CARE PLAN AND CARE PLANNING REQUIREMENTS

BHS UCRM

Completed By:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor**
4. Physician (MD or DO)
5. Licensed Psychiatric Technician
6. Registered Nurse
7. Master Level Student Intern*
8. MHRS*
9. Peer Support Specialist*

** Master Level Student Intern, Licensed Vocational Nurse, and MHRS, and Peer Support Specialists can complete care plans but must be co-signed by one of the above. Co-signatures must be completed within timelines.*

Compliance Requirements:

1. DHCS no longer requires prospectively completed, standalone client plans for Medi-Cal Specialty Mental Health Services. The intent of this change is to affirm that care planning is an ongoing interactive component of service delivery rather than a one-time event*.

2. Required care plan elements may be notated within the assessment record, problem list, or progress notes, or the provider may use a dedicated care plan template within the Electronic Health Record.

3. The provider shall be able to produce and communicate content of the care plan to other providers the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws if requested.

4. Federal or state laws continue to require the following service lines to have care plans and/or specific care planning activities in place. All required elements of the Care Plan must be addressed as indicated in Enclosure 1a of BHIN 23-068 *(which may be more specific than requirements of the BHIN and this Explanation Guide)*:

   a. TCM – Federal requirement for development and periodic revision of specific care plan based on information collected through assessment that includes specific goals and action to address medical, social, educational, and other services needed by the client; includes active participation of the client and other identified supports, and action steps of provider to respond to client needs. (42 CFR § 440.169 (d)(2))

   b. ICC – ICC services are considered TCM and may be documented in the manner noted in BHIN 23-068 (Items 1-3). Ongoing ICC care planning should occur during CFT meetings and be documented within the CFT progress notes. CFT meetings are required within 60 days of assignment/ICC eligibility with updates to care plan as clinically appropriate, or at minimum every 6 months.
      - IHBS, TFC – DHCS will no longer enforce the use of a care plan, or specific care planning requirements, as part of monitoring compliance specific to IHBS or TFC, however children receiving these services are likely to have a care plan developed as part of ICC, which continues to require a care plan per Federal regulations.

      - IHBS and TFC services, if provided, should be addressed as part of ICC care planning

during CFT meetings. Documentation of IHBS and TFC care planning within CFT progress notes required for prior authorization.

c. Peer Support Services – State requirement for care plan at start of Peer Support Services; updated as clinically appropriate.

d. TBS – client plan must be completed prior to initial coaching session and updated every 30 days.
   - TBS care plan is required to address the following elements: targeted behaviors identified in the TBS assessment process, specific observable quantifiable goals tied to the targeted behaviors, objectives, interventions for each targeted behavior, transition plan.
   - TBS plan updates should document any significant changes in youth or youth's environment, effectiveness of interventions and revisions to planned interventions, if applicable.

e. STRTPs – initial care plan completed within 10 days of admission date and reviewed every 30 days – documentation in client record must indicate care plan has been reviewed with client and indicate if changes to plan or reviewed without revision.
   - STRTP care plans shall include anticipated length of stay, specific behavioral goals for client and specific mental health interventions and services to assist client to accomplish goals and include transition goal(s) to support rapid and successful transition back to community based mental health care.
   - Care plan must be signed by Licensed/waivered/registered professional or Head of Service.

f. Crisis Houses – care plan completed within 24 hours of admission and updated at least every 7 days at minimum.
   - Care plan shall include at minimum the following elements: statement of specific treatment needs and goals, description of services to address identified needs, anticipated length of stay and method to evaluate achievement of goals. (9 CCR § 532.2)

g. Full Service Partnership (FSP) Individual Services and Supports Plan (ISSP) - 9 CCR § 3620 requires an ISSP be developed for each client by the assigned Personal Service Coordinator/Case Manager. The ISSP should be developed with the client/family in collaboration with other agencies that have shared responsibility for service and/or supports to the client and client's family.

h. Requirements for Medicare and/or Medi-Medi clients remain unchanged; CalAIM initiatives (BHIN 23-068) do not supersede CMS client plan requirements for Medicare beneficiaries receiving Outpatient SMH services.
   - Individualized Treatment Plan: Services must be prescribed by a physician and provided under an individualized written plan of treatment by a physician after any needed consultation with appropriate staff members.
   - The plan must state the type, amount, frequency, and duration of services to be furnished for covered services provided by MD, NP, PA, LCSW/LMFT/LPCC, the diagnosis and anticipated goals. (Only Medicare approved provider types such as MD/DO/LCSW/LMFT/LPCC/PA/NP can create a treatment plan. If the treatment plan is created by an LCSW/LMFT/LPCC/PA/NP, the treatment plan must be reviewed and co-signed by the MD/DO as regulations require that Medicare reimbursable services are prescribed by a physician) (A plan is not required if only a few brief services will be furnished.) (*CMS Publication 100-2, Medicare Benefit Policy Manual, Chapter 6,*

Section 70.1)

- It is recommended that programs utilize the Individualized Service Plan document in SmartCare.

*Prior Authorization timelines remain unchanged regardless of changes to client plan requirements.

5. CalMHSA Knowledge Base website Treatment Plans and Care Planning - 2023 CalMHSA provides information regarding the required care planning regulations for the different programs/service delivery lines and includes guidance on how/where to document care planning in the client's EHR.

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