Results of a Provider Survey of Dyadic Services & Billing

Barnard Center
for Infant & Early Childhood Mental Health

WA-AIMH
WASHINGTON ASSOCIATION FOR
Infant Mental Health

Contents

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Executive Summary

Purpose of the Survey

The purpose of the survey was to understand the challenges for clinicians around billing processes and reimbursement options for the prenatal—5 population.

Respondents

The survey was completed by 27 respondents, representing only a small portion of the state's IECMH workforce. Over half of the respondents (52%) were contracted to bill for Medicaid services, while 41% were not contracted with Medicaid; an additional 7% were not sure about their Medicaid status. Respondents included mental health respondents, as well as occupational therapists, primary care respondents and administrative staff.

Key Strengths

Survey respondents demonstrated many of the strengths that are present within the current IECMH system of care. Respondents possessed strong knowledge of best practices for dyadic work, as well as passion for addressing historical inequities within the mental health system. Many commented on systems of support among agencies, supervisors, and staff. In addition, even when faced with a challenging system, many expressed a desire for more communication and guidance, and an interest in expanding services to serve families.

Key Challenges

Inadequate rates for providing high quality dyadic IECMH services

A total of 80% of respondents identified "rates of services" as one of the top three challenges in billing for services. Many respondents shared that the rates for services were not enough to cover the additional work that goes into providing high quality dyadic care outside of sessions, which has limited their ability to provide necessary care and their ability to address issues of equity within their service. Specifically, respondents noted that home-based services and care coordination/case management are key components of high-quality dyadic care, but these aspects of service are not adequately covered by current rates. As one respondent shared,

> *"Rates of services are too low and does not pay for all the tasks/staff time that are critical to providing relational services to families with young children from historically marginalized communities."*

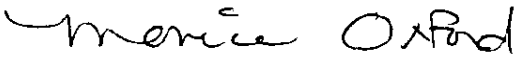
Lack of guidance around billing and documentation practices for dyadic IECMH services, particularly from the Health Care Authority

Following rates, lack of knowledge and guidance around billing practices was identified as the greatest challenge to providing dyadic IECMH services. Many respondents identified lack of knowledge of which Current Procedural Terminology (CPT) codes are reimbursable (63%) or of which CPT code to use (40%) as one of the top three barriers to billing for IECMH dyadic services. Several expressed that providing dyadic services

introduces additional complexities to billing and documentation in a system where the child is the identified client.

Some respondents expressed feeling "on their own" and a sense of frustration that the Health Care Authority (HCA) has not provided more guidance around billing for IECMH services. This lack of support, and communication from the HCA has created a sense of "distrust" within the IECMH community. As one respondent shared,

> *"I wish HCA would provide direct coaching and guidance on Medicaid billing for community mental health organizations that provide IECMH services. There has been absence of this, and we have been on our own in determining the appropriate billing practice in alignment with the older age groups."*



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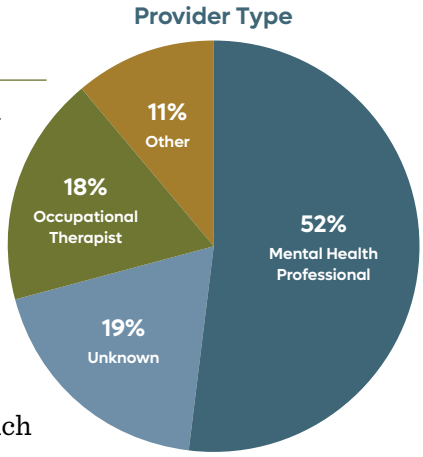
Key Findings

Purpose of the Survey

The purpose of the survey (see Appendix A & B) was to understand challenges around billing for dyadic infant and early childhood mental health services.

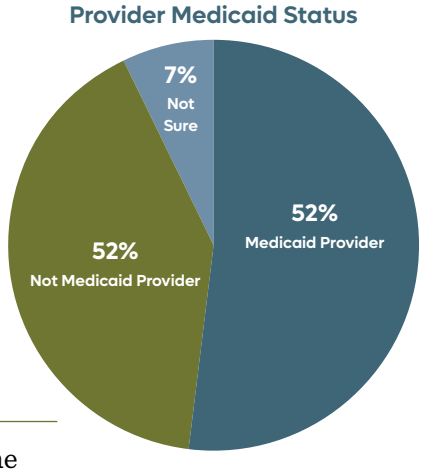
Respondents

A total of 27 respondents responded to the survey, 67% report working in community mental health/behavioural health setting, 30% in private practice, and 4% "other". While the survey was intended to be completed by mental health clinicians, no questions were asked about provider type. However, some respondents decribed their occupation in open-ended responses, which allowed for information about provider type to be identified for about 80% of the respondents. Half of the respondents were identified as mental health clinicians; 18% of respondents were identified as Occupational Therapists. 11% of the providers were identified as "Other" provider types, which included included primary care providers and administrative staff.



Half the respondents noted that they were contracted to provide services to children and families enrolled in Medicaid, 41% reported that they were not contracted as a Medicaid provider, and 2 respondents (8%) were not sure.

As a note, among respondents who identified as Medicaid providers, a higher percentage (71%) were mental health professionals than among respondents who were not Medicaid providers (36%).



Key Challenges to Billing for IECMH Dyadic Mental Health Services

Respondents[1] rated the top barriers to billing for IECMH dyadic services from the following options: knowledge of CPT codes to use, knowledge of which CPT codes are reimbursable, rates of service, restrictions on location of services, caregiver/parent only session limits, reimbursement for case management and care coordination services. This question was followed by an open-ended response option for respondents to describe barriers in greater detail.

Of these options 80% of respondents indicated the rates for services was the top barrier; next 63% respondents indicated that lack of knowledge of which CPT codes were reimbursable was a barrier, followed by 54% indicating reimbursement for case coordination/case management services. Both rates for services and reimbursement for case coordination/case management services were entangled as evidenced by the qualitative responses. Among providers who responded to the survey, inadequate rates were identified as the greatest challenge to providing dyadic IECMH services. One respondent commented,

1 Because billing and reimbursement systems for mental health are separate from those for occupational therapy, responses from participants who identified as occupational therapists (n=5) were not included in this section.

"First, we are challenged by the low reimbursement rates. To get providers skilled in perinatal mood disorders or effective trauma treatment, we need to pay more. But Medicaid will never cover more than a percentage of their salary."

Many respondents shared that the rates for services were not enough to cover the additional work that goes into providing high quality dyadic care outside of sessions, which has limited their ability to provide necessary care and their ability to address issues of equity within their service

"The amount of work outside of a session that is required to fully serve a family/dyad is significant, but it is not payable. So, we find ourselves limiting the work we do that is truly needed, because we can't afford to do it."

"Rates of services are too low and does not pay for all the tasks/staff time that are critical to providing relational services to families with young children from historically marginalized communities."

A total of 54% of respondents identified reimbursement for care coordination/case management as one of the top three challenges to billing for services. As one respondent commented,

"Insurance reimbursement has not kept pace with workforce needs/expectations/rates for private practice. Dyadic work with families involved in child welfare and court systems requires significant case management and care coordination that are not reimbursed."

While only 27% of respondents identified "restrictions around location of services" as a significant barrier to billing for dyadic IECMH services. It is worth noting that home visiting models are critical to the IEMCH field:

"It is more expensive to treat families in their own home. It is also generally more effective and equitable. This is an issue which definitely needs to be addressed."

63% of respondents indicated that lack of knowledge and guidance around billing practices was identified as the greatest challenge to providing dyadic IECMH services. Several respondents expressed that providing dyadic services introduces additional complexities to billing and documentation in a system where the child is the identified client. Participants indicated several needs:

"Dyadic documentation billing guidance/allowences; looking at reimbursmentrates for family sessions vs. individual sessions."

and

"Billing guidance training or professional development would be helpful"

Respondents reported on their current strategies they use to get billing questions answered, 61% of respondents report turning to their supervisor, 44% indicate they turn to agency documents/supports, and 30% use Google Searches. Only 22% indicate that billing guides from the Health Care Authority or other insurers are primary sources of billing guidance.

Lastly, in some cases, inadequate rates, in combination with the complexity of the Medicaid billing system, prevented some agencies from becoming Medicaid providers at all, preventing them from equitably serving this population. As one respondent shared,

> *"We have not billed for counseling services in the past because it seemed too complex for so low a reimbursement. The need in the community is now so high and there's nowhere to refer our home visiting clients that we are considering becoming a contracted Medicaid mental health provider."*

Need for More Guidance from the Health Care Authority

As noted above, only 22% of respondents noted that the refer to billing guides from HCA or insurers to get their billing questions answered. In open-ended questions, some respondents shared that they wanted more support and communication from the Health Care Authority.

Some respondents shared a sense of frustration that the Health Care Authority (HCA) has not provided more guidance around billing for IECMH services. This lack of guidance, support, and communication from the HCA has created a sense of "distrust" within the IECMH community. Qualitative comments include:

> *"HCA has offered so little direct guidance on this, even though they are meant to be providing this role."*

> *"I wish HCA would provide direct coaching and guidance on Medicaid billing for community mental health organizations that provide IECMH services. There has been absence of this, and we have been on our own in determining the appropriate billing practice in alignment with the older age groups."*

> *"HCA seems clueless; they have people who are supposed to be knowledgeable about IECMH work, they but have not provided us any guidance on IECMH billing."*

> *"We were so excited that the [Children & Youth Behavioral Health Workgroup] helped pass the law [HB1325] that should change the billing practices, but [we] have been extremely frustrated that HCA has given us no communication or guidance on it. They have been perceived as completely silent on the matter, leading to some distrust from the community."*

Importantly, the experience among respondents suggests that the lack of clarity on billing has exasperated existing inequities within the mental health care system. As one respondent shared,

> *"It's been a while since HCA has had designated IECMH persons, but we have received no support from them. The impact of this lack of leadership from HCA has been disproportionately experienced by agencies serving the historically marginalized populations. I hope HCA will center all of their IECMH-related work on core DEI principles."*

Conclusion

This survey was conducted in partnership with the Barnard Center for Infant and Early Childhood Mental Health and Washington State Association for Infant Mental Health as a way to begin to address the billing needs of providers in the community who serve families with young children. The respondents offered an insight to the barriers they experience in billing for and receiving reimbursement for IECMH services (for additional challeges noted please see Appendix C).

Several factors identified can be addressed through intentional actions to provide clarity, communication, and guidance from the Health Care Authority. Other issues will likely take sustained advocacy across IECMH serving agencies, State agencies, private insurance, and legslative bodies. For example, Washington's Children and Youth Behavioral Health Workgroup (CYBHWG) provides recommendations to the Legislature to improve behavioral health services and strategies for children, youth, young adults, and their families from prenatal to age 25, and meetings are open and invite public comment. The Prenatal to Five Relational Health Subgroup (P5RHS) of the CYBHWG has a large and diverse membership—contact bridget@wa-aimh.org for information about how to become involved.

Given the specific needs expressed regarding guidance from HCA, we shared the results of our survey and HCA offered a response. Please see the official HCA response below. We will continue to work with the HCA in partnership to provide the IECMH community the best informaiton possible that will enable your work with families. We will launch a follow up survey early in 2023 to assess improvemets in communicaiton and support for billing dyadic servcies.

For more information please contact Monica at mloxford@uw.edu or Bridget at bridget@wa-aimh.org.

Appendix A: Survey Invitation

We are reaching out to you with an important opportunity for clinicians to provide input about developmentally appropriate mental health treatment for infants and young children.

While Washington has made strides in creating opportunities for training on treatment models and approaches, providers continue to express challenges related to understanding billing processes and reimbursement options for the birth—5 population. To better understand the specific challenges providers are facing, the Washington Association for Infant Mental Health and Barnard Center for Infant and Early Childhood Mental Health created this survey to gather input from providers about their experiences.

Responses from this survey will be reviewed with community partners to understand the unique needs and challenges in serving pregnant/postpartum persons and children birth—5. Partners will collaborate to identify and develop training opportunities. Additionally, results will be shared with the Children and Youth Behavioral Health Work Group: Prenatal to Five Relational Health Subcommittee to explore opportunities to address challenges requiring solutions beyond training.

This survey is intended for licensed and license-eligible clinicians in the state of Washington working with pregnant/post-partum persons and children birth to 5.

Appendix B: Survey Questions

Title

Infant and Early Childhood Mental Health Services for Pregnant/Postpartum Persons & Children Birth to Five Years Old

Survey Introduction

This survey is intended for licensed and license-eligible clinicians in the state of Washington working with pregnant/post-partum persons and children birth–5. We are interested in collecting feedback related to challenges experienced in billing and reimbursement of infant and early childhood mental health and dyadic services for the birth–5 population.

Responses from this survey will be shared and reviewed with Health Care Authority (HCA) staff and community partners to understand the unique needs and challenges in serving pregnant/postpartum persons and children birth–5. Partners will collaborate to identify and develop training opportunities.

This survey is anonymous unless you choose to provide contact information at the end of this survey. Your individual results will be kept confidential, and data will be stored within a secure, password-protected account.

Question 1: What type of organization, setting or practice do you provide services?

- Community Mental/Behavioral Health Agency
- Private Individual/Group Mental Health Practice
- Primary Care Clinic/Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)
- Other (please specify)

Question 2: Are you/your organization a contracted provider with Apple Health/Medicaid?

- Yes, I'm contracted with a Managed Care Organization/s (MCO)
- Yes, I'm contracted with Fee for Service (FFS)
- Yes, I'm contracted with both MCO/s and FFS
- No
- Don't Know

Question 3: If you are contracted with an MCO, which MCO/s are you contracted with?

- Amerigroup Washington (AMG)
- Community Health Plan of Washington (CHPW)
- Coordinated Care of Washington (CCW)
- Molina Healthcare of Washington (MHW)
- UnitedHealthcare Community Plan (UHC)

Question 4: Who is your primary client when delivering mental health services?

- Children birth to five
- Pregnant/Post-partum persons
- Caregiving-child relationship
- None
- Other (please specify)

Question 5: Do you currently or have you historically provided dyadic mental health treatment?

- "Dyadic Treatment is a form of therapy in which the infant or young child and parent are treated together. A clinician is present with the Parent-Child dyad, or in a nearby room, and coaches the parent to encourage positive interactions that can help improve parenting, the Parent-Child relationship, and the child's behavior." (Source: https://www.nccp.org/dyadic-treatment/)
- Yes
- No
- I don't know/I would like to learn more

Question 6: What is the most frequent barrier you encounter in billing for services? (rank in order)

- Knowledge of which CPT codes to use
- Unsure what CPT codes are reimbursable
- Rates of services
- Restrictions on location of services
- Caregiver/Parent only sessions
- Reimbursement for Case Management/Care coordination activities

Question 7: Please describe/add details around the barriers you've faced (based on what you've selected)

Question 8: Are you getting denials on services that limit your ability to provide Evidence-Based dyadic treatment?

- Yes
- No

If yes, please elaborate.

Question 9: What types of help do you need in order to provide reimbursable dyadic treatment? (rank in order)

- Training on billing guidance
- Training on documentation guidance
- Billing guides/desk aids
- Technical Assistance/Office Hours for specific situations/cases

Question 10: How do you currently get your questions around billing answered? (check all that apply)

- Google/own searching
- Supervisor
- Agency documents/information
- HCA/Ins. Billing guides
- Other (please specify)

Question 11: Please share any specific questions or suggestions you have regarding billing and reimbursement for infant and early childhood mental health services with pregnant/post-partum persons and children birth to 5.

Appendix C: Additional Findings

In addition to the key findings presented in the report, additional findings are noted below.

Additional challenges

Complexity of billing for insurance, including Medicaid

While inadequate rates and lack of billing guidance were the most referenced barriers to providing services, providers noted other barriers as well. Several providers noted the complexity of the billing system as a barrier to becoming Medicaid providers in the first place, despite the need in their community. As one provider shared,

> *We have not billed for counseling services in the past because it seemed too complex for so low a reimbursement. The need in the community is now so high and there's nowhere to refer our home visiting clients that we are considering becoming a contracted Medicaid mental health provider.*

Another provider shared that their agency had found the process of working with insurance companies expensive and cumbersome, and funded their services through a combination of state funds, grants, and private pay as a result.

Complexity of the King County billing system software/electronic health record

Within the Medicaid system, providers from King County noted that the county's billing system software is difficult to use and "incompatible" with electronic health record (EHR) systems. Specifically, providers shared that the "unreasonable complexity" of the system leaves "too much room for error," resulting in inaccurate claim denials. Because of this, clinicians must spend more of their time addressing billing errors, rather than serving families.

Multiple providers noted a lack of sufficient response from King County and the Health Care Authority regarding this matter, and they raised the issue that this issue has further exacerbated already existing inequities within the mental health system. As one provider shared,

> *"Why is King County Medicaid billing system so complicated? Their billing system (software) seems to be incredibly outdated and incompatible with most major electronic health records, which have caused so many issues, wasting precious hours of highly trained IECMH clinicians to be spending on fixing billing errors. King County and HCA have seriously failed our community by not improving the billing system. Without a doubt, we could be serving more low-income Medicaid families if our licensed IECMH clinicians did not have to waste so much time on documentation and billing issues."*

Another provider shared,

> *"Our county's antiquated system [is] incompatible with the electronic medical record system. This had created huge inequity issues that I wish the county and HCA would prioritize and address. Neither appear to understand deeply and thoroughly enough. Ultimately, the historically marginalized population will continue to suffer because of the cascades of multiple impacts that they have failed to address."*

Eligible Diagnoses

Two respondents raised shared that they were unsure what specific diagnoses would make a child eligible to receive infant-early childhood mental health services.

Early Support for Infants & Toddlers (ESIT) & Medicaid

Two respondents shared that they worked for ESIT service agencies that served many Medicaid-enrolled children, but their ESIT mental health providers did not bill for Medicaid services.

Other challenges

Other challenges that were noted by one provider included:

- Barriers to service during covid, and the developmental appropriateness of telehealth services for young children
- Restrictions around catchment areas and not being able to serve a family when they move out of the area
- Issues around billing for cpt Code 90847 (Family Therapy with patient present)
- Issues around billing for Medicaid clients without both (parent-child) being individually listed as clients.
- Getting paneled with Coordinated Care of Washington in order to serve children in foster care
- Needing more than one session for diagnostic assessments
- Decrease in rates from insurance companies once children turn 3 years old
- Serving clients who are receiving Child Parent Psychotherapy

Additional challenges for dyadic occupational services

The original purpose of the survey was to better understand challenges around billing for dyadic infant & early childhood mental health services, with a focus on Medicaid providers; IECMH is a multi-disciplinary field, and some of the participants who responded to the survey were occupational or speech therapists, rather than mental health clinicians. However, many insurance systems, including Medicaid, having different billing structures for mental health services are than for services like occupational therapy. For this reason, billing challenges raised by occupational therapists are described here separately.

A key challenge to billing for dyadic occupational therapy services was **billing for sessions with the parent/caregiver**. All respondents who identified as Occupational Therapists noted that "caregiver/parent only sessions" was the primary barrier they faced in billing for services. Respondents identified that the child had to be present for visits, even though it is clinical best practice to meet with just the parent/caregiver for some sessions. As one respondent shared,

> *"Insurance will only cover for the child and the child has to always be present to bill for services, which restricts meeting with the parents to reflect with them and guide them in their understanding of their strengths and challenges with their child."*

Another respondent commented,

> *"As an IMH OT trained in developmentally-minded, relationship-based practices, I'm not allowed to bill insurance for services where the parent is present without the child, even though it is often the most efficacious way to improve developmental outcomes, parental self-efficacy, and family quality of life. It doesn't respect the child or the relationship to speak directly in front of them, nor does it honor adult learning to expect the caregiver to divide their attention or speak/listen to coded language. This is easily the biggest barrier to providing equitable access to best practice."*

Occupational therapists also shared that the medical model within which they are required to frame their services does not fit with the imh principles they bring to the work. In order to receive OT services, children must have a diagnosis or clear functional deficit, and must demonstrate progress in specific functional skills.

> *As OTs, we have to use medical/deficit model concepts to describe the work we do in order to bill insurance. This means that the child has to have a diagnosis or clear developmental/functional deficits and we have to be able to document their progress. This narrow way of conceptualizing intervention limits access for families. It also puts a significant burden on us OTs, as we do mental gymnastics in our documentation for each and every client we see to translate what we really do into a language that bean counters understand.*

As one respondent shared this framework directly impacts their ability to provide a relationally drive, culturally sensitive and equitable services:

> *The medical model for billing only reimburses for identifiable developmental deficits. This means that the burden is on the clinician to translate the mental health concepts of co-regulation, felt safety, and relational health into the language of the medical/deficit model. This is not only a waste of time and mental energy, but it's also not conducive to clinical reasoning in strength-based, relationally-oriented, culturally sensitive practice model . . . When can we redefine the health of the child by the quality of their experience of relational safety and support, rather than white-normed discrete motor and language skills?*

Response to IECMH Billing Survey Key challenges

Infant-Early Childhood Mental Health (IECMH) is an emerging field, especially as it relates to capturing Medicaid services and aligning policy with best practices. The IECMH Billing survey elevated many areas for growth and improvement across the IECMH system. This response aims to clarify how HCA can support the IECMH field in addressing some of these areas.

Inadequate rates for providing high quality dyadic IECMH services

HCA's Role in Medicaid Rate Setting

State's Medicaid rates are generally adjusted on an annual basis using cost factors established by CMS and state-specific service data. The adjustment methodology is approved by the Centers for Medicare and Medicaid (CMS) and the Washington State Legislature. A key factor in this process is that state Medicaid agencies must maintain budget neutrality; this means while rates for specific services may increase or decrease, the total estimated cost to provide all state Medicaid services must stay the same, unless there is additional state investment.

Most Washington Apple Health (Medicaid) clients are enrolled in managed care organizations (MCOs). HCA has contracts with MCOs to manage cost, utilization, and quality of care for the majority of Medicaid enrollees in Washington state. Capitated rates (cost per member, per month) that HCA pays to MCOs are a key component in managed care and used to cover comprehensive enrollee health care costs. Managed care capitated rates are determined annually by outside actuaries and approved by CMS. The actuaries use payment and service information provided by the MCOs to calculate rates. However, individual providers and agencies contracted with MCOs reimbursement rates for specific services are determined by their contractual agreement with the MCOs.

Outside of this annual process, rate increases can only occur through the legislative process, where the state legislature can mandate HCA to increase rates and allocates state and federal funds to support the adjustment. There are several active Washington groups who contribute to the legislative process by advocating on issues related to behavioral health. The Children & Youth Behavioral Health Workgroup and the Washington Workforce Training and Education Coordinating Board are two groups that convene behavioral health providers and other stakeholders to address workforce barriers and propose recommendations to legislators prior to each legislative session. Recommendation topics from past legislative sessions have included Medicaid rates, network adequacy standards, retention incentives, documentation and supervision requirements, loan repayment and training programs, and many others. HCA staff often attend these groups as subject matter experts to provide education and information as recommendations are developed. Both groups are open to the public and interested parties can reach out to work group leads for details on how to participate.

HCA's Recent Work on IECMH Rates

The passage of legislation regarding mental health assessments for youth children (HB 1325) is one example of how advocacy from these groups can impact Medicaid rates. Over many years, the Children & Youth Behavioral Health Workgroup worked with IECMH providers, advocates, and HCA to develop HB 1325. This included HCA cost analysis of the anticipated reimbursement changes. The final session law required HCA to provide additional reimbursements specific to Mental Health Assessments for Young Children (MHAYC), including reimbursement for multiple assessment sessions and provider travel for assessment sessions in home and community settings. Following the passage of this legislation, HCA worked with internal billing staff and managed care organizations to implement MHAYC-specific reimbursements, which became available January 1, 2022.

HCA's Next Steps for IECMH Rates

In September 2022, HCA will solicit feedback from providers and agencies about their experience implementing reimbursement changes. Feedback will inform ongoing quality improvement and identify additional steps needed to support adoption of the MHAYC policies.

HCA will continue to follow the direction of CMS and legislators on rate setting related to infant-early childhood mental health services. HCA anticipates that themes generated through the Children and Youth Behavioral Health Workgroup strategic planning may inform the direction of future work children and youth behavioral health services, including IECMH services, needs and gaps, and proposed solutions.

Lack of guidance around billing practices for dyadic IECMH services

HCA's Role in Medicaid Billing Guidance & Communication

The Apple Health program billing guides provide information on Medicaid billing practice for all Apple Health providers. HCA publishes Apple Health billing guides for specific programs, including mental health services, and these guides are updated on a regular basis. HCA staff cannot give explicit instructions on how to code claims, as that is up to the individual provider and agency to follow current coding standards. Providers who serve clients enrolled in Apple Health without a managed care plan (also known as fee-for-service) may direct billing guide questions to HCA's Medical Assistance Customer Service Center (MACSC) online or at 1-800-562-3022.

Providers who are contracted with Managed Care Organization (MCOs) should refer to their contractual agreements with MCOs for billing guidance. For example, licensed Behavioral Health Agencies contracted with MCOs follow the Service Reporting Encounter Instructions (SERI) to bill for mental health and substance use disorder services. Managed care providers should contact their managed care provider relations representative for questions about billing guidance.

HCA's Recent Work on IECMH Billing Guidance & Communication

Billing is a complex process in general, and billing for newer concepts for care like dyadic mental health services can feel even more complex. HCA has hired two staff with Infant-Early Childhood Mental Health (IEMH) knowledge and experience to address the known complexities of Apple Health policy and support IECMH program implementation. These positions facilitated statewide investment to drive evidence-informed policy and practice for infants, young children, and their families. Key priorities for these staff have included understanding complex Apple Health systems and implementing the new Mental Health Assessments for Young Children (MHAYC) policies.

The implementation of MHAYC policies has provided an opportunity for the IECMH team to build communication pathways and share billing guidance with the IECMH workforce. The IECMH team is utilizing GovDelivery to send out real-time implementation updates, including where and how to access ongoing provider directed information. Specifically, the IECMH team sends messages regarding infant-early childhood mental health services through the Prenatal to Age 25 Behavioral Health topic; interested parties can sign up for this topic, as well as other topics, on HCA's GovDelivery subscription page.

HCA has also developed a centralized MHAYC webpage for providers to access information, tools, and resources. The Mental Health Assessment for Young Children webpage includes:

- Guidance in the Mental Health Billing Guide (Part I and II) and the Service Encounter Reporting Instructions (SERI),
- Presentations to key partners and Apple Health providers generating awareness of IECMH principles and MHAYC billing guidance, and
- Informal Office Hours to address provider and agency questions.

HCA IECMH staff are focusing efforts on the adoption of MHAYC policies across Washington, including ongoing billing office hours, revising the Apple Health DC:0-5™ Crosswalk, and supporting the roll out of DC:0-5™ trainings for clinicians and allied professionals. HCA is committed to receiving and responding to feedback regarding providers' experience with these efforts, to ensure implementation aligns with provider needs adopting these new policies. Provider feedback has been crucial in updating current billing resources to add clarity to guidance specific to the IECMH workforce.

HCA's Next Steps for IECMH Billing Guidance & Communication

The IECMH team at HCA is dedicated to prioritizing provider-identified needs to inform next steps, with the recognition that there already exists immense knowledge and valuable perspective within the IECMH community. For this reason, HCA IECMH staff's central priority is to foster connections with the IECMH field, to inform broader IECMH communication strategies and engagement. These efforts will focus on implementing an IECMH-specific communication plan, aiming to offer opportunities to hear directly from the community about needs, barriers, and opportunities.

The communication plan includes:

- Hosting monthly IECMH billing office hours, starting July 2022.
- Continue partnering with Barnard and WA AIMH to redistribute the IECMH billing survey with a larger sample size and more targeted questions to inform HCA's efforts to support the IECMH community.
- Use themes generated through the Children and Youth Behavioral Health Workgroup strategic planning to inform the direction of future work around IECMH services, needs and gaps, and proposed solutions.

Though these initial steps will begin to create opportunities for input, as the team builds relationships with providers across the state, they plan to identify new ways to bring the IECMH community together to partner and share lessons learned. HCA would like to hear from the IECMH community about ways to build connections and foster communication that are meaningful and accessible to providers.

Stay Connected

HCA is grateful to the IECMH providers who completed the survey. The behavioral health system of care depends on the wisdom and perspective of its providers, and the IECMH team feels honored to hear and respond to the concerns of the IECMH community. Systems-level work happens, like all growth, in developmental stages, and HCA looks forward to long-term partnership with the IECMH community to support high quality services for families and children. HCA is currently using the Prenatal – Age 25 Behavioral Health GovDelivery to share real-time updates about IECMH work and encourages all interested parties to sign-up for alerts. If you have comments or feedback on any of the issues raised in this report, please reach out to our IECMH team members.

For more information

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