ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

BHCCA Redesign CYE26
Frequently Asked Questions

Q1: Is a Corrective Action Plan (CAP) required if a provider scores below 85% on a single element or in their overall score?

A1: The decision to issue a CAP lies with the health plan.

- A low score alone may not automatically trigger a CAP; however, it may indicate the need for further review, provider feedback, or technical assistance.
- CAPs should be designed to address identified issues or concerns, rather than simply penalizing low scores. They should be utilized as a tool that health plans use to support providers in enhancing quality and ensuring compliance with AHCCCS standards.

Q2: Does AHCCCS have a list of identified health homes that can be provided to the health plans?

A2: No. AHCCCS does not maintain a centralized list of health homes as this status is determined by the individual health plans. Health home designations vary according to the structure of each health plan's provider network.

- A provider may be designated as a health home in some health plan networks and the same provider may function as a specialty provider within a different health plan network.
- To assist health plans in identifying eligible health home and primary behavioral health providers, the BHCCA Instruction Guide includes service codes commonly associated with health home functions that should be used to determine if the provider is eligible to be audited.

Q3: Can the health plans use the Microsoft Database to record provider audit results instead of the standardized Excel spreadsheet?

A3: Health plans are required to submit the standardized AHCCCS issued BHCCA Scoring Data Tool to record and submit BHCCA audit results. This ensures that results can be aggregated, compared, and analyzed uniformly across the system. If the health plan uses a database to record internal results, the health plan shall ensure that the database is able to export the data in a format that can duplicate or be transferred into the standard form, forms that are altered in anyway will not be accepted or approved by AHCCCS.

Q4: How should the health plans score assessment elements when nearly all criteria are met, but the guidelines state that all requirements must be met to receive a "Yes" score? Is it possible to give a "Yes" score when most, or almost all requirements are satisfied?

A4: If the guideline states that all requirements must be met to receive a "Yes" score, then every criterion listed must be documented in the chart. If **any** component is missing, the appropriate score is "No." This approach is designed to ensure consistency and fairness across all health plan audits and providers. Allowing partial credit would introduce subjectivity and undermine the reliability of comparing results throughout the system.

- A "No" in this context is not meant to be punitive or that the provider is failing. Instead, it highlights an opportunity for improvement, which can be achieved through training, technical assistance, or feedback aimed at strengthening documentation and practices. The BHCCA is not simply a pass/fail evaluation; it serves as a Quality Improvement Tool that supports providers in meeting standards and, ultimately, enhancing outcomes for members.

Q5: What is the rationale for not allowing N/A responses, unless the response is related to age or subpopulation criterion (e.g., SMI, CALOCUS screening)?

A5: "N/A" responses are limited to age-based or subpopulation-specific elements because the BHCCA evaluates whether providers are actively engaging members and families in meaningful assessments and service planning. Scoring Yes/No promotes clarity by indicating whether the provider has met the standard or if there is room for improvement.

Q6: Why does the BHCCCA require an audit of proportionally representative samples between adults and children?

A6: Representative sampling means that the charts selected for review accurately reflect the composition of members served by a provider across different programs, populations, or lines of business. For instance, when 30 charts are chosen, if 60% of a provider's members are children, then 18 charts will be selected from that group and 12 from the adult population.

This approach ensures that the audit results fairly represent the provider's overall performance for all members served. It also maintains statistical validity, reduces bias, and allows AHCCCS to evaluate performance and identify system-level trends across all providers consistently.

Q7: How can health plans explain to the providers the significance and rationale for the changes in the audit structure?

A7: The BHCCA has undergone a strategic redesign to transition to a more person-centered, outcome-focused audit that aligns with Arizona's evolving vision for behavioral health care.

Q8: What does AHCCCS recommend when providers report that other health plans do/did not score the audit elements in the same way?

A8: AHCCCS recognizes that consistent interpretation and scoring of the BHCCA elements are essential for fair and effective oversight. To ensure this, AHCCCS recommends the following:

- Utilize the BHCCA Scoring Instruction Guide, which has been redesigned to promote uniform scoring.
- Encourage auditors to focus on alignment with the "Golden Thread" (Assessment-Service Plan-Progress-Outcomes). Some audit elements may require professional judgement based on documentation context.
- AHCCCS strongly encourages all health plans meet together to improve interrater reliability, including follow up discussions when providers bring differences regarding potential misalignment. AHCCCS is willing to participate in any health plan meetings to review changes to the audit tool and discuss scoring.

Q9: What kind of documentation would be sufficient if the member turned 17.5 during the review period, but there has not been any additional contact with the member.

A9: Turning 17.5 should not be the single focus. The transition process involves multiple activities to assist the youth in becoming an adult, not just completion of an SMI evaluation. At minimum, examples of documentation may demonstrate a larger focus of transition may include:

- Request and/or submission of an SMI evaluation only if applicable/appropriate for the member,
- Transition planning activities (e.g., employment, education, independent living, level considerations),
- Discussion or evidence of attempted referrals to or connection with an adult provider.

Q10:	**Will AHCCCS share the BHCCA Data spreadsheet with the health plans for their review prior to initiation of the audit process on October 1, 2025?**
A10:	AHCCCS plans to share the finalized BHCCA Scoring Data Tool with all health plans shortly after the audit launch of October 1.
Q11:	**Can AHCCCS provide more clarity on the requirements for the Mental Status Exam MSE)? If one element is missing, should it be scored as a "no"?**
A11:	AHCCCS does not require a standardized MSE checklist. The structure and format of the MSE is left to the discretion of the provider. To score Yes, the MSE must be fully completed in the provider's chosen format. If one or more elements of the provider's MSE are missing or incomplete, the score should be No.
Q12:	**Will AHCCCS distribute a formal memo to the health plans explaining the new audit process and the updated direction? If AHCCCS does not distribute the memo, will AHCCCS allow the health plans to distribute a memo?**
A12:	AHCCCS does not plan to distribute a formal memo to health plans regarding the redesigned BHCCA audit process. Health plans are encouraged to inform their provider networks about the redesign and audit process. AHCCCS will provide official tools and instructions and it will be the responsibility of the health plans to communicate with providers. This communication should include direct meetings and notifications to ensure that providers understand the new audit expectations.
Q13:	**Is it acceptable for multiple health plans to review the same member when the member receives services from different providers over the course of the one-year review period prior to the audit?**
A13:	**Yes.** Since the portal is currently suspended, AHCCCS will conduct a data check to prevent duplicate member reviews once all health plans have submitted their scoring data.
Q14:	**If the Assessment is not current, should the Service Plan elements and section be reviewed and scored?**
A14:	**Yes.** If the Service Plan is current, health plans should review and score the service plan elements even if the assessment is not current or has not been completed.

Q15: What is the definition of Voice and Choice?

A15: Voice and Choice refers to the involvement of members (and their families, when appropriate) as active participants in their own care. This means incorporating their perspectives, strengths, and goals into treatment planning and service delivery. Members are provided with genuine options for services and supports, and their preferences are respected whenever clinically appropriate. The service plan should consider the individual as a whole, rather than solely focusing on their clinical diagnosis. OIFA One-Pager Voice & Choice

Q16: What information within the BHCCA Instructions are the most important to read for understanding how to identify chart content related to the audit requirements.

A16: Auditors may be tempted to review only the Requirements/Guidelines pertaining to the individual elements in order to identify how to complete scoring of the element. However, all content within the instructions provides written technical assistance and context to guide auditors through the entire audit process (i.e. Introduction, Rationale, Golden Thread, Section Summaries, etc.). Auditors should review and be comfortable with all the information in the BHCCA Instructions and Audit Tool.

Q17: What changes has AHCCCS made to the BHCCA Instructions that will be effective October 1, 2025, for CYE26?

A17: AHCCCS has collaborated with the health plans, as well as national subject matter experts to make significant improvements to the BHCCA Instructions including, but not limited to:

- Addition of the Golden Thread concept and rationale for focusing the audit on member outcomes and person-centered planning,
- Elements of the BHCCA have been streamlined to reduce provider burden,
- Visual cues have been added to distinguish each section or subsection,
- Multiple hyperlinks for reference within the policy tables beginning on page 5. Hyperlinks have also been added throughout the document
- Specific policy references have been added after every individual audit element header ("Requirements/Guidelines"),
- Clarifying Guidance and check boxes have been added to offer visual cues and a more concise method of identifying requirements for each element,
- Streamlined reporting and suspension of the portal.

Q18: Can the providers utilize multiple assessment documents, and do they all need to be signed off by a BHP?

A18: **YES**. Providers are permitted to use multiple assessment documents. When combined, these documents create a comprehensive and clinically necessary overview of the member's needs, strengths, life history, preferences, and risk factors. Any assessment documents that inform the clinical necessity for treatment and serve as the foundation for developing the member's service plan must be reviewed and signed off by a BHP. The BHP's signature indicates that a qualified professional, with the appropriate training and credentials, has reviewed the assessment and determined its medical necessity.

AHCCCS specifies the requirements for assessment components in AMPM 320-O, which references Arizona State requirements outlined in the Arizona Administrative Code. Additionally, A.A.C. R9-10-1011 mandates that behavioral health services provided by an outpatient treatment center must be under the direction of a BHP who meets the criteria outlined in R9-10-115. This code also details the requirements for conducting a behavioral health assessment.

Q19:	Can AHCCCS provide trends we are seeing across the system?

A19: AHCCCS is working on the development of a statewide summary report as part of the redesigned BHCCA for CYE26. This type of report would compile provider scores, highlight systemic trends, and identify areas for improvement across all providers. AHCCCS anticipates that the first report would be available in early 2027, following the conclusion of the CE26 audit cycle and the completion of data analysis.

Q20:	Can we get relief this year from doing separate Summary LOB reports?

A20: No, AHCCCS will not make that change for the BHCCA reports due October 1, 2025.

Q21:	Do all assessments need to be completed prior to the Service Plan?

A21: Annual assessments are the foundation for service planning. The BHCCA highlights the importance of ensuring that the assessment, service plan, services provided, and subsequent progress and outcomes are all aligned. Completing the assessments first ensures that all identified needs are addressed during service planning resulting in a plan that is clinically appropriate, person-centered, and focused on achieving outcomes.

Q22:	Are there any timeframes for a BHP and/or Member/HCDM sign off on the Service Plan or give verbal consent?

A22: No. Currently there are no timeframes established under Arizona Administrative code or AHCCCS policy.

Q23:	Bundling the Assessment elements can distort the data making it more difficult to trend specific issues; What is the rationale for this change?

A23: While breaking out each assessment element individually might seem to provide more detail, it creates several challenges that diminish the usefulness of the audit:

- **Overemphasis on Documentation:** Evaluating 22 assessment elements turns the audit into a documentation checklist. The redesigned BHCCA aims to assess effective member care, rather than just the presence or absence of paperwork. This focus on documentation is one primary reason why provider scores tend to be high.
- **Complexity without Clarity:** Separate scoring for every element generates a wealth of data points but complicates the ability to grasp the overall picture. It becomes more challenging to determine whether the assessment is timely, effectively identifies clinical needs, and aligns with the service plan.

- **A Shift in Philosophy:** The redesigned BHCCA focuses on measuring effective member care, rather than documentation. The goal is to ensure that the assessment meaningfully informs care. Instead of tracking 22 separate data elements, grouping them helps ensure that the BHCCA supports positive member outcomes by identifying clinical needs and linking them to service plan goals.

Q24: Can we include a question in the tool that addresses whether the goals in a service plan are measurable?

A24: **No.** While a service goal can include measurable objectives, it may still not reflect what is most important to the member or fail to address the needs identified in the assessment. The primary requirement is that goals must align with the member's needs, preferences, and priorities.

The BHCCA Instruction Guide already specifies that goals and objectives should be individualized, measurable, and directly informed by the assessment.

Q25: GCC 4 & 5 CALOCUS: If the CALOCUS is missing or outdated (GCC-4), should we score GCC-5 No as well? This will make the data look like the provider is not assigning an HNCM.

A25: **Yes.** The AHCCCS contract requires that all Contractors ensure the use of the CALOCUS (or other assessment as directed by AHCCCS) for all children receiving behavioral health services. AMPM 320-O provides further guidance regarding administration of the CALOCUS. The Children's System of Care has incorporated use of the CALOCUS as an essential part of the Child and Family Team (CFT) process (see AMPM 580). It is a standardized, evidence-based tool designed to identify the level of intensity required for clinically appropriate CFT practice, service planning, treatment and coordination.

Q26: What are the requirements for auditing the SED Eligibility/Identification process?

A26: Responses to Q26 divided into multiple responses. See below:

Q26-a: **What if the member has been in services for more than a year, and we cannot see if the member was initially assessed for SED because it was outside of the review window?**

A26-a: The clinical chart should reflect historical information that identifies completion of an SED Eligibility Identification OR declination of an SED Eligibility Identification. Absent evidence of either of these, there should be documentation that the member's HCDM was asked if an SED Eligibility Identification was completed in the past.

Q26-b: **Does the provider need to update this annually?**

A26-b: No. AHCCCS does not have a set schedule for SED Identifications.

Q26-c: **How does the auditor determine whether the member should have been referred for SED Identification evaluation? How does the auditor clinically assess that the provider is accurately referring members for this?**

A26-c: The auditor should not be making any kind of clinical determination of whether or not the member should have been referred for an SED Identification evaluation. Either there is evidence in the chart history of a request for an SED Identification, or (via CFT notes, progress notes, assessments, or the SED Identification itself) that: (1) the child was referred or the HCDM declined the option, OR (2) the child was referred and either did or did not meet the criteria for an SED Identification.