California Children's Trust

CONNECTING CHILDREN TO THE CARE THEY NEED

Ending the Same-Day Exclusion Policy Increases Access to Mental and Behavioral Health Support

Overview

California is currently distinguishing itself as an innovative leader in child and adolescent wellness with significant reforms through the CalAIM initiative and the Children and Youth Behavioral Health Initiative (CYBHI). The overarching goal of these efforts is to promote equitable and easy access to behavioral health services for children and youth.

However, meaningful access to vital mental and behavioral health care is essentially out of reach for many low-income families because of an antiquated billing policy called "same-day exclusion," which prohibits Federally Qualified Health Centers (FQHCs) and rural health centers from separately billing Medi-Cal for primary care and behavioral health services delivered on the same calendar day.

FQHCs and rural health centers serve over seven million Californians, including 30% of California children on Medi-Cal.[1] The same-day exclusion policy runs counter to both evidence-based and promising practices that advance the integration of behavioral health and primary care,[2] and creates a significant barrier to preventive and early mental health interventions, especially those benefitting from dyadic and family-centered approaches.

California has made impressive commitments and reforms through CalAIM, CYBHI, and an array of investments and grant programs. The same-day exclusion policy is not only inconsistent with these efforts but directly undermines them. Additionally, the policy undermines integration of supports and services and limits innovation for how to more proactively address child and youth mental and behavioral health.

State leadership should eliminate the same-day exclusion policy for children and youth ages 0-20, thereby expanding access to mental health services and increasing both administrative efficiency and equitable access to care.

FEBRUARY 2023

California Policy Counters Federal Guidance

Same-day exclusion is a policy of the state of California that runs counter to both federal policy and Centers for Medicare and Medicaid Services (CMS) guidance. CMS's letter from August 18, 2022, outlines a range of strategies to improve access to behavioral health care, and specifically encourages states to remove same-day billing requirements, recommending:

> *Removal of prohibitions on same-day billing for behavioral health and primary care, and reimbursement parity for the same billing codes across primary care and behavioral health clinicians. (CMS guidance to states, 2022)*

The same-day exclusion policy is also problematic when considering the underlying federal intent and policy regarding the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which entitles children to comprehensive care and specifically prohibits capping state spending for children covered by this benefit.[3]

The integration of mental health treatment in primary care increases the effectiveness and efficiency of providing care and reduces costs in the care of primary care patients.[4,5] Research also shows that integrated and collaborative care models have better clinical outcomes for patients.[6,7,8] Medicaid requires a set of services be provided so beneficiaries have meaningful access to health care while allowing flexibility to tailor support to local needs and policy priorities and address socioeconomic barriers to care.

Other states, like Nevada, allow same-day Medicaid billing as an explicit strategy to increase access to integrated care. California can do the same—either DHCS or state lawmakers can modify or eliminate the same-day exclusion policy. California's leadership should no longer ignore Federal recommendations to states specifically suggesting that same-day exclusion policies be removed.

SAME-DAY EXCLUSION: FEDERAL GUIDANCE TO END THE POLICY

Policy and Guidance from the Centers for Medicare and Medicaid Services (CMS).

AUGUST 2022: CMS Encourages States to Remove Same-Day Exclusion

CMS guidance letter outlines a range of strategies to improve access to behavioral health care, and specifically encourages states to remove same-day billing requirements, recommending:

> *Removal of prohibitions on same-day billing for behavioral health and primary care, and reimbursement parity for the same billing codes across primary care and behavioral health clinicians.*

OCTOBER 2022: CMS Provides Formal Billing Guidance to Remove Same-Day Exclusion[9]

More than one visit with an FQHC practitioner on the same day, or multiple visit with the same FQHC practitioner on the same day, counts as a single visit, except when:

- The patient suffers an illness or injury requiring additional diagnosis or treatment on the same day. For example, a patient sees their practitioner in the morning for a medical condition and later in the day falls and returns to the FQHC.
- A patient has a qualified medical visit and a qualified mental health visit on the same day.

Children and Youth Are Not Alright

California's choice to limit mental and behavioral health care access through the same-day exclusion policy continues at a time when children and youth are in even greater need of support. Even prior to the COVID-19 pandemic, there were signs of a youth mental health crisis. Over the past decade, California children ages 10–14 experienced a 151% increase in inpatient visits for suicide, suicidal ideation, and self-injury.[10] Behavioral health emergency room utilization for youth at Rady Children's Hospital in San Diego increased 1,746% between 2011 and 2019. UCSF Benioff Children's Hospital Oakland reported double the number of youth suicide attempts in the fall of 2020 than in 2019.

One-third of California's middle and high school students experienced serious psychological distress between 2019 and 2021, according to the California Health Interview Survey, an annual statewide survey led by the UCLA Center for Health Policy Research. According to experts, those stakes are higher for LGBTQ+ students.

In California, the Trevor Project found that 44% of LGBTQ+ youth seriously considered suicide in 2022, including 54% of transgender and nonbinary youth. Those responses came despite the fact that in California, 75% of LGBTQ+ youth said their own communities were accepting of LGBTQ+ people.[11]

In response to these and other alarming data, in October 2021, Children's Hospital Association, the American Academy of Pediatrics (AAP), and the American Academy of Child and Adolescent Psychiatry (AACAP) declared a national mental health emergency for children and teens. Here in California, Governor Gavin Newsom and the leadership of nearly every child-serving agency in the state have echoed these urgent concerns.

Access Is Already Inadequate for Children and Youth

"It's clear the system in California has been failing its most vulnerable and at-risk children and families. Behavioral health care is not readily available, and California's children are paying a high cost for this system failure. It is imperative that California eliminate outdated policies which create barriers to behavioral health care."

— Alex Briscoe, Principal, California Children's Trust

In California, among those who say they or a family member sought treatment for a mental health condition in the past year, 23% say they had to wait longer than they thought reasonable to get an appointment for mental health care,[12] which rises to four in 10 people (42%) for Medi-Cal enrollees.[13] A 2020 report by the Commonwealth Fund found California ranks 48th among 50 states for providing children with mental health care and has worsened over time.[14] In 2018, fewer than 5% of children on Medi-Cal received "specialty mental health services," despite a federal entitlement guaranteeing access for all who are eligible.[15] Medi-Cal enrollees needing behavioral health services must navigate a complex array of benefits and providers, often seeking services from very different systems[16] frequently including two completely separate county agencies and a managed care plan.[17]

ABOUT FEDERALLY QUALIFIED HEALTH CENTERS

Federally Qualified Health Centers serve 30 million Americans[18]—one in every 12 people nationwide; 1 of every 3 people living in poverty, and 1 in 7 racial/ethnic minorities.[19] In California, FQHCs serve 7.2 million individuals—one in every five Californians.[20] Located in high-needs areas, FQHCs provide comprehensive medical supports to underserved populations regardless of insurance status, citizenship, or capacity to pay for care. FQHCs operate clinics in over 2,000 locations in California[21] and are staffed by 2,985 physicians and 1,885 behavioral health specialists.[22] Adeptly responding to public health needs, FQHCs have long served as the healthcare safety net throughout the state. In addition to providing comprehensive medical care, FQHCs also provide programs that target the unique health needs of migrant seasonal farmworkers, people experiencing homelessness, individuals living in public housing, and children and adolescents receiving school-based healthcare.

California Policy Perpetuates Inequities

By design, the Medi-Cal program serves many of California's most vulnerable residents. Seventy-three percent of all patients served in California live at or below the federal poverty line, 79% are racial/ethnic minorities, and 32% are under the age of 18).[23] FQHCs also serve as vital medical suports for individuals with public insurance (65% of patients are Medi-Cal enrollees[24]) and those with no insurance.[25] Given these features and the diversity of beneficiaries in California, the Medi-Cal program has unique potential to overcome racial inequities in health care.

While there are numerous issues restricting access to mental health treatment for Medi-Cal enrollees, the same-day exclusion policy reinforces specific barriers by forcing these Californians to either forgo behavioral health care altogether or take on additional, completely unnecessary administrative, transportational, logistical, professional, and/or childcare-related burdens. Sixty-four percent of Medi-Cal enrollees are employed and 86% live in households in which they or another family member work part- or full-time.[26] Furthermore, Medicaid patients are 20% more likely than the privately insured to wait longer than 20 minutes for each appointment.[27] Requiring additional, entirely separate visits is extremely disruptive and burdensome.

Policies that restrict access to services among Medi-Cal enrollees seeking care through FQHCs—often placing greater burden on historically marginalized populations—are unjust and inequitable.

> *"As the single working mom of a child living with complex, chronic health conditions, I miss a lot of work and my child misses a lot of school for her medical care. Travel time, finding parking, extended waits to see the doctor, and the actual appointment time usually means missing a third to a half a day of work and school. I want my daughter to get the mental health care she needs, but I cannot always take an additional day off work to take her back to the clinic."*
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> **—NANCY NETHERLAND, CAREGIVER**

About the Same-Day Exclusion Policy

As previously stated, under current California policy, Federally Qualified Health Centers (FQHCs) cannot be reimbursed for both medical and mental health services rendered to a single Medi-Cal patient on the same day. There is nothing preventing them from scheduling both visits and providing both services—they just cannot expect to be reimbursed by Medi-Cal if both "encounters" take place on the same day.

Much of the same-day exclusion debate in California centers around interpretations of the Prospective Payment System (PPS) rate structure, through which FQHCs bill and are reimbursed for Medi-Cal eligible services.[28] In California, each licensed clinical site (clinic site) has its own PPS rate, with a fixed per-visit rate for qualifying visits. The process to negotiate these rates is arduous and typically only conducted when new sites are established.

DHCS treats behavioral health and primary care services provided on different days as distinct. However, DHCS asserts that behavioral health care is also included in the PPS rate for standard primary medical care, such as well-child visits, consultations for acute conditions, support for chronic disease management, and other health needs. But as we know, pediatric primary care visits rarely exceed 20 minutes. In practice, FQHCs tend to use a model where a very quick "meet and greet" is conducted by a BH provider during the visit (these are not billed) and then an appointment is rescheduled for another day, which does not directly address the barriers to care created by the same-day exclusion policy.

PROVIDER PERSPECTIVE

As the director of the embedded behavioral health program in San Francisco's largest pediatric primary care clinic for publicly insured children—that is also an FQHC and part of a safety net health system—I comb through dozens of referrals generated by our pediatric providers every week. These internal referrals to our behavioral health team are generated most often when a behavioral health concern was identified as part of a routine medical visit and yet a clinician was not available for a warm hand off. The pattern of these referrals is too often followed by unsuccessful attempts to re-engage the patient (either through multiple outreach attempts or no-show appointments) and ultimately ends with a closed referral and worst of all, an unmet behavioral health need. This often occurs in spite of the patient having been successfully engaged and open to receiving the service when initially identified by their provider during their medical visit. The result is an unfortunate missed opportunity for patients to receive a critical and time sensitive behavioral health service that supports their health and well-being.

We hope to see the same-day exclusion policy for behavioral health interventions removed. It will lead to better care for our patients and their families. This would provide a critical piece of the puzzle required to adequately address the current youth mental health crisis and to prevent the next one.

Additionally, and holding central the high rates of clinician burnout and a workforce shortage amidst a youth mental health crisis, the consequence is that behavioral health clinicians expend much of their time in outreach and re-engagement efforts with limited success. This pattern is demoralizing for all involved, leads to exacerbating mental health concerns due to missed opportunities, is a poor use of critical and limited resources, and unfortunately is completely predictable based on what the science of motivation to change and engagement in mental health treatment has taught us. While the access challenges created by the same-day exclusion policy are clearly a factor, an important point is that the benefits of providing same day behavioral health services extends beyond asking the patient to come to the clinic more than once.

Meeting a patient during their pediatric health visit to introduce a behavioral health clinician who will provide a brief assessment, intervention, and recommendations is the secret sauce of integrated behavioral health. It is also scientifically proven to be effective. We need to shift thinking around integrated behavioral health as being a warm hand off "meet and greet" for scheduling a follow up appointment, to understanding the pediatric medical visit as the critical ingredient to fostering therapeutic engagement and cultivating therapeutic change. This is especially important for children and youth whose behavioral health outcomes rely heavily on successfully engaging their caregivers and for whom timely, early intervention is critical to preventing and mitigating the developmental trajectory of mental illness.

Routine pediatric well visits are a non-stigmatizing intervention in and of themselves, and are of critical relevance to child behavioral health services because they already include the partnership and participation of caregivers. A trusted pediatric provider is responsible for screening behavioral health as part of their routine care—a process that for a child, also includes environmental health, such as caregiver and family wellbeing. These screenings often result in a child or caregiver voluntarily opening up about a behavioral health need, which for patients and families can be a raw and vulnerable moment in time. If this opportunity is left unaddressed it may be difficult to reopen or even to re-access when the setting and circumstances are different. On the other hand, when a behavioral health clinician is introduced to a family from within that trusted space during those vulnerable moments, the likelihood for engagement and therapeutic progress becomes exponentially higher. This is not coincidental. In fact, science has made it abundantly clear that "motivation to change" is highly contingent on patients' trust in providers, timing of intervention, and the way in which engagement occurs.

Science has also taught us that patients and families who have experienced trauma or adversity often activate protective mechanisms that impact the way they reveal their experiences, when they choose to do so, and with whom. For example, after a patient initially discloses to a pediatric provider their vulnerable feelings related to a traumatic event or stressor, an individual may "compartmentalize" or pack these feelings tightly back inside as a way to be able to more easily function in everyday life. This is actually a highly adaptive strategy that serves an important purpose for survivors of trauma and adversity. Yet, as it relates to a missed opportunity to leverage that unique moment of disclosure that occurred in the "safe space" of the pediatric well visit, this is where we see the initiation of the pattern of the behavioral health clinician outreach and re-engagement attempts that so often result in a patient being lost to follow up.

When these critical, time sensitive and natural touch points for engaging patients and caregivers with an in-the-moment assessment and evidence-based brief intervention are missed, the negative impact on child health outcomes, that are so highly correlated with timely, early intervention, is devastating. Unfortunately, the culture of FQHC integrated behavioral health has evolved into referrals for follow up, non-same-day services, and is counterproductive to what we know about promoting engagement with behavioral health care—especially for children. While behavioral health clinicians themselves may not be intimately familiar with the way in which reimbursement differs between a same-day versus a stand alone visit, it is difficult to deny that financial sustainability needs that are informed by the same-day exclusion policy play a role in how clinicians are trained to structure their services.

When evaluating the impact of missed opportunities, it is important to factor in those touch points created by the periodicity of pediatric care, as informed by the science of prevention and early intervention. There are 12-15 pediatric visits during the first three years of a child's life, which map onto the critical period of brain development that have been shown to play a significant role in the downstream development of mental health concerns. Since babies do not show up alone to their pediatric visits, we have a captive audience for up to 15 times during a child's most critical period of development with a caregiver who may be disclosing emotional vulnerability, or a parenting support need, or a desire for dyadic behavioral health assistance. It is inconceivable that we would not provide them with a fully and separately reimbursable, evidence-based distinct behavioral health service during those very moments when they are open to receiving it and when they are already in the clinic.

This is compounded by the fact that the etiology of behavioral health concerns mean that early mental health risk factors, and mild behavioral health concerns that manifest early in child development, are much more likely to benefit from behavioral health prevention and early interventions that are actually more cost effective and accessible due to their effectiveness in small doses. The impact of missed opportunities to provide early behavioral health promotion and prevention on child health and family well-being arguably contributes to poorer health outcomes, worsening health disparities and avoidable costs to our health care system. Simply put, the culture of FQHC behavioral health practice that is created by the same day exclusion extracts a higher price from children, and even higher for young children.

For the reasons described above, our clinic offers same-day dyadic services during routine well baby visits using an evidence-based model that prioritizes team-based care and same-day visits. We are thrilled by the steps that California has taken to create a Medi-Cal benefit that in theory could pay for the full range of dyadic services in pediatric primary care. However, the reality is that with the same-day exclusion policy prohibiting additional payment for dyadic services delivered during well child visits, we will be unable to fully implement the benefit or to realize its intended impact on child and family health. Because we understand the well child visit as the critical intervention context for families with young children, we will continue to provide same day dyadic interventions and will aim to draw revenue critical to sustaining our program from the limited follow up visits we provide. However, this puts the sustainability of our program and the best practices for operating it at risk, including raising the potential to fall into the 'referral-lost-to-follow-up' cycle that is more detrimental for children with time-sensitive behavioral health prevention needs.

The Same-Day Exclusion Policy: A Barrier to Change

Contradicts Current Reforms

Until recently, children on Medi-Cal had to wait for a psychiatric diagnosis before being referred to mental health care. In 2020, California committed to eliminating Diagnostic and Statistical Manual of Mental Disorders (DSM-V) diagnosis as the sole authorizing condition for Medi-Cal funded mental health care. Young people under the age of 21 are now eligible for benefits and services in response to a mental health diagnosis, and now for behavioral health promotion and prevention along with services for risk factors, such as, a range of traumatic and adverse life experiences including parental separation or loss, maltreatment, experiencing foster care, food insecurity or housing instability, bullying, or experiencing discrimination.

For younger children in particular, these risk factors are commonly identified through well-child and other medical visits. Same-day exclusion at best complicates and at worst directly undermines the equitable implementation of specific new benefits and commitments made by the State through CalAIM and CYBHI. This includes the new Dyadic Benefit, the 1915b waiver that allows systems-involved youth and those without a diagnosis presumptive eligibility for Specialty Mental Health Services (SMHS), and the new Enhanced Care Management (ECM) benefit. Same-day exclusion also counters recent efforts by California's Medi-Cal health care delivery system to provide Whole Person Care (WPC) and parallel efforts by Health Resources and Services Administration (HRSA) to integrate behavioral health services into FQHC medical homes.

Limits Service Integration and Innovation

There are promising models in California, and nationally, demonstrating the effectiveness of coupling primary care and behavioral health care visits to prevent and avert mental illness and substance abuse in children and adolescents. There is clear evidence that the most effective approach to pediatric and adolescent mental health treatment is early intervention, caregiver education, and preventive strategies.[29,30] The same-day exclusion puts barriers in the way of effective practices like "warm hand-offs," preventive interventions during well-child check-ups, and the integration of the Dyadic Services benefit in primary care visits.

The recent integration of dyadic approaches to pediatric health care into California's Medi-Cal program offers an evidence-based approach to proactively support the caregivers who bring children to their medical appointments, offering a family-centered model of behavioral health that effectively targets the environmental health of the child. Despite these realities and efforts to integrate care, the delivery of behavioral health services in California remains largely isolated from primary care.

California should embrace the full guidance contained in the recent CMS letter which, in addition to eliminating the same-day exclusion, recommends "removing requirements for a behavioral health diagnosis for the provision of EPSDT services…[and] increasing integration of behavioral health and primary care…"

Conclusion: Fulfilling the Promise

California has demonstrated leadership by responding to other system failures with promising policy shifts and an explicit commitment to addressing health and access disparities for children on Medi-Cal. However, California's same-day exclusion policy effectively prohibits best practices and access to new and existing service streams, and in many ways appears to run counter to DCHS's recent proposal to reform the Medi-Cal system through CalAIM's "whole person" care model.

The same-day exclusion policy harms families, hampers providers, and counters the best practices of a well-documented evidence base showing that same-day appointments, warm hand-offs, and coupling early behavioral health interventions in well-child visits with integrated models of behavioral care improves access and health outcomes, especially for low-income and patients of color. The solution is within reach. The new CMS guidance offers California the opportunity to scale and sustain innovative Medicaid practices to champion equity and redefine wellness. California can follow the new CMS guidance and join other states like Nevada in advocating for health equity by taking advantage of federal policies that allow for same-day billing.

Endnotes

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California Children's Trust

The California Children's Trust (CCT) is a statewide initiative to reimagine our state's approach to children's social, emotional, and developmental health. We work to transform the administration, delivery, and financing of child-serving systems to ensure that they are equity driven and accountable for improved outcomes. The Trust regularly presents its Framework for Solutions and policy recommendations in statewide and national forums. For more information, visit www.cachildrenstrust.org.