Advancing Infant and Early Childhood Behavioral Health in Hawai‘i: Exploring Options for Financing Sustainability

FINAL REPORT

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September 15, 2021

Social and emotional health is critical to positive child outcomes and development, and relationship-based services promote brain development and social and emotional well-being to establish healthy foundations for life.

-- Hawai'i's Integrated Infant and Early Childhood Behavioral Health Plan, March 2021

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Executive Summary

Background

Hawai‘i’s *Integrated Infant and Early Childhood Behavioral Health (IECBH) Plan* (March 2021) was developed with the understanding that “Social and emotional health is critical to positive child outcomes and development, and relationship-based services promote brain development and social and emotional well-being to establish healthy foundations for life.” Noting that it is essential for public and private partners in Hawai‘i to coordinate efforts to address gaps, avoid duplication, and maximize all resources, the plan seeks to identify ways to help meet the behavioral health needs of infants/young children and their families. The goal is healthier keiki and families, and healthier communities overall.

This report *Advancing Infant and Early Childhood Behavioral Health in Hawai‘i: Exploring Options for Financing Sustainability* summarizes efforts from several other states to provide sustainable funding for IECBH services, including information on diagnosis coding and billing, as well as potential funding sources. The report also includes information on an “imminent risk” reimbursement code for infants/young children at risk of a behavioral health or developmental condition due to one or more risk factors for themselves or a family member. It concludes with recommendations for Hawai‘i policymakers to consider as they seek to support the IECBH services and workforce that will foster healthier keiki, families, and communities.

Introduction

There is increasing recognition across the country that the goal of healthy infant/young children and their families is best achieved by having a workforce that understands their unique behavioral health needs. Various states including Hawai‘i have begun to specify needed IECBH services, develop specially trained personnel, and secure needed funding.

Funding for IECBH Services

While no two states are alike, many rely on federal health (e.g., mental health and substance use disorder block grants, home visiting program funds) and child development education programs (e.g., child development block grants, early intervention funds) as well as state funds. States have identified Medicaid as a critical resource to fund IECBH services for infants/young children and their families and recognized that it is important to pursue/leverage other funding sources as well. Some states have supported the financing of IECBH services through Medicaid by obtaining a waiver or submitting a state plan amendment to the federal Centers for Medicare & Medicaid Services (CMS), while others have used a legislative or state policy approach. Several states have sought other federal/state/philanthropic funding for complementary/needed services not covered by Medicaid.

Diagnosis Coding and Billing

Because young children experience mental health issues differently than adults, a separate coding system, the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5)*, has been developed. Several states and national organizations have developed crosswalks of DC: 0-5 diagnoses (tailored to conditions in infants and young children), DSM-5 diagnoses (used for mental health conditions for people of all ages), and ICD-10 diagnoses and codes (used by US healthcare providers to classify and code diagnoses that include cause and severity of a condition) that can be used for billing purposes.

The codes frequently billed to Medicaid for IECBH services include screening/assessment and intervention/treatment (dyadic/family therapy and psychotherapy are most common, with several states requiring/encouraging use of evidence-based therapies that are relationship-based and involve an infant/child and their parent/caregiver). Several states are embracing the IECBH Consultation model. At least one or two (Michigan, New Mexico) can bill Medicaid for services proved by professionals with Category 2 Endorsement (Infant Family Specialist) and at least one other (Tennessee) is pursuing being able to bill Medicaid. Commonly-billed assessment codes are 90791 and 90792 and therapy codes include:

- Dyadic/family therapy (90847 and 90846 – with and without client present)
- Psychotherapy (90832 – 30 minutes, 90834 – 45-50 minutes, 90837 – 60 minutes)
- Multifamily group therapy (90849)
- Add-on code for case complexity (90785)

Medicaid programs typically require an individual client to be identified and a diagnosis given for a service to be reimbursed. However, recognizing that infants/young children can be at "imminent risk" of developing a behavioral health or developmental disorder due to themselves or their parent/caregiver having specific risk factors and would benefit from family therapy, some state Medicaid programs allow the use of a Z code for a certain number of visits prior to a diagnosis being required (e.g., California uses ICD-10 code Z65.9, Oregon permits use of Z63.8 secondary to F43.8). The availability of an imminent risk code may be helpful to clinicians as it can be challenging to diagnose young children, especially infants and those who are not yet speaking.

Recommendations

The following recommendations are grouped into four categories and represent next steps that Hawai'i' could take to ensure that keiki and their families are able to obtain needed behavioral health services with sustainable funding sources.

I. Engage A Financing Leadership/Action Group

1. Develop a financing leadership/action group to advance these recommendations.
2. Partner with Medicaid to design a reimbursement structure for IECBH services in Hawai'i and develop other public/private partnerships to identify and secure additional funding for complementary and other wraparound services.
3. Building on other state examples, partner with the relevant state agencies (such as Med-QUEST, DOH) and other public/private partners to review existing DC: 0-5 crosswalks that identify eligible behavioral health conditions and can be used by a variety of eligible provider types to bill for IECBH services rendered.

II. Engage and educate existing providers of IECBH services

4. Review the details of programs in states that were able to implement changes to Medicaid billing for IECBH services and determine what changes (e.g., state plan amendments, waivers), if any, are necessary for Hawai'i.
5. Inform providers, medical billers, and others of current or new opportunities to bill for IECBH services.

III. Onboard new providers of IECBH services

6. Identify what changes other states such as Michigan have made to enable individuals with Category 2 Endorsement (Infant Family Specialists who are supervised by a Medicaid-eligible provider) to bill Medicaid for their services and determine if the same changes are needed and can be made in Hawai'i.

IV. Evaluate pre/post changes to demonstrate impacts

7. Evaluate changes in processes and outcomes that may result from increasing Medicaid or other payer reimbursement (or provider knowledge about the ability to bill) for IECBH services.

Implementing the Recommendations

We recommend that Hawai'i move forward simultaneously on both the longer-term vision for improving access to IECBH services through the financing leadership/action group and a set of discrete tasks related to Med-QUEST that are part of an overall strategy. While the members of the financing leadership/action group are being identified, invited to participate, and convened, several activities that will help prepare for the implementation of these recommendations can begin. Our consultant team proposes to continue work with the Med-QUEST team to continue to move forward on the practical implementation of the recommendations in the following areas:

- Facilitating meetings between the Med-QUEST team and representatives of Medicaid programs in other states who can provide insights and share their approaches regarding the *use of Category 2 Endorsed individuals* and imminent risk codes.
- Working with the Med-QUEST team on an evaluation plan, including identifying the desired data elements on IECBH services currently being provided so that an analysis of existing data for the 0-5 population can commence.
- Reviewing with the Med-QUEST team the list of covered services on pages 5-6 of this report to determine whether each of these services is covered in policy, actual practice, or both.
- Working with a small group of representatives from organizations such as Med-QUEST, DOH, and AiMH HI to review existing DC: 0-5 crosswalks and create one for Hawai'i that can be shared with providers to use for accurately diagnosing infants/young children and billing for IECBH services.

Undertaking these discrete tasks and any others that are identified in the short-term will inform the work of the financing leadership/action group in the longer term. Some policy and practice changes likely can be implemented in the next several months, whereas others may take many months or 1-2 years or more to implement. All are important for improving access to IECBH services, thereby improving the health of Hawai'i's keiki and families.

Report

Background

Despite advances in health insurance coverage of mental health services over the past decade, children's mental health has steadily declined in the US during this time period.[1] A 2020 report and analysis found that federal laws require health insurers and Medicaid to fairly reimburse for services that prevent mental health conditions in children, but that few insurers or states meaningfully cover these services and most children cannot access them.[2] The report recommends that the federal government provide enhanced matching funds for children's mental health services in Medicaid, bolster training programs for providers of these services, increase funding for programs that meet families' health-related social needs, and enforce compliance with existing laws related to children's mental health.[3] Further exacerbating this situation, the COVID-19 pandemic and its economic impacts have disproportionately affected racial, ethnic, and socioeconomic groups already experiencing disparities and inequities.[4]

To advance a path forward in Hawai'i, a five-year *Integrated Infant and Early Childhood Behavioral Health (IECBH) Plan* was developed and is being disseminated. The Plan states that IECBH "comprises cross-disciplinary practices that focus on the well-being of very young children within the context of their early relationships, family, community, and culture." Because children under the age of five in Hawai'i do not consistently receive needed behavioral health services, the Plan proposes to integrate child and family mental health and trauma-informed care into the health and early care and learning systems throughout the state. To achieve this goal, the Plan identifies four component areas (systems and policy; marketing, outreach, and community education; workforce development; and programs and services) with strategies and objectives in each area.

The State of Hawai'i's Infants/Toddlers

According to 2019 data from Zero to Three, about 29% of infants and toddlers up to age 3 in Hawai'i lived in households with incomes less than twice the federal poverty level (FPL), and 25% were in crowded housing.[5] In terms of mental health, 16% of mothers reported less than optimal mental health.[6] The percentage of babies who had one adverse childhood experience (ACE) was 15.2% and the percentage with two or more was 6.5%.[7] About 35% of infants and toddlers 9 through 35 months old were reported to have received a developmental screening using a parent-completed tool in the past year, 7% of infants/toddlers received Individuals with Disabilities Education Act (IDEA) Part C services, and 3.4% of low/moderate income infants/toddlers were in child care with subsidized funding.[8] The impact of the COVID-19 pandemic on these indicators is unknown, but it is likely that it contributed to a deterioration in economic indicators such as the proportion of families who are low

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[1] Counts, NZ, Walker-Harding, LR, Miller, BF. *Coverage of Services to Promote Children's Mental Health: Analysis of State and Insurer Non-Compliance with Current Federal Law*, Well Being Trust. December 8, 2020.
WellBeingTrust.org.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Zero to Three. *State of Babies Yearbook 2021*.
[6] Ibid.
[7] Ibid.
[8] Ibid.

income or living in crowded housing. The longer-term physical and mental health impacts of the pandemic will require ongoing monitoring and assessment.

Sources of Health Insurance in Hawai'i

Data from the Kaiser Family Foundation showed a total of 236,800 individuals enrolled in Medicaid and the Children's Health Insurance Program (CHIP) in Hawai'i in 2019.[9] Of the 1.34 million total population in Hawai'i in 2019, 54.3% had health insurance coverage through an employer, 15.9% Medicare, 4.0% military, and 4.1% non-group.[10] About 4.1% or 54,500 individuals were uninsured. While 17.6% of the population in Hawai'i was covered by Medicaid in 2019,[11] more than 34% of the approximate 17,500 births in that year were covered by Medicaid.[12,13]

Desired Project Outcomes

Golden State Health Policy, LLC was retained to assist with identifying strategies for operationalizing the Plan related specifically to funding IECBH services, with a focus on identifying opportunities for systemic change and long-term sustainability.

The Importance of Intervening in Early Childhood

The architecture of the human brain begins to develop before birth and continues through adulthood, with the quality of the architecture establishing either a sturdy or fragile foundation that impacts subsequent learning, health, and behavior.[14] Genetics and experience shape the developing brain, with a major factor being the relationship between a child and their parents and other caregivers in the family or community.[15] The flexibility of the young brain – its plasticity – means it is easier and more effective to influence a baby's developing brain than to intervene in the adult years, with emotional and physical health, as well as social and cognitive-linguistic skills, being important for success in school and beyond.[16] Toxic stress (strong, unrelieved activation of the body's stress management system that may be caused by poverty, abuse or neglect, parental substance use or mental illness, or exposure to violence) changes brain architecture and can lead to lifelong learning, behavior, and physical and mental health problems.[17,18] The more adverse experiences that occur in childhood, the greater the likelihood of developmental delays for children, as well as health and other problems in adulthood.

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[9] Kaiser Family Foundation. State Health Facts: Health Insurance Coverage of the Total Population. Accessed June 20, 2021.
[10] Ibid.
[11] Ibid.
[12] March of Dimes. Medicaid coverage of births: Hawai'i, 2019. Accessed June 20, 2021.
[13] March of Dimes. HEALTHY MOMS. STRONG BABIES. Hawai'i. Accessed June 20, 2021.
[14] National Scientific Council on the Developing Child. *In Brief: The Science of Early Childhood Development*. Harvard University Center on the Developing Child.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] National Scientific Council on the Developing Child. *In Brief: The Impact of Early Adversity on Children's Development*. Harvard University Center on the Developing Child.

Research studies have found that intervening earlier can prevent the consequences of early adversity and is significantly more effective than waiting.[19] Supportive, responsive relationships with family members, early care and education providers, and community members are a key factor to preventing or reversing the damaging effects of toxic stress.[20]

The Integral Role of Medicaid

The Medicaid program is a federal/state partnership and covers eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. An essential component of Medicaid is the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit that provides comprehensive and preventive health care services for children under age 21 enrolled in Medicaid. States are required to furnish all Medicaid coverable, appropriate, and medically necessary[21] services needed to correct and ameliorate health conditions, based on certain federal guidelines. States must make necessary health care services available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

Because of these requirements, Medicaid can be an integral building block in the funding for IECBH services. States such as Michigan and California have identified Medicaid as a key funding source due to the EPSDT benefit, while recognizing the importance of tapping into other federal and state funding opportunities such as mental health and substance use block grants, IDEA Part C funds, etc. Some of these funding sources are ongoing, while others are of limited duration. One important reason to use Medicaid as a key source of funding for IECBH services is that the Medicaid program and the EPSDT benefit seem to be stable, whereas other funding sources may be reduced or eliminated based on the priorities of new federal administrations that change every four to eight years. As stated in a recent National Center for Children in Poverty (NCCP) report, "CMS rules and guidance convey strong support for Medicaid coverage of key IECMH services."[22]

Diagnosis Coding and Billing for IECBH

The *Diagnostic and Statistical Manual of Mental Disorders (DSM-5*) is used by health care professionals to diagnose mental disorders such as those related to mood, personality, identity, or cognition. Because young children experience mental health issues differently than adults, a coding system was developed specifically for infants and toddlers – *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5)*. The DC: 0-5 coding manual and training on its use for IECBH professionals are available through the Zero to Three

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[19] Ibid.
[20] Ibid.
[21] Medical necessity refers to a service that will, or is reasonably expected to, do one or more of the following: arrive at a correct diagnosis; reduce, correct, or ameliorate the physical, substance, mental, developmental, or behavioral effects of a covered condition; assist the individual to achieve or maintain functional capacity to perform age-appropriate or developmentally appropriate daily activities, and/or maintain or increase the functional level of the individual; and ameliorate the effects of abuse or neglect, and/or when there is a need to repair or build attunement and attachment with a caregiver after a significant disruption (Oregon Health Authority, 2020).
[22] Sheila Smith and Maribel Granja. November 26, 2018. *How States use Medicaid to Cover Key Infant and Early Childhood Mental Health Services: Results of a 50-state Survey (2018 Update)*, NCCP.

organization.[23] Further, the *International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM)* is used by healthcare providers in the US to classify and code diagnoses of health conditions including cause and severity.

In addition to a diagnosis code, encounters with a health care provider often involve one or more procedures, which are coded using the *Current Procedural Terminology (CPT)*, which is a code set maintained by the American Medical Association (AMA) and was designed to describe medical, surgical, and diagnostic services accurately.

Several states and two national organizations (Zero to Three and NCCP) have developed crosswalks for the DC: 0-5, DSM-5, and ICD-10 systems that can be used by providers to bill and receive payment for IECMH services. Perceived benefits of using a crosswalk include increased ability to diagnose relationship and other behavioral health disorders in infants and young children, enhanced ability to provide appropriate treatment services to infants and young children, increased ability to bill and be reimbursed for these services, increased recognition of behavioral health and developmental challenges in young children, improved understanding of how relationships and environmental factors contribute to behavioral health and developmental disorders, and enhanced ability to work more effectively with parents and other professionals to develop effective-treatment plans.

The Zero to Three crosswalk, for example, shows the DC: 0-5 diagnosis, DSM-5 diagnosis, and ICD-10 diagnosis and code for each of the following categories: neurodevelopmental disorders; sensory processing disorders; anxiety disorders; mood disorders; obsessive-compulsive and related disorders; sleep, eating and crying disorders; trauma, stress, and deprivation disorders; and relationship disorders.

An example of where the diagnoses are similar across the three coding systems is for "developmental language disorder" in the DC: 0-5, "language disorder" in the DSM-5, and "developmental disorder of speech and language, unspecified" in the ICD-10. An example of where the diagnoses differ across the three coding systems is "disorder of dysregulated anger and aggression of early childhood" in the DC: 0-5, "disruptive mood dysregulation disorder" in the DSM-5, and "other persistent mood disorder" in the ICD-10. A condition of "excessive crying disorder" in the DC: 0-5 has no code listed in the DSM-5, and "nonspecific symptoms peculiar to infancy (excessive crying in infants)" in the ICD-10.

NCCP compiled a crosswalk of DC: 0-5, DSM-5, and ICD-10 codes that indicates for which states (including Colorado, Minnesota, Nevada, North Carolina, Oregon, and Tennessee) the ICD-10 code is billable to Medicaid.[24] This crosswalk also notes whether the diagnosis qualifies for Part C early intervention eligibility in Minnesota. It shows, for example, that autism spectrum disorder is not billable in Colorado, nor are global developmental delay, developmental language disorder, developmental coordination disorder, or other neurodevelopmental disorder. This crosswalk shows the same ICD-10 code for Zero to Three and multiple states for "separation anxiety disorder", for example, while ICD-10 codes differ for "social anxiety disorder (social phobia)" with Zero to Three, Colorado, North

[23] Zero to Three. DC: 0-5™ Manual and Training.
[24] NCCP Bank Street Graduate School of Education. State DC :0-5 Crosswalks.

Carolina, and Tennessee using code F93.2, Minnesota and Oregon using F40.10, and Nevada using F93.0.

Background Research into Actions of Other States

By combining various federal and state funds, several other states have implemented strategies to improve access to IECBH services. These services are often grouped into three categories: prevention, promotion, and intervention/treatment, with the following definitions from Hawai'i's Integrated IECBH Plan.

- *Prevention* services and supports buffer effects of risk and stress and address potential early relationship challenges or vulnerabilities that have a documented impact on early development. Specific strategies are designed to nurture mutually satisfying relationships between young children and the significant adults in their world to prevent the progression of further difficulties. Health and developmental vulnerabilities, parenting difficulties, domestic violence, family discord, and other major child and family stressors may warrant the delivery of prevention services in a variety of settings.
- *Promotion* services and supports recognize the central importance of early relationships on brain development, learning, and the emotional and social well-being of all young children. Services include a focus on positive early relationships and guidance within the home, child development settings, and other service settings for young children and their families.
- *Intervention/treatment* services and supports target children and their families in distress or with clear symptoms indicating a mental health disorder. The services address attachment and relationship problems and the interplay between the child and significant caregivers that jeopardize achieving optimal early behavioral health and early emotional and social development outcomes. Specialized early mental health treatment services may focus on child-parent dyads or other important relationships and are designed to improve child and family functioning and the mental health of the child, parents, and other caregivers.

Recommended IECBH services may include behavioral health screening, mental health assessment, behavioral health prevention education service for the caregiver(s), developmental delay prevention activities, family therapy (with and without client present), multifamily group therapy, case management, mental health consultation, parenting education/family peer delivered services, and skills training.[25]

National results from a 2018 survey of state use of Medicaid to cover key IECMH services included:[26]

- 43 states including Hawai'i reported that Medicaid covers social-emotional (SE) screening of young children with a SE tool; of these, 23 states have a separate CPT code for this service (Hawai'i did not report this), and 34 states including Hawai'i permit same-day SE and developmental screenings
- 32 states reported that Medicaid pays for maternal depression screening during pediatric or family medicine visits, under the child's Medicaid (Hawai'i did not report this)

[25] Oregon Health Authority, Diagnostic Criteria for Other Specified Stressor, October 2016.
[26] Sheila Smith and Maribel Granja. November 26, 2018. *How States use Medicaid to Cover Key Infant and Early Childhood Mental Health Services: Results of a 50-state Survey (2018 Update)*, NCCP.

- 13 states allowed, 5 states recommended, and 1 state required that providers use DC: 0-5 to receive reimbursement (Hawai‘i did not report doing any of these)
- 9 states including Hawai‘i reported that Medicaid pays for a health navigator to help connect families to appropriate services when a child has a positive SE screen or a parent has a positive depression screen
- 47 states including Hawai‘i said Medicaid pays for a mental health clinician to address a child’s mental health needs in a pediatric or family medicine setting; this includes screening and diagnostic assessment (45 states) and treatment (44 states); 14 states including Hawai‘i that pay for mental health clinicians in a pediatric or family medicine setting require the use of evidence-based practices
- 35 states including Hawai‘i said Medicaid pays for an early childhood mental health specialist to address a child’s mental health needs in child care and early education settings; 15 states require use of evidence-based practices in these settings (Hawai‘i did not report this)
- 50 states including Hawai‘i reported that Medicaid pays for a mental health clinician to provide services in the home to address a young child’s mental health needs; 12 states including Hawai‘i reported these services are sometimes provided as part of a state home-visiting program; 19 states including Hawai‘i require the use of evidence-based tools or practices in these settings
- 42 states including Hawai‘i said Medicaid covers dyadic treatment, of which 11 including Hawai‘i have a specific billing code; 12 states (Hawai‘i did not report this) require providers to use an evidence-based dyadic treatment model; and 18 states (the state names were not reported) offer treatment without a child’s diagnosis when there are family risk factors such as parental depression; dyadic treatment can be provided and paid for by Medicaid in a variety of settings including a mental health clinic (41 states), home/foster home (41 states), pediatric/family medicine practice (35 states), child care or early education program (28 states), and other community settings such as family resource center (7 states)
- 23 states (the state names were not reported) said that children can receive treatment without a diagnosis when there are family risk factors such as depression that make it likely the child will experience a mental health condition (i.e., imminent risk)
- 16 states (Hawai‘i did not report this) reported that Medicaid pays for parenting programs designed to help promote children’s SE development and address child mental health needs, of which only 5 require providers to use an evidence-based parenting program.

NCCP researchers plan to update this survey. In the meantime, it may be useful for Hawai‘i to review this list and determine whether each of these services is covered in policy, actual practice, or both, including better understanding coverage status for those services where no Hawai‘i-specific data was reported from the 2018 survey.

Examples of five states (California, Colorado, Tennessee, Oregon, and Michigan) that were described as innovative in their use of Medicaid and other funds to reimburse for IECBH services follow.

California	
Overview	• Psychologists, LCSWs, LPCCs, and MFTs may only bill Place of Service codes for the following: office, home, outpatient hospital, community mental health center, comprehensive rehabilitation facility, state or local public health clinic, rural health clinic, or other. • Family therapy that is evidence-based or incorporates evidence-based components is reimbursable for a child who has a mental health diagnosis using either the DSM-5 or the DC: 0-5. Some examples of evidence-based family therapy are: Child-Parent Psychotherapy (CPP) (ages 0-5 years), Triple P Positive Parenting Program (ages 0-16 years), and Parent Child Interactive Therapy (PCIT) (ages 2-12 years).
Key Features	If the child does not have a diagnosis but has at least one of several specified risk factors, or has a parent/guardian with one of several specified risk factors, family therapy must be billed using ICD-10 code Z65.9, which is used to specify a diagnosis of "problem related to unspecified psychosocial circumstances."
Billing Codes	Family psychotherapy is a covered benefit as of January 1, 2020, and can be billed using CPT codes 90846 if the patient is not present and 90847 if the patient is present.
Interesting Characteristics	If a medical provider suspects a mental health disorder and has referred the patient under age 21 for evaluation, a specific diagnosis is not required for the first five sessions. Claims for these visits must be billed with ICD-10 code F99.

Colorado	
Overview	• Developed a diagnostic crosswalk for the DC: 0-5, DSM-5, and ICD-10. • Recommends use of DC: 0-5 for diagnosis of children ages 0-5 years. • Has implemented the HealthySteps[27] program across the state.
Key Features	Medicaid covers dyadic treatment, including CPP, with billing codes 90847 and 90846 (family therapy with and without client present, respectively).
Billing Codes	Varies from $60-108 for individual therapy and $64-66 for family therapy.
Interesting Characteristics	Uses federal mental health block grant funds to train mental health clinicians working with young children on the DC: 0-5, including train-the-trainers sessions.

Tennessee	
Overview	• One of 10 participants in Zero to Three Financing Policy Project. • In June 2019, convened a statewide 25-30 member stakeholder group to discuss sustainability of IECMH programs and services. Participants represented various child-serving state agencies as well as TennCare (Medicaid program) and the IECMH sector (e.g., community mental health, Head Start, managed care organizations).
Key Features	Areas of desired focus included establishing cross-agency IECMH leadership, ensuring use of developmentally appropriate assessment systems (e.g., training on and use of DC: 0-5 vs. DSM-5, crosswalk), embedding IECMH practices in child-serving systems and strategies (e.g., outreach to the medical community, sharing quantitative data with legislators, setting expectation for endorsement among all professionals working with or on behalf of young children), financing IECMH services with non-governmental partners including business and faith-based organizations, training the workforce on IECMH strategies (e.g., advocating for IECMH tracks in higher education, ensuring workforce has reflective supervision), and raising awareness of IECMH through commercials and message delivery to the community at large.
Billing Codes	N/A, pursuing Medicaid support for the provision of IECBH services.
Interesting Characteristics	Accomplishments: 1) TN IECMH Financing Policy Team, led by AIMHiTN and TennCare, developed first-of-its-kind billing code for multisession, multi-informant assessment for infants through age 5, 2) hosted statewide IECMH Summit "Little Brain Builders: Investing in IECMH for a Strong Tennessee" with 100+ attendees, and 3) developed a DC: 0-5 crosswalk with partners in Alabama.

[27] HealthySteps is a program of Zero to Three and is an evidence-based, team-based pediatric primary care program that promotes the health, well-being. and school readiness of babies and toddlers, with an emphasis on families living in low-income communities.

Oregon	
Overview	• Medicaid program covers list of prioritized services that is updated periodically by the state's Health Evidence Review Commission (HERC) and approved by the legislature. • IECMH services have been billable to Medicaid since 2006. • Developed a guidance document with a diagnostic crosswalk for the DC: 0-5, DSM-5, and ICD-10, as well as place on the prioritized list and other comments relevant to coding.
Key Features	• Supports use of evidence-based dyadic therapy such as PCIT and trauma-focused cognitive behavioral therapy (TF-CBT) and emphasizes these over individual therapy in young children. • Has trained more than 150 professionals including IECMH consultants and has 34 state-funded IECMH consultant positions.
Billing Codes	• Common dyadic therapy CPT codes include family therapy with client present (90847) and family therapy without client present (90846) – must be clearly directed toward client treatment; other potential codes are for psychotherapy with or without family member present (90832 – 30 minutes, 90834 – 45-50 minutes, 90837 – 60 minutes), with an add-on code of 90785 for complex cases. Multifamily group therapy (i.e., multiple children and parents together) can be billed using code 90849. • As of January 2016, permits reimbursement for Z63.8 (Other specified stressor related to the primary support group), secondary to F43.8 (Other specified reactions to severe stressor). This allows children who do not meet criteria for any specific disorder but who need some form of family or dyadic services to reduce risk factors that could lead to a mental health or developmental disorder. Other Z codes that can be used for children experiencing symptoms related to abuse and neglect include Z62.810, Z62.811, Z62.812, Z69.010, Z69.020). • As of July 1, 2017, Oregon Health Plan (state's Medicaid plan) covers services provided by family support specialists (FSS) to help a child's family understand mental health development or issues, access care, navigate systems, or overcome mental health or behavioral health barriers when the FSS provider is a rendering Oregon Medicaid provider; the services are in accordance with the child's client-centered treatment plan; the clinic bills under procedure codes H0038 (peer support), T1016 (case management), or H2014 (skills training and development); and the diagnosis and treatment codes are on the prioritized list of health services. FSS are individuals who are parenting or have parented a child with emotional or complex health challenges, and have learned to navigate complex systems of services and benefits.
Interesting Characteristics	Identified diagnostic codes (ICD-10 and DSM-5) for behavioral health trauma and relationships that commonly need to be added to electronic health record (EHR) systems, including mental health services for victim of child neglect or abuse by parent, mental health services for victim of non-parental child abuse, parent-child relational problem, other specified problems related to the primary support group, and other specified trauma and stressor-related disorder, or other reactions to severe stress.

Michigan	
Overview	• Obtained a 1915(b) Medicaid waiver in which IECMH Consultation could be billed; must be medically necessary and promote community inclusion and participation, independence, or productivity when identified in an individual's plan of service developed during person-centered planning. • Medicaid has covered IECMH Consultation services since 2010 as a Prevention Direct Service model – using individual, family, and group interventions designed to reduce the incidence of behavioral, emotional, or cognitive dysfunction, thus reducing the need for individuals to seek treatment through the public mental health system. Incremental changes were made to the behavioral health chapter of the Medicaid provider manual over time. Services include observation and functional assessment at home and at a childcare setting. Interventions include coaching, training and support for parents/ caregivers and providers to build their reflective capacity, learn new ways to interact with the child to build their social-emotional skills and resilience, by providing educational resources for parents and providers, connecting family to community resources, providing counseling for families in crisis and referral for ongoing mental health services, if needed.
Key Features	• Communicated about IECMH Consultation as a Prevention Direct Service option to various providers and invited them to join a 12-month learning collaborative on evidence-based model of implementation and receive support in the use of IECMH Consultation as a Prevention Direct Service. • State regulation requires use of DSM-5 but state supports use of DC: 0-5 and developed a diagnostic crosswalk including training providers on how to use it.
Billing Codes	See provider manual.
Interesting Characteristics	See separate table below on Medicaid coverage of IECMH Consultation services.

Details on Michigan's use of Category 2 Endorsed staff to support the provision of IECBH services via the state Medicaid program are shown in the table below.

Who can provide services as an Infant Family Specialist (Category 2 Endorsement)?	Must have Infant Family Specialist/Category 2 endorsement or get a waiver from the state (for people pursuing but not yet receiving endorsement).
What are their qualifications/ credentials?	Michigan Association for Infant Mental Health (MI-AIMH) Endorsement® of Infant Family Specialist (previously Category 2), with Infant Mental Health Specialist (previously Category 3) preferred. Exceeds Category 2 Endorsement minimum requirements of a bachelor's degree; requires clinical master's degree in clinical psychology, social work, or marriage and family therapy; believe Infant Mental Health (IMH) is evidence-based practice, including infant parent psychotherapy that someone with only a bachelor's degree cannot provide.
What services they can provide?	• *Home-based Services* require 4 hours of face-to-face time per month. When providing IMH as a Home-based Service, infant parent psychotherapy, parent education, social support care management, and emotional support are included in the service. • *Prevention Direct Services*: IMH and IECMH consultation. • *Family Therapy* using a child-parent psychotherapy (CPP) model.
What locations?	Home and community-based settings. In practice, the home is the site over 80% of the time. The exception is if there is domestic violence in the home and a "neutral" location needs to be identified for the safety of the parent and infant/young child.
Who are their supervisors?	Master's or PhD level Clinical Supervisors, no peer-to-peer supervision.
What are the Reflective Supervision (RS) qualifications/ credentials?	Must be a children's mental health professional. Clinical Supervisors with Category 3 and 4 Endorsement provide RS, which can be provided by the Clinical Supervisor directly or through a contract with a person with appropriate endorsement/training.
What are the billing codes?	See provider qualifications and HCPCS/CPT codes. Mostly H0036, home based services. Other codes include Prevention Direct Services – IMH (S9482) and IECMHC (H0025), and family therapy when providing CPP (90846, 90847, 90849).
What amounts are paid?	Varies by Prepaid Inpatient Health Plans (PIHPs), which manage Medicaid funds for the public Community Mental Health Services Programs (CMHSPs).
What are funding sources?	• Medicaid/EPSDT for infant mental health Prevention Direct Services that are aimed at parents with perinatal depression or other conditions that impact the relationship/ attachment with the infant but fewer hours per month than for Home-based Services. • Medicaid/EPSDT for Home-based Services and Family Therapy (CPP). • Child Care and Development Fund (CCDF), Medicaid, and mental health block grant funds for IECMH Consultation in early care.
Other notes	• Michigan Department of Health and Human Service (DHHS) contracts with PIHPs who set the payment rates for services, submit encounter data to the state's behavioral health treatment episode data system (BHTEDS), and have affiliated CMHSP providers. • Recommend bringing student interns into settings to provide IECBH services as they're easier to retain afterwards. • For a few people with Category 2 Endorsement in small rural programs, supervision is required but may not have a Clinical Supervisor also trained to provide RS and therefore the CMHSP would be required to contract for RS. • Currently have 600+ Category 2 or 3 Endorsed providers across the state • Used 1915b waiver as vehicle to get IECBH consultations identified as a Medicaid-covered Prevention Direct Service.

Current Funding Sources for IECBH

Hawai'i currently uses a variety of federal and state funds to pay for IECBH services, with funds being distributed across at least three state agencies: HI Department of Human Services (Med-QUEST, Child Welfare Services), HI Department of Health (Early Intervention, Children and Adolescent Mental Health Division (CAMHD)), and HI Department of Education. Federal funding sources with department/agency names include:

- Department of Health and Human Services (HHS)
    - Medicaid funds including EPSDT, Centers for Medicare & Medicaid Services (CMS)
    - Children's Health Insurance Program (CHIP), CMS
    - Child Care and Development Fund (CCDF)/Child Care and Development Block Grant (CCDBG), Administration for Children & Families (ACF)
    - Preschool Development Grant (PDG), ACF
    - Head Start/Early Head Start, ACF
    - Child Abuse Prevention and Treatment Act (CAPTA) funds to improve child protective service systems, ACF
    - Title IV-B of the Social Security Act (child welfare funding), ACF
    - Title IV-E Foster Care Program, ACT
    - Social Services Block Grant, ACF
    - Promoting Safe and Stable Families (PSSF) Program, ACF
    - Family Violence Prevention and Services, ACF
    - Families First Prevention Services Act (FFPSA/Title IV-E funding), ACF
    - Temporary Assistance for Needy Families (TANF), ACF
    - Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, Health Resources and Services Administration (HRSA)
    - Maternal and Child Health Block Grant (MCHBG, Title 5 of the Social Security Act), HRSA
    - Community Mental Health Services Block Grant (MHBG), Substance Abuse and Mental Health Services Administration (SAMHSA)
    - Substance Abuse Prevention and Treatment Block Grant (SABG), SAMHSA
- Department of Education
    - IDEA:
        - Part B (Assistance for All Children with Disabilities), which is administered by the HI Department of Education
        - Part C (Infants and Toddlers with Disabilities), which is administered by the HI Department of Health.

Further analysis is needed to assess whether each of these funding sources is being used to the maximum extent allowed and being used optimally to advance outcomes and effectiveness.

Other Federal Funding Opportunities for IECBH

The American Rescue Plan Act (ARPA) includes a variety of federal funding opportunities to support IECBH. These include:

- HRSA:

    - New funds for pediatric mental health consultation program – up to $445,000 per year per award for 5 years
    - Additional MIECHV funds - $150M thru 9/30/22
- SAMHSA:
    - Community Mental Health Services Block Grant - $1.5B thru 9/30/25
    - Substance Abuse Prevention and Treatment Block Grant - $1.5B thru 9/30/25
    - National Child Traumatic Stress Network - $10M until spent

Discussion

In developing a strategy for financing sustainability for IECBH services in Hawai'i, Medicaid can continue to be considered a critical resource to fund services to meet the needs of infants, young children, and families, while recognizing there are limits to Medicaid funding and that it will be important to pursue/leverage other federal and state funding sources to pay for complementary and needed services that cannot be billed to Medicaid.

While a variety of prevention, promotion, and intervention/treatment IECBH services may be helpful for infants and children up to age five, much of the information gathered from states and included in this report focuses on screening/assessment and intervention/treatment; the personnel who can provide such services; whether Medicaid can be billed for these services, and if so, using what mechanism; and what billing codes can be used.

Several states are billing Medicaid for some IECBH services, with at least two (Michigan and Oregon) having done so for more than 10 years. Descriptions of innovative approaches in many states noted the importance of having all the relevant agencies (and especially the Medicaid agency) and other stakeholders together "at the table" to discuss developing the workforce, seeking additional funding sources, or building other capacity around IECBH services. In at least two states (Michigan and Tennessee), the Alliance for the Advancement of Infant Mental Health affiliate played a key role in convening and advancing IECBH in the state.

Screening and Assessments

As for the types of IECBH services commonly provided, screening and assessment were common, with some states specifying approved screening and assessment tools. Commonly used tools are the Ages And Stages Questionnaire: Social-Emotional (ASQ: SE), the Devereux Early Childhood Assessment Program (DECA), Parents' Evaluation of Developmental Status (PEDS), and the Survey of Well-being of Young Children (SWYC). Typical billing codes for administering these tools via a psychiatric diagnostic evaluation are 90791 (often used by nonmedical providers) and 90792 (typically used by medical providers).

Dyadic and Psychotherapy Interventions

Dyadic/family therapy and psychotherapy were the most frequently mentioned intervention/treatment services, with several states requiring or encouraging the use of evidence-based therapies such as CPP, PCIT, and TF-CBT that are relationship-based and involve the infant/child and their parent(s)/ caregiver(s).

IECMH Consultation Model

Several states have strongly embraced the IECMH Consultation model, and Michigan (as described above) indicated that they were able to bill Medicaid for services provided by individuals with Category 2 Endorsement (Infant Family Specialist). Education and credential/license requirements for individuals with Category 3 or 4 Endorsement mean that they are more likely to currently be eligible to bill Medicaid for services.

Billing

In terms of billing, several states shared their codes for dyadic/family therapy, psychotherapy, and multifamily group therapy, and at least one state allows an add-on code for psychotherapy due to case complexity. State Medicaid programs typically require an individual client to be identified as well as a diagnosis given for a service to be reimbursed. In California and Oregon (and potentially several other states), the Medicaid programs allow the use of a Z code for a certain number of visits in cases where there is imminent risk of a behavioral health condition based on risk factors of either the infant/young child or parent prior to a diagnosis being required. This may be helpful to clinicians, since it can be challenging to diagnose young children, especially infants and those who are not yet speaking. Potentially related to this issue, there appears to be a controversy about whether or not it is appropriate to give a young child a mental health diagnosis, with both pros and cons being articulated.

As noted above, the DC: 0-5 was created to provide developmentally specific, relationship based and contextually grounded diagnostic criteria and information about mental health disorders in infants and young children. Several states and at least two national organizations have developed crosswalks of the DC: 0-5 to the DSM-5 and ICD-10 that can be used for diagnosis and billing purposes. These crosswalks align diagnostic codes between different classification systems. Colorado developed a "Frequently Asked Questions" document that includes the rationale for their crosswalk being offered to clinicians who assess and treat very young children to facilitate use of the DC: 0-5 to ensure "better assessment, developmentally appropriate diagnosis, and more accurate clinical formulation that can lead to the selection of the most appropriate treatment strategies." Development of a crosswalk seemed to be an essential step for states seeking to advance IECBH services and Medicaid billing; while one state (Michigan) has regulations that require the use of DSM-5, the Medicaid agency encourages the use of the DC: 0-5. As noted above, the DC: 0-5 is tailored to conditions in infants and young children, while the DSM-5 is used to diagnose all ages and is less specific to the younger population. Because each state Medicaid program specifies what services it covers, national crosswalks such as the ones available from Zero to Three or NCCP likely cannot be used by states without some customization to reflect Medicaid coverage specific to the state.

States that developed DC: 0-5 crosswalks or made changes to their Medicaid provider manuals related to billing for IECBH services stated that communication and ongoing education for providers and medical billing staff were essential to increasing awareness of services and billing codes that could be used, which would enhance understanding and use of the existing EPSDT benefit. While some trainings were conducted in-person, others were done virtually. Ongoing training seems essential, both to keep the information top of mind for relevant parties and to train new staff when turnover occurs.

Further Research and Analysis

The impacts of state changes to increase the availability of IECBH services, improve billing opportunities, or add new categories of staff and increase training of the workforce warrant further analysis. For example, state Medicaid agencies may wish to compare the number of children ages 0-5 for whom specific services (e.g., assessments, family therapy, psychotherapy) were provided or requests for reimbursement submitted prior to any changes to Medicaid billing practices. Over time, outcome measures could be assessed to see whether infants and young children are receiving services at a younger age, when the impacts can be greater or achieved more quickly, rather than when they are older and whether more mental health conditions are prevented or successfully treated. Researchers at the University of Michigan, for example, have partnered with the state to evaluate its provision of infant mental health services.

Recommendations for Hawai‘i

The following recommendations, based on the research and innovative state practices reviewed, are grouped into four categories and represent next steps that Hawai‘i' could take to ensure that keiki and their families are able to obtain needed behavioral health services with sustainable funding sources.

I. Engage A Financing Leadership/Action Group

1. **Develop a financing leadership/action group to advance these recommendations.** For the following recommendations to move forward, it is essential to convene a group of key decisionmakers who are committed to the cause and authorized to implement changes on behalf of their agencies or organizations. In addition to Med-QUEST leadership, the group should include representatives from entities that play an essential role such as other Department of Human Services (DHS) agencies (e.g., Child Welfare Services), DOH (e.g., Early Intervention, CAMHD, Developmental Disabilities Division), Department of Education, the Executive Office of Early Learning (including Head Start), nonprofits (e.g., AiMH HI, Hawai‘i Community Foundation), providers, and families/patients/consumer advocacy organizations. Ongoing engagement of these stakeholders will be essential for continued momentum and implementation of agreed upon changes.
2. **Partner with Medicaid to design a reimbursement structure for IECBH services in Hawai‘i and develop other public/private partnerships to identify and secure additional funding for complementary and other wraparound services.**
    a. Med-QUEST's commitment to being a key partner for this effort and a building block of funding for IECBH services can be used to encourage other stakeholders to follow Med-QUEST's lead, thereby benefitting more of Hawai‘i's children and families.
    b. Convene all the Hawai‘i state agencies working with IECBH to monitor funding opportunities and determine which agency or agencies are the most appropriate to apply to a particular funding source. This will allow the state to address complementary needs that are the domains of other agencies (e.g., DHS for child welfare services, DOH for Early Intervention and CAMHD, Department of

Education) and more comprehensively meet the often complex and inter-related health and other needs of children and families.

c. Identify gaps in the types of IECBH services (and the personnel that can provide these services) that cannot be supported by federal or state funds and pursue philanthropic support for these services/personnel. This will help fill the identified gaps and bring more IECBH services to infants/young children and their families

3. **Building on other state examples, partner with the relevant state agencies (such as Med-QUEST, DOH) and other public/private partners to review existing DC: 0-5 crosswalks that identify eligible behavioral health conditions and can be used by a variety of eligible provider types to bill for IECBH services rendered.**
    a. Review current DC: 0-5/DSM-5/ICD-10 crosswalks (and the rationales for their use) from other states and national organizations and develop a crosswalk that is specific to Hawai‘i. Such a crosswalk could be used to educate providers about behavioral health diagnoses specific to infants and young children ages 0-5 and the DSM and ICD-10-CM billing codes that correspond to those diagnoses, thereby enhancing their understanding and use of the existing EPSDT benefit.
    b. For settings where EHRs are used, ask vendors to add more diagnoses related to IECBH. This will make it easier for providers to select an appropriate diagnosis and a bill to be generated for reimbursement.
    c. DOH should consider recognizing DC: 0-5 diagnoses as eligibility criteria for state Part C Early Intervention services.

II. Engage and educate existing providers of IECBH services

4. **Review the details of programs in states that were able to implement changes to Medicaid billing for IECBH services and determine what changes (e.g., state plan amendments, waivers), if any, are necessary for Hawai‘i.** For example, some states made changes through a state plan amendment (SPA) or 1115 or 1915b waivers, while others have used a legislative or state policy approach.
    - Examples of states to learn from include Michigan (allows Medicaid billing for Category 2 Endorsement), Oregon and Colorado (cover dyadic and family therapy, have developed a billing crosswalk), and Oregon and California (allow for billing using Z codes when children are at imminent risk of a behavioral health condition but do not yet have a diagnosis). During the COVID-19 pandemic, many behavioral health services were provided virtually (via phone or video) rather than in person. Federal guidance regarding reimbursement for telehealth may be a starting point, and Hawai‘i may want to consider state-level policy changes that would further support telehealth post-pandemic.
5. **Inform providers, medical billers, and others of current or new opportunities to bill for IECBH services.**
    a. Disseminate resources, such as the crosswalk, via trainings (in-person or virtual) to help providers use the DC: 0-5 for eligibility determination, treatment planning, and billing purposes. This will help providers understand billing opportunities for IECBH services, potentially increasing both the number of providers willing to provide the services and the number of infants and young children who receive them.

b. Make training and technical assistance opportunities available to providers on an ongoing basis regarding how to navigate multiple funding streams and what IECMH services are allowed to be billed. Continuing trainings will help providers to keep top of mind that infants and young children ages 0-5 need behavioral health services and that providers can be reimbursed for these services.

III. Onboard new providers of IECBH services

6. **Identify what changes other states such as Michigan have made to enable individuals with Category 2 Endorsement (Infant Family Specialists who are supervised by a Medicaid-eligible provider) to bill Medicaid for their services and determine if the same changes are needed and can be made in Hawai'i.** These providers could be called Certified Infant Family Specialists, defined as practitioners who meet the standard of endorsed AIMH HI Infant Family Specialist (Category 2) or its equivalent (e.g., Georgetown University Center of Excellence for Infant & Early Childhood Mental Health Consultation, UCSF Infant-Parent Program, certified Child-Parent Psychotherapist) who are certified by a Hawai'i Competency Review Team. This would increase the number of personnel trained to provide IECBH services to infants and young children and potentially expand the types of settings (e.g., community health centers) in which these services are provided.

IV. Evaluate pre/post changes to demonstrate impacts

7. **Evaluate changes in processes and outcomes that may result from increasing Medicaid or other payer reimbursement (or provider knowledge about the ability to bill) for IECBH services.** Evaluation results can be used for a variety of purposes including educating/engaging stakeholders (may improve buy-in from families, providers, state agencies, other policymakers, funders, etc.) and identifying areas where desired changes were not achieved and should be revised going forward.
    a. *Identify desired changes in processes and outcomes*. This will set the stage for allowing Hawai'i to evaluate the impacts of any changes made. Examples of potential process and outcome changes include the:
        - Number of infants, children, and families receiving these types of services,
        - Types of services being provided (e.g., prevention vs. treatment),
        - Number of suspensions/expulsions from childcare settings,
        - Number of children entering special education preschools not showing developmental challenges they had before,
        - Number of parents being able to access IECBH services, and
        - Use of specific billing codes such as for dyadic and family therapy or Z codes for at-risk infants and young children.
    b. *Obtain baseline information on the types of IECBH services currently being billed for the 0-5 population*.
        - Run Med-QUEST data queries to see which of the specific assessment/screening and treatment/intervention billing codes are being used, by what types of providers, and in what settings. This baseline information will be essential for the evaluation.
    c. *Track information over time to evaluate changes and share results with stakeholders*.

Implementing the Recommendations

We recommend that Hawai‘i move forward simultaneously on both the longer-term vision for improving access to IECBH services through the financing leadership/action group and a set of discrete tasks related to Med-QUEST that are part of an overall strategy. While the members of the financing leadership/action group are being identified, invited to participate, and convened, several activities that will help prepare for the implementation of these recommendations can begin. Our consultant team proposes to continue work with the Med-QUEST team to continue to move forward on the practical implementation of the recommendations, as follows:

1. Facilitating meetings between the Med-QUEST team and representatives of Medicaid programs in other states who can provide insights and share their approaches on topics including:
    a. Provider billing for IECBH services and *use of Category 2 Endorsed individuals* to provide IECBH Consultation services in various settings. While approaches from other states will be informative, the solutions will need to be tailored to meet the specific needs of Hawai‘i residents so that this additional category of IECBH providers can be recognized, with a goal of increasing the number of service providers and access for infants and young children and their families.
    b. Provider billing for services provided to infants and young children at *imminent risk* of needing IECBH services due to their own risk factors of those of other family members rather than requiring a diagnosis. This could also increase access to care.
2. Working with the Med-QUEST team on an evaluation plan, including identifying the desired data elements on IECBH services currently being provided so that an analysis of existing data for the 0-5 population can commence. This baseline information will be useful both in the short term to determine the extent to which IECBH services are being billed to Med-QUEST and to make future comparisons once any changes to billing or personnel are implemented.
3. Reviewing with the Med-QUEST team the list of covered services on pages 5-6 of this report to determine whether each of these services is covered in policy, actual practice, or both, including better understanding coverage status for those services where no Hawai‘i-specific data was reported from the 2018 survey.
4. Working with a small group of representatives from organizations such as Med-QUEST, DOH, and AiMH HI to review existing DC: 0-5 crosswalks and create one for Hawai‘i that can be shared with providers to use for accurately diagnosing infants/young children and for billing IECBH services.

Undertaking these discrete tasks and any others that are identified in the short-term will inform the work of the financing leadership/action group in the longer term. Some policy and practice changes likely can be implemented in the next several months, whereas others may take many months or 1-2 years or more to implement. All are important for improving access to IECBH services, thereby improving the health of Hawai‘i’s keiki and families.

APPENDIX

Examples of DC: 0-5 Crosswalks include:

- National Center for Children in Poverty/NCCP: State DC: 0-5 Crosswalks
- Zero to Three: Crosswalk from DC: 0-5™ to DSM-5 and ICD-10
- State of Colorado: COLORADO DC: 0–5™ CROSSWALK TO DSM AND ICD-10 and separate FAQ document explaining DC: 0-5 and the need for a crosswalk
- State of Michigan: Crosswalk between DC: 0-3 R, ICD-10 & DSM-5
- State of Oregon: Oregon Early Childhood Diagnostic Crosswalk
- Association of Infant Mental Health in Tennessee (AIMHiTN): DC: 0-5 Crosswalk

Acknowledgements

We would like to thank the following individuals for their participation in an Advisory Group and review of draft reports for this project. Any errors remain the responsibility of the authors.

Justina Acevedo-Cross, Hawai‘i Community Foundation
JoAnn Farnsworth, Association for Infant Mental Health in Hawai‘i (AiMH HI)
Cheryl Gramberg, Hawai‘i State Department of Health
Chris Jackson, Executive Office on Early Learning/Head Start State Collaboration Office
Stacy Kong, Hawai‘i Department of Health/Early Intervention Section
Amanda Luning, AiMH HI
Keiko Nitta, Hawai‘i State Department of Health/Children with Special Health Needs Branch
Sharon Thomas, Med-QUEST, Hawai‘i Department of Human Services
Kerrie Urosevich, Hawai‘i Early Childhood Action Strategy