

July 22, 2024

## Position Statement on Documentation Requirements for Comprehensive Treatment Plans

We join the American Association for Community Psychiatry (AAPC) and American College of Physicians (ACP) in calling for a review and revision of the treatment plan documentation requirements across the nation, engaging consumers, providers and regulatory agencies in all states — as well as national reimbursement and regulatory agencies — to promote better access to care, improved patient care experience, better quality care and compliance with mental health parity requirements.

### Reasons to Change Requirements for Treatment Planning

Regulators and payers for behavioral health treatment services, particularly for serious mental illness and substance use disorders in Medicaid, commonly require treatment plans that are substantially more detailed and lengthier than those used in other areas of health care delivery as a precondition of receiving treatment services. Historically, the requirements for overly detailed and complicated treatment planning documentation for people receiving behavioral health care have been driven by the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) for psychiatric hospitals and community mental health centers. Written over 50 years ago, these requirements remain substantially unchanged and were designed for the needs of people who had previously spent years residing in state hospitals. Substantially similar requirements were adopted by state regulators to assure meeting federal requirements.

In its recent position statement, the AAPC pointed out that treatment plans as a documentation requirement are distinct from the process of treatment planning. The AAPC is concerned that treatment plan documentation in its current state creates unnecessary administrative burden for physicians, with no evidence of benefit for the patients. It reduces direct patient contact time, thereby negatively impacting quality of care. The AAPC's position echoes the statements made by the ACP in its position paper, titled [Putting Patients First by Reducing Administrative Tasks in Health Care](#).

## Flaws and Negative Impacts of Current Treatment Plan Documentation Requirements

- 1) **Parity violation for access and payment** — Requiring comprehensive treatment plans that are substantially more detailed and lengthier than those used in other areas of health care delivery as a precondition of receiving treatment services is not consistent with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Affordable Care Act. Primary care and other specialty care areas routinely initiate care and receive payment following a brief problem-focused assessment — with a focus treatment plan incorporated as part of that assessment — usually completed by a single provider in the first treatment session.

Another parity violation under the category of nonquantitative treatment limitations occurs when payers frequently include documentation in a treatment plan as a utilization management requirement for payment. This is not a utilization management requirement in other areas of medicine.

The length and complexity of mandated comprehensive treatment plan documentation is inherently more restrictive and constitutes a nonquantitative treatment limitation compared to the briefer assessment and planning required to access and receive payment for medical-surgical health care services.

- 2) **Lack of evidence** — Requirements for comprehensive treatment plans are not evidence based. There is a general lack of studies showing that people who receive a comprehensive treatment plan have better outcomes than those who do not. There are several small-scale studies showing no difference.
- 3) **Negative impact on access and workforce** — Overly detailed and complex comprehensive treatment plan documentation requirements are not an efficient, effective use of a limited behavioral health workforce. Comprehensive treatment planning is usually done at a later appointment following the assessment and can often require multiple care providers. Using a briefer problem-focused treatment plan, as is common in the rest of health care delivery, would allow more people to receive treatment by the same size behavioral health care workforce.
- 4) **Communication failure** — Overly detailed and complex comprehensive treatment plan documentation usually results in a document that is so lengthy that most people involved in the individual's ongoing care delivery do not have the time to read and refer to them during subsequent treatment visits. After their initial creation, they are usually only read subsequently at the time that they are mandated to be updated. A major reason for the poor quality of treatment plans is that they are usually drafted by case managers who are the team members with the least training and who tend to have the highest turnover. The physician signing off on the treatment plans often report that they do not have time to read them, nor is there an effective process for

revision, prior to signing. The resulting document is seldom read and has little value for health care providers outside of behavioral health because it is too long, too complicated, and emphasizes nuanced considerations that are not appreciated or valued in general health care. Overall, the current overly comprehensive treatment plans are a barrier to integration and contribute to behavioral health being siloed from the rest of health care delivery.

- 5) **Negative engagement effect** — Overly detailed and complex comprehensive treatment plan documentation is not person centered. People request care and treatment for specific focal symptoms or impairments; they are not requesting a comprehensive plan for everything that might be wrong and anything that might impact that condition. Requiring a comprehensive treatment plan prior to the person receiving treatment for their chief complaint results in them spending a great deal of time talking about issues that have no obvious direct relationship to their current distress. Many people receiving behavioral health care find the experience irritating and frustrating.
- 6) **Delayed treatment** — The time it takes to complete the current overly detailed and complex comprehensive treatment plan documentation often substantially delays the treatment or services to relieve the person's distress. Conferences for treatment planning usually occur at a subsequent appointment than the assessment and can often involve multiple care providers.

## Position Statement

CMS CoPs and state regulations for behavioral health treatment related to treatment planning should not be substantially different from or more extensive than requirements for treatment planning for medical-surgical conditions

The current CMS CoP for comprehensive treatment planning in psychiatric hospitals and community mental health centers and similar state regulations are:

- A nonquantitative treatment limitation violation of parity as described in The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Affordable Care Act for people who are required to receive more extensive comprehensive assessments and treatment plans for medical-surgical conditions.
- Not evidence-based since there is no substantial research showing that people receiving comprehensive assessment and treatment planning have better outcomes than people receiving assessment and treatment planning consistent with the general standard of medical care.
- Not a necessary or efficient use of limited behavioral health workforce resources.
- Creating delays and barriers for people receiving care.
- Unnecessarily intrusive for the person receiving care.



## Change Is Needed

The Medical Director Institute of the National Council for Mental Wellbeing:

1. Formally endorses the position statements of the AACAP and the ACP here (in the same way the AACAP formally endorsed the ACP in its position statement).
2. Joins the AACAP in calling for “elimination of the requirement that provision of a psychiatric visit in a behavioral health clinic necessitates documentation of a formal ‘treatment plan.’”
3. Joins the AACAP’s call for elimination of using treatment plans as the primary basis for payment.
4. Calls for CMS and the Department of Labor to treat requirements for comprehensive treatment plans that are substantially more detailed and complex than those in other areas of health care delivery, and that are used as a precondition of receiving treatment services or payment, as nonquantitative treatment limitations that violate federal mental health parity statutes and regulations.
5. Joins the AACAP in calling for a national collaborative effort to formally revise the documentation requirements in behavioral health care service delivery. The field needs guidance on how to create a treatment plan that is:
  - Patient centered as experienced by the patient.
  - Easily understood by the patient and the behavioral and other health care providers.
  - Efficient, so that writing or referring to the plan does not take the provider’s time away from actual treatment.
  - Not a violation of parity due to mandated complex content or a process that is substantially more complicated than in other areas of health care, and is not used in a restrictive utilization management process.
  - Adaptable to setting-specific clinical needs.
  - Advancing interdisciplinary clinical care and treatment beyond a compliance-focused documentation checklist.

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