Behavioral Health Clinical Chart Audit Findings and Summary Report Requirements

The Contractor shall produce a separate, annual report for each line of business (ACC, ACC-RBHA, ALTCS-DD, ALTCS-EPD, DCS/CHP), which summarizes the trends identified for completion of the Behavioral Health Clinical Chart Audit.

The following information shall be incorporated into the Contractor's annual deliverable:

- The Contractor shall **structure the written deliverable report according to the section requirements and content identified below.**
- When uploading the report into the compliance deliverable system, **include the name of the health plan AND the LOB in the report file name. The required naming convention is as follows: "BHCCA_FFY##_Health Plan_Submission Date" (e.g., BHCCA_FFY##_HealthPlan_10-01-##").**

This template outlines minimum reporting requirements that shall be followed in the order that is provided within the sections below. **Deviation from the template may interfere with AHCCCS' ability to fully assess reported information and may lead to rejection of the BHCCA report.**

As Identified under Contract Section F, Attachment F3, Contractor Chart of Deliverables,
Effective October 1, 2024

Portal Data
A description of the Behavioral Health Audit Report Findings and Trends shall include at minimum: 1) Copies of the reports are available within the AHCCCS BH Audit Portal. If more than one Line of Business, each Line of Business report is to be submitted. a) **Health Plan/Provider Report: Summary** of total count and percentages of responses for YES, NO, or NA. b) **Line of Business Report:** Summary of total count and percentages of responses for YES, NO, or NA.

Description Of the Contractor's Narrative Description Of Audit Process
2) Brief narrative description of the audit process: a) Health Plan Information, (Name, Region/GSA) b) Summary of Lines of Business within the report, or specific verbiage to identify that the report is only for one line of business, i) NOTE: Contract requires that separate reports shall be submitted for each line of business and they should be uploaded to separate Compliance SharePoint sites. c) Time period of audit from beginning to end, d) Number of audits conducted by GSA (region) and individual lines of business for the identified GSA (region), e) Methodology utilized by health plans and AzAHP to develop provider distribution, i) Include provider distribution by health plan and line of business; distribution should be broken out by LOB & GSA (region) if applicable (e.g., how many charts per provider for each LOB and corresponding GSA); differences by line of business and corresponding GSA should be identified.

ii) Include any changes made to provider distribution (e.g., exchange of providers from one health plan to another), and

iii) Include identification of any providers excluded due to having the National Committee for Quality Assurance (NCQA) Accreditation as a Patient Centered Medical Home (PCMH) with Behavioral Health Distinction as evidence that the provider has met the standards of the audit.

f) Number of member records for each provider included in the audit,

g) Sampling technique, including process followed to obtain statistical significance with provided membership numbers of all members served through behavioral health and per assigned provider site, and:

i) For any providers that are audited for more than one line of business, the auditing health plan shall include line-of-business specific information related to:

(1) A stratified random sampling methodology, representative of the provider's member population. Other than the ACC-RBHA, health plans must ensure that both adults **and** children are representative of children being served by the providers being audited and the health plan conducting the audit.

(2) How providers are selected based upon the representative sample size required per LOB,

(3) Results shall **not** be aggregated even when a provider is being audited for multiple lines of business under a single Contractor,

(4) If sample size does not meet statistical significance, please explain barriers to meeting statistical significance. If 30 charts were not included, what were the barriers to having 30 charts (i.e., limited number of members for a particular line of business or population. Specific membership number shall be included).

(5) If fewer than 30 charts, what measures were taken to increase to 30 charts (e.g., outreach to the provider for increased number of charts, expansion to other locations for that particular provider).

h) Identify Inter-Rater Reliability process.

i) Within health plan, and

ii) Across health plans.

Description of Members Included in the Audit (Population & LOB Descriptions)

3) Description of members included in the audit:

a) Total number of members included,

b) Total number of members identified under each GSA and Line of Business as applicable (ACC; ACC-RBHA; ALTCS-DD; ALTCS-EPD; DCS/CHP),

c) Total number of adults vs. children for ACC, ALTCS-DD, and ALTCS-EPD,

d) Total number of members on COT (if part of sample).

Summary of Findings and Trends

4) Summary of Findings, Trends, and potential explanations for variance by:

a) Overall scores by line of business,*

b) Overall scores by audit section for each provider,*

c) Identification of elements that do not meet threshold of 85% (for each provider and according to line of business),*

d) Comparison of overall scores for adults vs. children,

e) Comparison of scores within and/or across GSAs (if contracted in more than one GSA,

f) Comparison of scores for SMI vs GMHSU (if ACC-RHBA, ALTCS-E/PD; ALTCS/DDD), and

g) Summary of strengths and/or deficiencies for the providers.

*Included in the preset reports, but trend comparisons should be summarized (e.g., if more than one line of business);

Graphs are encouraged, in addition to the written description of findings and trends.

Exit Interview Process

5) Exit Interview Process and Guidance

a) Briefly describe technical assistance offered to the provider and verify that other contracted health plans were informed of aggregate results,

b) Include general information regarding QOCs identified as a result of the audit (excluding member sensitive data),

c) CAPS or Performance Improvements; number of CAPS or Performance Improvements requested and due date for completion. Provide feedback and activities related to monitoring the need for corrective action of providers, based on deficient findings as a result of the audit.

Audit Process Strengths and Opportunities for Improvement

6) Audit Process Strengths and Opportunities for Improvement

Provider Suspensions or Terminations: Actions Taken

7) Process to Identify Actions Taken for Provider Suspensions or Terminations. Link to provider AHCCCS suspension or termination list: https://www.azahcccs.gov/Fraud/Providers/actions.html. Terminated providers will be excluded from the audit if all criteria below are met:

a) Identify any provider that was initially identified for BHCCA auditing purposes, but suspended or terminated from the audit during the provider notification process and AHCCCS suspension or termination list reviewed prior to scheduled audit, and

b) If a provider was suspended at the time of the scheduled audit date but reinstated, identify the provider and include suspension and reinstatement dates. If reinstatement did not occur prior to August 15th of the audit cycle and it was not possible to complete the BHCCA due to lack of time, indicate and confirm that this provider will be included within the next audit cycle. Identify how suspension or termination may have affected BHCCA outcomes (e.g. decreased sample size, reduction in representation of any particular line of business, population or subpopulation, region/GSA, etc.).