ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Behavioral Health Clinical Chart Audit (BHCCA)

Findings & Summary Report

Effective 10/1/25 (CYE 26)

October 1, 2025

BHCCA Findings and Summary Report CYE25

Introduction: BHCCA Findings & Summary Report

Contractors are required to submit a single, consolidated "Behavioral Health Clinical Chart Audit (BHCCA) Findings and Summary Report" that encompasses all awarded Lines of Business (LOBs), which may include ACC, ACC-RBHA, ALTCS-DD, ALTCS-EPD, DCS/CHP, H2O). This report shall be a unified document and not divided by each LOB, unless identified otherwise with subsections of this reporting template. It must present clearly defined data, findings, and analyses for all LOBs to ensure transparency, accountability, and compliance with all relevant audit and reporting requirements. 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, contract year (CYE) and submission date in the report file name. **The required naming convention is as follows: "BHCCA_FFY##_Health Plan Submission Date" (e.g.,BHCCA_CYE26_ABCHealthPlan_10-01-26").**

Health plans must include pagination if a separate document is submitted outside of this reporting template. This allows for accurate commentary and feedback from AHCCCS to the reporting health plan.

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.

> **Important Update: The AHCCCS Behavioral Health Audit Portal will not be used for audit submissions unless notified otherwise. Instead, Contractors must use the AHCCCS-designated Excel template for data submission to report BHCCA data. All raw data related to audit elements must be entered directly into this spreadsheet.**

As Identified under Contract Section F, Attachment F3,
Contractor Chart of Deliverables,
Effective October 1, 2025
CYE 26

PORTAL DATA

A description of the Behavioral Health Audit Report Findings and Trends shall include at minimum:

1) Health Plan Provider Report (Summary of raw data totals from the Excel template provided by AHCCCS):

a) Summary of total count and percentages of responses for YES, NO, or NA (using table below, for multiple lines of business as appropriate).

Health Plan Name:

Count	ACC	ACC/RBHA	DCS CHP	DDD	E/PD	H2O
Yes						
No						
N/A						

b) Number of audits conducted by GSA (region), based on contract.

Health Plan Name:

GSA/Region	ACC	ACC/RBHA	DCS CHP	DDD	E/PD	H2O
Central						
North						
South						

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

Health Plan Name:

Subpopulation	ACC	ACC/RBHA	DCS CHP	DDD	E/PD
Adults					
Children					

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

Health Plan Name:

COT Count	ACC	ACC/RBHA	DDD	E/PD	H2O
Adults					

e) Any members identified as COT.

Contractor's Narrative Description Of Audit Preparation (Sampling & Methodology)

Brief description of the audit process in preparation for conducting the BHCCA:

Description of Provider Sampling Process:

1. Summary of provider identification process prior to collaboration with vendor (e.g., AzAHP) and the collaboration steps utilized to identify final provider distribution,
2. Include the final list of health homes or primary behavioral health providers identified for the health plan,
3. Identify any changes to the final provider list that became necessary to ensure adequate distribution across populations and/or subpopulations according to health plan contract responsibilities,
4. Include details of the process followed to ensure providers are included that will facilitate a statistically significant sample based on members served by any given provider site, including the requirement for 30 charts per provider.
5. Line of Business (proportional distributions, as applicable based on contract),
6. ACC-RBHAs shall identify process to ensure proportional representation of both adults with SMI designation, as well as children and adults that are designated as General Mental Health Substance Use (GMHSU),
7. For all other health plans (not limited to adults), if the audit distribution for any given provider reflects a disproportionate number of adults vs. children, over-sampling or re-evaluating claims and encounters for that provider may be necessary.

Provider Sampling Adjustments: The final list of providers to be audited shall be adjusted as needed to achieve a minimum statistical significance, based on the contractor-provider relationship and the proportional numbers based on the line of business and health plan subpopulations (e.g., SMI vs. GMHSU, adults vs. children, etc.). Health plans are responsible for ensuring that the group of providers selected for audit is sufficiently large and diverse to accurately represent the member population across all applicable service areas and LOBs and subpopulations (e.g., adults, children, SMI, GMHSU, H2O).

Contractor's Narrative Description Of Audit Completion (Sampling & Methodology)

Description of final provider distribution, samples and methodology:

1. Include provider distribution by health plan and line of business; describe final distribution that reflects raw numbers and percents by LOB & GSA (region) if applicable (e.g., how many charts per provider for each LOB and corresponding GSA);
2. Differences by line of business and corresponding GSA should be identified, based on completion of the audit.
3. Number of total member records for each provider included in the audit, as identified within the tables under the "Portal Data" section above.
4. Include table that includes raw data and percentages by line of business and region (e.g., pivot table).

Methodological/Sampling Changes: For any sampling or methodology changes that became necessary once the

audit process began, provide a summary of the changes that were implemented (e.g., provider inclusion or exchanges with other health plans, sampling techniques for populations or subpopulations, or any other methodological changes that became necessary during the actual audit process).

1. Identification by a provider chosen for the audit, that reported ineligibility for audit due to lack of health home status; include name of provider and AHCCCS ID
2. Identification of any providers (name/address/AHCCCS ID) that **were** 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.)
3. If provider status changed in any way other than through Provider Suspensions, state exact reason why provider was not audited,
4. Provider decision to close,
5. Provider closed by health plan,
6. Provider no longer a health home.

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

Summary of Findings and Trends

Summary of Results, Trends, and potential explanations for variance:

This section is intended to summarize key findings of the BHCCA, identify trends across lines of business (LOBs) and regions, highlight gaps in care, and outline opportunities for systemic improvement. The purpose is not only to report scores, but to ensure results are used to improve member outcomes and strengthen the quality of care across the system.

General Guidelines for Delineation of Results:

1. If there are large increases or decreases in performance since the last audit conducted, provide possible explanations for the differences.
2. Identification of individual elements (DO **NOT** INCLUDE SECTION SCORES) that do not meet threshold of 85% (for each provider and according to line of business), and
3. Summary of strengths and/or deficiencies for the providers. If there are differences (e.g., line of business, GSA/region, rural vs. urban, adult vs child) for any given element or section:
   a. Describe those differences and,
   b. Present critical analysis of what potential causes and what would be necessary to improve outcomes. This summary can be based on exit interviews technical assistance discussions with the providers, or other potential contributing factor.

Gaps in Care and Service Delivery:

In addition to provision of data tables that reflect raw numbers and percentages that reflect BHCCA element scores (as identified within page 1 tables), health plans shall identify:

- Elements with performance scores that consistently fall below the 85% threshold; focus on those elements that represent barriers to effective member-centered care,
- One or more elements demonstrating gaps in service delivery that may require targeted action plans for next year
- Proposed resolutions that involve a combination of efforts (e.g., training, technical assistance, PIPs/CAPS, root cause analysis, letter of concern, health plan policy or contract changes, etc.).

These trends are examples of what health plans may identify to compare/contrast results based on one or more of the following:

1. Line of business (if health plan is contracted for more than one line of business)
2. Urban vs. rural
3. GSA/regional differences
4. Child vs adult, for elements that show differential results
5. BHP signature, assessment completion),
6. SMI vs. GMHSU for ACC/RBHA plans, ALTCS E/PD and DDD
7. High needs case management (and for children, whether CALOCUS was completed as required)
8. Differential results for DD members (United/Mercy Care) reflective of adult vs. children or rural vs. urban.

The overall goal for this summary and discussion of results is for health plans to identify how they can utilize audit results to create system improvements and member outcomes.

Exit Interview Process

Exit Interview Process and Guidance/TA Provided:

1. Briefly describe technical assistance . This may include, but is not limited to evidence of training, clinical supervision activities, review of audit results, etc.
   a. *How the plans and their providers will implement processes to address performance issues based on trends identified within the audit)..*
   b. *How the audit results for the provider indicate what training, processes or policy changes are necessary to improve results?*
2. Were any QOCs identified as a result of the audit (excluding member sensitive data). Include provider information, date and the reason(s) for the QOC. This may be based on consistently low audit scores or individual member issues that may be a potential QOC concern. Definition of QOC (Quality of Care Concern)

As stewards of clinical quality, each health plan has an opportunity to utilize the behavioral health audit results to improve outcomes at both the member and system levels. Therefore, it is incumbent upon the health plans to provide thoughtful and critical analysis of the results as part of the audit process, while going beyond the basic acts associated with conducting the audit. An important and

necessary aspect of the process is to collaborate with the providers to proactively engage in improving outcomes and systemic issues. This may involve a range of options including Corrective Action Plans, Performance Improvement Projects, technical assistance or training and education.
Provider Suspensions or Terminations or Changes in Status (e.g., ownership, function, etc.): Actions Taken
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: 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 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.).