June 7, 2023

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Assistant Deputy Director, Behavioral Health
California Department of Health Care Services

Re: BH Doc Redesign – Targeted Stakeholder Workgroup Comments

Sent via email to: BHCalAIM@dhcs.ca.gov

Dear DHCS,

The California Alliance of Child and Family Services (The Alliance) is pleased to offer feedback on concepts being contemplated by DHCS on Behavioral Health Documentation Redesign. The Alliance represents 160 non-profit nationally-accredited community-based organizations serving children, youth, and families in public human services systems.

Draft Documentation Streamlining Feedback.

I. We Strongly Support Several of DHCS's Proposals to Streamline Treatment Planning Requirements.

As discussed below, we strongly support several of the proposals listed on Slide 15 of the Behavioral Health Documentation Redesign: Targeted Stakeholder Workgroup (May 26, 2023).

A. The format or location [of the treatment plan elements] in the clinical record (e.g. use of a treatment plan template vs. progress notes) would be left to provider discretion.

We strongly support this proposal. This approach is critical in order to: 1) avoid the need to document duplicative treatment planning elements in multiple locations and 2) facilitate the use of integrated treatment planning for all the services a client receives.

B. BHIN attachment would list treatment planning requirements that remain in effect.

We support this proposal and encourage DHCS to describe in detail in the BHIN any documentation requirements that are unique to a particular service – rather than simply referring to guidance documents such as the ICC, IHBS, and TFC Medi-Cal Manual. This will help to prevent counties from imposing their own county-specific requirements for certain services. If, for example, TBS treatment planning still requires a "plan clearly identifying specific targeted behaviors" (IN 08-38, p. 6), this language should be quoted in the BHIN so that counties understand that no additional requirements (other than those listed in the BHIN) can be required.

To the maximum extent possible, for all services that still require a care/treatment plan, these treatment planning requirements should be standardized for all services, to facilitate the use of a single integrated treatment plan template (or standardized list of treatment planning elements that must be

documented somewhere in the client record). If DHCS finds that a particular service requires additional treatment planning elements, those should be described with specificity in the BHIN, so that they could be added to the standardized list of treatment plan requirements whenever that service is provided.

We believe that the treatment planning requirements for most services would be included in the federal care plan documentation requirements for case management, as required by 42 CFR § 440.169(d)(2) and listed in the BHIN 22-019, page 8: 1) the beneficiary's goals; 2) the active participation of the beneficiary/family in developing those goals; 3) the services to be provided to address the client's goals and needs; and 4) (when the client has achieved their goals) a transition plan. For example, we see no additional treatment planning requirements for In-Home Behavioral Services (IHBS) in the ICC, IHBS, and TFC Medi-Cal Manual. 2

C. Counties would not be permitted to impose different, county-specific treatment planning requirements.

This proposal is vital to the success of documentation streamlining efforts. For this requirement to succeed, however, the BHIN needs to state this requirement very clearly. We therefore recommend that, on page 2, under "Overarching Policy," the BHIN add the following text in bold: "deviations from the standards, **including any additional documentation or "format" requirements**, will require corrective action plans.

This additional clarity is needed because, currently, counties are continuing to impose many county-specific documentation requirements and standards that are unrelated to the quality of care provided. For example, one county requires providers to conduct an additional CANS that aligns with the youth's initial county enrollment date – even when this rule forces a clinician to complete a second – unnecessary – CANS within the first few months of a client's treatment.

Another important example is the decision regarding whether to administer the PEARLS, which we recommend be left to the discretion of the provider. One county currently requires providers to conduct a PEARLS for every youth client. Yet, in many cases, the information gathered in the PEARLS already has been gathered in the CANS trauma module. Moreover, because the information covered in the PEARLS can be very difficult to discuss, the need to answer the same questions multiple times can be needlessly distressing for the family and can also undermine efforts to develop a rapport with the youth and family.

Additional examples include counties that continue to: 1) require a care plan embedded in progress notes for every type of service; 2) require client and family signatures on care plans; 3) require that TCM Care plans be embedded in every progress note (rather than every 60 days or whenever an upate is needed; and 4) set county-specific deadlines (e.g. that progress notes must be approved by a note reviewer within one day of submission). Counties also differ in terms of the type of progress note (e.g. plan development vs. TCM) that must contain the care plan.

D. Progress notes need not include treatment planning information that is captured elsewhere.

We strongly support this proposal. We also encourage DHCS to clarify as well that MHPs should not impose their own standards for the format in which the required information is documented. One county, for example, recommends a particular "ACT" format for progress notes (Activity/Action; Consumer Progress/Perspective; The Next Steps). While most if not all of this information would already be included in the progress note requirements listed in the current BHIN, the county's "recommended format" for progress notes could lead to unwarranted audit issues (e.g.: if the county reviewer decides that the consumer's "perspective" was not adequately described.)

II. Add CFT/Wrap Action Plans to the List of Services with Treatment Planning Requirements that Need to be Integrated.

We ask DHCS to add CFT/Wrap Action plans to the list of services on slide 13 with treatment planning requirements that should be integrated and standardized whenever possible. Three counties have allowed providers to use a client's CFT/Wrap Action plan as the foundation for documenting SMHS treatment plan elements. In addition, in three audits of Full-Service Partnership (FSP) programs, the MHSA has allowed providers to use the CFT/Wrap Action Plan as the FSP care plan, as long as it also includes the elements required of an FSP care plan. This approach significantly streamlines treatment plan documentation, and we urge DHCS to encourage all MHPs to allow this approach.

III. Provide Further Clarification Regarding Fraud, Waste and Abuse, and the Types of Issues that Will **Not** Raise Audit Concerns.

We ask that DHCS provide further guidance to counties regarding which issues constitute potential fraud, waste and abuse. MHPs have continued to raise audit issues that are unrelated to quality of care or fraud, waste, and abuse. Below are just a few examples.

- One county reviewer flagged a progress note because it indicated a service was delivered "in the home" when in fact the provider took the client to the park during a portion of the session.
- One MHP stated that it might reject a claim if there are "inconsistencies" in the problem list. Currently, however, because providers are not always updated when a provider from another organization updates a client's problem list, "inconsistencies" are sometimes unavoidable.

IV. Additional Streamlining Measures

In addition to the DHCS proposals discussed above, we would strongly recommend the additional streamlining measures below.

A. Eliminate the requirement to administer the PSC – 35

This form is duplicative of the CANS (in addition to the CSE-IT and the ASQ). It also undermines the establishment of relationships with new clients because providers must ask additional questions that are both repetitive and highly sensitive.

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B. Eliminate Need for Prior Authorization for IHBS and TBS

We urge DHCS to eliminate the requirement to pre-authorize IHBS and TBS services. These services are for youth who are in, or at risk of placement in, hospital or residential settings, but who could be effectively served in a home or community setting. By definition, therefore, the need for these services is urgent. Yet prior authorization requirements often delay access to these services by many days or even weeks. From a mental health parity perspective, these services are just as urgent as many physical health conditions that receive urgent care with no prior authorization.

The need to avoid the delays caused by a prior authorization requirement has been recognized since the inception of the TBS program. When DHCS began implementing the TBS litigation settlement in 2009, it removed from its county contracts the requirement for prior authorization of TBS, in order to reduce administrative requirements that limited access to care. (IN 08-38, p. 7.) This was done as part of implementing the Emily Q settlement. (See page 6 of Second Quarterly Report of Special Master.)

We look forward to continuing to work with DHCS on documentation streamlining and the creation of more consistent standards across the 58 counties.

Sincerely,

Adrienne Shilton

Adrienne Shilton, Director of Public Policy and Strategy
California Alliance of Child and Family Services