaid in and of itself is very confusing. Medicaid pays for Medicaid services, depending on the service provider type, what the service code is, and what is in the Medicaid state plan. There's federal Medicaid, but every state is different in terms of what they decide to cover and how to cover it. … To build a sustainable workforce, our goal is to figure out what we need to think about from a competency and quality perspective in terms of what is different about infant and early childhood mental health rather than what always needs to change about the financing structure."

—HCA staff member

Perigee Fund also supports a facilitator with lobbying experience to provide central coordination to the CYBHWG's Prenatal to Age Five Relational Health advisory group, and it provides some of the parent stipends that have been offered to engage people with lived experience in shaping policy. In 2021, Perigee Fund published a **series of issue briefs** about the Washington State IECMH landscape. Partners across agencies have reported that these briefs support the ongoing policy and strategic planning process to move forward with building an equitable, culturally responsive, and integrated system to support the social-emotional development and mental health of infants, toddlers, young children, and their families.

Reforming a Complex System From Within

The groundwork for the public–private partnership between HCA and Perigee Fund was established in part by a multiyear reorganization of Washington's state agencies. This reorganization culminated in a legislatively mandated merger between HCA and the Department of Social and Health Services—also endorsed by the Washington state governor—at the beginning of 2020 to integrate the community

[3] According to federal health care guidance, a bundled rate is "a payment structure in which different health care providers who are treating you for the same or related conditions are paid an overall sum for taking care of your condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments" (HealthCare.gov, n.d.).

mental health system into the managed care system (S.B. 6312, 2014). The stated goal of this merger was to advance "whole person care" that integrates physical health and behavioral health services (HCA, 2019).

According to HCA staff, one implication of the merger between agencies was bringing more people with clinical expertise to work on Medicaid issues at the state level. For example, one staff member worked as a clinical social worker who provided direct therapy to young children and their family members, and as an IECMH consultant and clinical supervisor of consultants. Another HCA staff member with a background in applied child development and research and evaluation described how much had been learned so far about "changes in financing and the structuring of mental and behavioral health services along a continuum once services with a history of being administered separately are better integrated." Now that there is a small team that is partially funded through the Perigee Fund to enact an IECMH financing agenda, IECMH program leaders in other Washington state agencies are hopeful that work that had proceeded in "fits and starts" for many years can now move forward more definitively.

HCA staff agreed there are opportunities for Medicaid financing reform to better support the IECMH continuum. For example, the transdisciplinary nature of early childhood services and supports is not always consistent with billing practices. HCA staff members concluded that, in some cases, it was not that a *service* provided to a young child and their family was not "billable," but that the *provider* offering the service "was not a designated provider for that service."

On translating IECMH practices to Medicaid contexts

"Many of us share an infant and early childhood mental health approach that's very relational and is thinking about how we build resiliency, and how interconnected elements work together. …We do a really nice job of bringing folks into transdisciplinary work in early childhood, but then we are not careful about defined roles, so it makes it harder to align efforts. … So role definition in which everyone understands their scope of work and what value they bring to collective practice would also help us learn how to collaboratively advocate for reforms."

—HCA staff member

Another example of a bundled service is **Wraparound with Intensive Services (WISe)**, or voluntary services for older children and youth with complex behavioral health needs. WISe involves care coordination, peer support for parents, case management, and an overall higher level of outpatient mental health treatment than is typically available. Any mental health code within the scope of WISe can be included in a monthly bundled rate for all of the services. Additionally, some WISe services—such as case management— are outside of Medicaid but are covered by state general funds and braided with Medicaid funds to cover services. Currently, DCYF is working with HCA to investigate how the WISe model could be layered onto DCYF's Early Childhood Intervention Prevention Services (ECLIPSE) program offering therapeutic child care. Although leaders and staff in both DCYF and HCA reported that take-up of wraparound services has not been as high as expected among families involved in

ECLIPSE,[4] the collaboration has been a productive way of thinking through how to modify a financing structure that exists for older children for an IECMH context.

Lessons Learned From Washington State's Efforts to Grow and Support an IECMH Continuum

Over the past several years, Washington state leaders have made progress in building the infrastructure and field capacity necessary to establish and support an IECMH system. However, partners across public and private settings acknowledge there is much more work to do to integrate supports and services across programs that can be underfunded and fragmented. To date, HCA, the state legislature, multiple state agencies, and partners from private agencies and organizations have collaborated on promising work that leverages the voices of families with lived experience in behavioral health systems to advance the assessment and diagnosis of infants, toddlers, and young children in culturally and developmentally appropriate ways. With continued investment, momentum, and intentionality, this work can be the foundation of a more integrated IECMH system. Lessons from Washington State that could be instructive to other state and national leaders include:

- Cultivating champions who understand IECMH, can help with educating partners, and understand how to navigate the political and policy process.
- Collaborating with IECMH champions across government, the private sector, advocacy, philanthropy, and health care finance.
- Empowering parents and other caregivers from underserved racial and ethnic groups with lived experience in behavioral health systems to shape policy, by supporting their participation in policy activities.
- Centering financing reform efforts on caregiving relationships and investigating bundled rates for a suite of services focused on strengthening the dyad between adults in caregiving relationships and young children.
- Addressing IECMH financing issues in ways that build field capacity to grow the IECMH workforce and thereby increase the number and type of providers who can promote, screen, assess, and treat IECMH using developmentally and culturally appropriate practices.
- Refining legislative recommendations that support IECMH financing reform over time in ways that build on best practices in other states and a national consensus among experts.
- Facilitating financing reform from within state government by incorporating folks with clinical experience or content knowledge about IECMH into Medicaid and other health policy contexts.

[4] DCYF staff reported that because a proportion of the families involved in ECLIPSE also receive support from Washington State's child welfare system as foster families, the more intensive supports offered through WISe could be duplicative. DCYF is studying other issues associated with take-up of this program.

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Appendix A. Key Recommendations Related to Financing Infant and Early Childhood Mental Health, From Washington State's Children and Youth Behavioral Health Work Group

Year	Key CYBHWG Recommendation supporting IECMH	Significance & Outcome
2016 & every year	Increase Medicaid rates for behavioral health services, & ground in rate-setting for provider type or practice setting.	A necessary first step in addressing broad, statewide behavioral health workforce shortages. This recommendation was continuously refined.
2016; 2021	Use standardized mental health assessment, outcome and diagnostic tool for children aged 0-5. Fund training and increase number of allowable assessment sessions.	Approaches to build infrastructure for developmentally appropriate assessment and diagnosis and were passed and funded in 2021 (H.B. 1325).
2016; 2020	Delineate billing options adequate to cover reimbursement for culturally appropriate behavioral health screening; focus on maternal depression screening as part of Early & Periodic, Screening, Diagnostic & Treatment (EPSDT) benefits.	Maternal depression screenings have been required since 2017 (H.B. 1713) in a child's first 6 months. 2020 follow-up recommendations include additional study of postpartum mood and anxiety screenings and investigation of barriers to more screening.
2016	Remove limitations on treating the family dyad, or work with the child and caregiver together.	Critical for the treatment of infants, and young children; "family supports" was added as allowable service in 2018 (H.B. 2779).
2016	Fund infant mental health services and training; focus on billing support, specialized services required for assessment of young children & increasing the IECMH workforce.	To support and grow the IECMH workforce 2020 legislation (S.B. 6168) created flexible funding for training and mentoring clinicians serving children 0-5. Many of these provisions were passed and funded in 2021 (H.B. 1325)
2017	Develop a strategy for Medicaid coverage of home visiting.	2018 legislation (H.B. 2779) funded a report released in 2019 to develop a strategy for Medicaid funding by expanding existing Medicaid maternal and infant case management program & other initiatives.
2019	Extend Medicaid coverage to 365 days postpartum.	2020 legislation (S.B. 6128) directed HCA to submit a waiver request to implement expanded parental coverage during a child's first year of life for families with income <193% of FPL. The bill vetoed as part of governor's pandemic response though advocacy for this coverage continues.
2016, 2020; 2021	Create a tuition loan repayment program for behavioral health professionals working in underserved areas.	H.B. 1668 (2019) created a tuition loan repayment program broadly across children's mental health clinicians. 2020 recommendations focused on expanding the program and prioritizing applicants from underserved racial and ethnic groups. H.B. 1035 (2021) strengthened partnerships with clinical training facilities for children's mental health practitioners.
2017; 2020; 2021	Establish an IECMHC program for child care providers; preserve and expand existing funding for IECMH coordinated supports and services.	H.B. 1713 (2017) established the Early Achievers IECMHC program, with a particular focus on trauma-informed practices. This program is implemented through a contract with state chapter of Child Care Aware and was expanded in 2019.
2021	Invest in Perinatal Support Washington's Warm Line for underserved and expectant new parents. Compensate partners with lived experience in behavioral health systems to participate in policymaking.	The Warm Line is a help line for new parents experiencing mental health challenges staffed by peers with lived experience, particularly in perinatal or mood disorders. Compensating family and community partners with lived experience has been a consistent recommendation by multiple public and private partners in Washington State.

CYBHWG = Children and Youth Behavioral Health Work Group; IECMH = infant and early childhood mental health; HCA = Heath Care Authority.

Note. Adapted from key informant discussions and CYBHWG annual legislative recommendations (2016–2021).

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