Managed Care Program Annual Report (MCPAR) for Arizona: Comprehensive Health Plan

Due date	Last edited	Edited by	Status
03/30/2023	03/28/2023	Ruben Soliz	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Arizona
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Ruben Soliz
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	ruben.soliz@azahcccs.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Ruben Soliz
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	ruben.soliz@azahcccs.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	03/28/2023

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	10/01/2021
A5b	**Reporting period end date** Auto-populated from report dashboard.	10/01/2022
A6	**Program name** Auto-populated from report dashboard.	Comprehensive Health Plan

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Indicator	Response
Plan name	DCS/CHP

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	AHCCCS

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	2,452,743
BI.2	**Statewide Medicaid managed care enrollment** Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.	2,095,101

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	State Medicaid agency staff

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	1) Behavioral Health Fraud focus; specificially Substance Abuse within the Outpatient Treatment Setting. This focus has included a 6 year rolling report of top abused Hcodes within the IOP setting, providing summaries of expenditures and comparison by health plan, service provider, and billing provider. Behavioral Health continues to be a driving focus within OIG as evidence by the increased number of Credible Allegation of Fraud Payment Suspensions, terminations, and case partnerships with the MFCU and other law enforcement agencies. 2) NEMT continues to be a focus. This includes a Category of Service report created within the OIG to identify percentages of services rendered without a matching medical service. 3) Allergy and Immunotherapy services, to include the unbundling of kits, has proven to be a successful program integrity audit. 4) Billing for services after date of death is a rolling audit handled by OIG 5) Billing for outpatient services while a member is inpatient is another rolling audit 6) Hospice is a new focus handled both by Qlarant, the CMS UPIC assigned to OIG, and by OIG.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State requires the return of overpayments
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	The Managed Care Entities (MCE) refers all suspicions of fraud, waste, and abuse to the AHCCCS, OIG. The MCEs are required by the AHCCCS Contractors Operations Manual (ACOM), Chapter 100, Policy103, and by the Corporate Compliance Program as outlined in Section D, Paragraph 58 of the AHCCCS contracts, to report all suspected fraud, waste, and abuse to the OIG immediately upon suspicion. Additionally, MCEs shall not conduct any investigation or review allegations of fraud, waste, or abuse involving the AHCCCS program. Further in the same section, any denial of credentialing by the contractor must be reported to AHCCCS, to include but not limited to licensure issues; quality of care concerns; excluded providers; or actions due to fraud, waste, or abuse. In accordance with 42 CFR 455.14, AHCCCS, OIG, will conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation. Specifically, once a Contractor has referred a case of alleged fraud, waste, or abuse to AHCCCS, the contractor is not allowed to recoup, or otherwise off-set any suspected payments.
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the	In addition to the response given in BX3, ACOM 103 further outlines The Contractor agrees that AHCCCS has the sole authority to handle and dispose of any matter involving fraud, waste, and/or abuse. The Contractor assigns to AHCCCS the right to recoup any amounts

	plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	overpaid to a provider as a result of fraud, waste, and/or abuse. If the Contractor receives anything of value that could be construed to represent the repayment of any amount expended due to fraud, waste or abuse, the Contractor shall forward that recovery to AHCCCS/OIG within 30 days of its receipt. As specified in the AHCCCS Minimum Subcontractor Provisions (MSPs), the above requirements apply to any actions undertaken on behalf of a Contractor by a subcontractor. The Contractor relinquishes each, every, any, and all claims to any monies received by AHCCCS as a result of any program integrity efforts which include, but are not limited to: recovery of an overpayment,civil monetary penalties and assessments, civil settlements and/or judgments, criminal restitution, collection by AHCCCS or indirectly on AHCCCS' behalf by the Arizona Attorney General, and/or other matters as applicable.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	Encounters are utilized by AHCCCS' in-house actuaries as part of the capitation rate setting process. The actuaries review costs reported on encounters to financial statement costs. This activity validates the completeness of the encounter data, and vice versa. Several other activities are performed to ensure encounter data completeness and its appropriateness to set capitation rates. The medical loss ratio (MLR) is used in the capitation rate setting process to project the MCEs future medical loss ratio given the projected changes in the capitation rates. Encounters subject to overpayment recoveries as mandated in contract for all MCEs must be reprocessed appropriately either as a total void or a replacement of the encounter with updates to what was paid.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	N/A
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and	Not answered, optional

	determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	Not answered, optional
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	N/A

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Arizona Department of Child Safety Comprehenisve Health Plan
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	09/01/2022
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://azahcccs.gov/Resources/Downloads/ContractAmendments/ACC/ACC_100121_AMD_FINAL.pdf
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Dental Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1I.5	**Program enrollment** Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	12,662
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	N/A

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Encounter Data Reporting section of the MCO contracts.
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Encounter Data Reporting section of the MCO contracts.
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	Enhancement in a MCO's percentage for auto-assignment for encounter data quality.
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has	No significant barriers during the reporting period.

		experienced during the reporting period.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	The Contractor shall resolve standard appeals as expeditiously as the member's health condition requires no later than 30 calendar days from the date of receipt of the appeal unless an extension is in effect [42 CFR 438.408(a), 42 CFR 438.408(b)(2)].
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	The Contractor shall resolve all expedited appeals as expeditiously as the member's health condition requires but not later than 72 hours from the date the Contractor receives the expedited appeal (unless an extension is in effect) [42 CFR 438.408(a), 42 CFR 438.408(b)(3)].
C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	The Contractor shall address identified issues as expeditiously as the member's condition requires and shall resolve each grievance within 10 business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	No consistent gaps identified for time and distance, but periodic gaps during the period for some provider types, primarily in Apache County. No gaps identified through appointment standards.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	For time and distance, AHCCCS supplies lists of non-contracted providers in the area the could impact time and distance gaps, requires reporting in their submission on efforts to close gaps and in their annual network plan.

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Access measure total count: 29

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 29

C2.V.2 Measure standard

90% of members within 15min/10mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Maricopa and Pima County	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

2 / 29

C2.V.2 Measure standard

90% of members within 40min/30mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	All Other Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

3 / 29

C2.V.2 Measure standard

90% of members within 12min/8mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	Maricopa and Pima County	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

4 / 29

C2.V.2 Measure standard

90% of members within 40min/30mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	All Other Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

5 / 29

C2.V.2 Measure standard

90% of members within 45min/30mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Maricopa and Pima County	Members 15 to 45 yrs old

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

6 / 29

C2.V.2 Measure standard

90% of members within 90min/75mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	All Other Counties	Members 15 to 45 yrs old

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

7 / 29

C2.V.2 Measure standard

90% of members within 45min/30mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-SNF	Maricopa and Pima County	MLTSS Living in 'Own Home'

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

8 / 29

C2.V.2 Measure standard

90% of members within 95min/85mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-SNF	All Other Counties	MLTSS Living in 'Own Home'

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

9 / 29

C2.V.2 Measure standard

90% of members within 45min/30mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Maricopa and Pima County	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

10 / 29

C2.V.2 Measure standard

90% of members within 95min/85mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	All Other Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

11 / 29

C2.V.2 Measure standard

90% of members within 15min/10mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dentist	Maricopa and Pima County	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

12 / 29

C2.V.2 Measure standard

90% of members within 40min/30mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dentist	All Other Counties	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

13 / 29

C2.V.2 Measure standard

90% of members within 15min/10mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health - Crisis Stabilization Facility	Maricopa and Pima County	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

14 / 29

C2.V.2 Measure standard

90% of members within 45 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health - Crisis Stabilization Facility	All Other Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

15 / 29

C2.V.2 Measure standard

90% of members within 30min/20mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Cardiologist	Maricopa and Pima County	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

16 / 29

C2.V.2 Measure standard

90% of members within 75min/60mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Cardiologist	All Other Counties	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

17 / 29

C2.V.2 Measure standard

90% of members within 60min/45mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Cardiologist	Maricopa and Pima County	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

18 / 29

C2.V.2 Measure standard

90% of members within 110min/100mi

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider
Cardiologist

C2.V.5 Region
All Other Counties

C2.V.6 Population
Pediatric

C2.V.7 Monitoring Methods
Geomapping

C2.V.8 Frequency of oversight methods
Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

19 / 29

C2.V.2 Measure standard
90% of members within 15min/10mi

C2.V.3 Standard type
Maximum time or distance

C2.V.4 Provider
Behavioral Health Residential Facility

C2.V.5 Region
Maricopa and Pima County

C2.V.6 Population
Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping

C2.V.8 Frequency of oversight methods
Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

20 / 29

C2.V.2 Measure standard
90% of members within 15min/10mi

C2.V.3 Standard type
Maximum time or distance

C2.V.4 Provider
Behavioral health Outpatient and Integrated Clinic

C2.V.5 Region
Maricopa and Pima County

C2.V.6 Population
Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping

C2.V.8 Frequency of oversight methods
Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

21 / 29

C2.V.2 Measure standard
90% of members within 60 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health Outpatient and Integrated Clinic	All Other Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

22 / 29

C2.V.2 Measure standard

Urgent Care Appts no later than 2 Business Days Routine Appts no later than 21 Calendar Days

C2.V.3 Standard type

Ease of getting a timely appointment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	All Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

23 / 29

C2.V.2 Measure standard

Urgent Appts no later than 2 Business Days Routine Appts within 45 Calendar Days

C2.V.3 Standard type

Ease of getting a timely appointment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty Provider	All Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

24 / 29

C2.V.2 Measure standard

Urgent Appts no later than 3 Business Days Routine Appts within 45 Calendar Days For members in Foster care only: Routine Appts within 30 Calendar Days

C2.V.3 Standard type

Ease of getting a timely appointment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental	All Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 25 / 29

C2.V.2 Measure standard

1st Trimester within 14 calendar Days 2nd Trimester within 7 Calendar Days 3rd Trimester or High Risk Pregnancy within 3 Business Days

C2.V.3 Standard type

Ease of getting a timely appointment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Maternity Care	All Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 26 / 29

C2.V.2 Measure standard

Urgent Appts no later than 24 hours Routine Appts within 7 Calendar days for initial assessment, First service within 23 calendar days after initial assessment, subsequent services within 45 calendar days

C2.V.3 Standard type

Ease of getting a timely appointment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All Counties	Adult

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 27 / 29

C2.V.2 Measure standard

Urgent Appts no later than 24 hours Routine Appts within 7 Calendar days for initial assessment, First service within 21 calendar days after initial assessment, subsequent services within 21 calendar days

C2.V.3 Standard type

Ease of getting a timely appointment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All Counties	Pediatric members in foster care or adopted

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 28 / 29

C2.V.2 Measure standard

Urgent Appts no later than 24 hours Routine Appts within 7 Calendar days for initial assessment, First service within 21 calendar days after initial assessment, subsequent services within 45 calendar days

C2.V.3 Standard type

Ease of getting a timely appointment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All Counties	Pediatric members not in foster care or adopted

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Semi-Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 29 / 29

C2.V.2 Measure standard

Appt within a timeframe ensuring the member: 1) doesn't run out of meds, or 2) doesn't decline in their condition, but no later than 30 calendar days from identified need.

C2.V.3 Standard type

Ease of getting a timely appointment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
	All Counties	Adult and pediatric

Appointment for Psychotropic Medication

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Semi-Annually

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	Not answered
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	Not answered
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	Not answered
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Not answered

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	Not answered, optional

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**DCS/CHP** 12,662
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**DCS/CHP** 0.5%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**DCS/CHP** 0.6%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**DCS/CHP** 91%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**DCS/CHP** Program-specific statewide
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**DCS/CHP** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**DCS/CHP** Yes
N/A	Enter the start date.	**DCS/CHP** 10/01/2020
N/A	Enter the end date.	**DCS/CHP** 09/30/2021

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**DCS/CHP** No later than 210 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later. AZ Data Entry Note: While AHCCCS collects information on both the number of encounters submitted as well as the timeliness of the encounters submitted, those pieces of information are tracked in disparate areas of the system. AHCCCS will look at ways to make these two data elements available to provide the requested information.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**DCS/CHP** 0%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**DCS/CHP** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**DCS/CHP** 8
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**DCS/CHP** 1
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**DCS/CHP** N/A
D1IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any	**DCS/CHP** N/A

	service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**DCS/CHP** 32
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**DCS/CHP** 0
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**DCS/CHP** N/A
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**DCS/CHP** N/A
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**DCS/CHP** N/A

D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**DCS/CHP** N/A
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**DCS/CHP** N/A
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**DCS/CHP** N/A
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**DCS/CHP** N/A

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**DCS/CHP** N/A
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**DCS/CHP** N/A
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**DCS/CHP** N/A
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**DCS/CHP** N/A
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**DCS/CHP** N/A

D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**DCS/CHP** N/A
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**DCS/CHP** N/A
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**DCS/CHP** N/A
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**DCS/CHP** N/A
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	**DCS/CHP** N/A

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**DCS/CHP** 1
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**DCS/CHP** 0
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**DCS/CHP** 0
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	**DCS/CHP** 0
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**DCS/CHP** N/A

D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**DCS/CHP** N/A

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**DCS/CHP** 43
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**DCS/CHP** 1
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**DCS/CHP** N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new	**DCS/CHP** N/A

	populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**DCS/CHP** 43

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**DCS/CHP** N/A
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**DCS/CHP** N/A
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**DCS/CHP** N/A
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**DCS/CHP** N/A
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**DCS/CHP** N/A

D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**DCS/CHP** N/A
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**DCS/CHP** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**DCS/CHP** N/A
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**DCS/CHP** N/A
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**DCS/CHP** N/A

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**DCS/CHP** 12
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**DCS/CHP** N/A
D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**DCS/CHP** 3
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**DCS/CHP** N/A
D1IV.16e	**Resolved grievances related to plan communications**	**DCS/CHP**

	Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	0
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**DCS/CHP** N/A
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**DCS/CHP** N/A
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**DCS/CHP** N/A
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**DCS/CHP** N/A

D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**DCS/CHP** N/A
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**DCS/CHP** N/A

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Quality & performance measure total count: 1

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care - Poor Control (CDC) 1 / 1

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0059

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

DCS/CHP

29.7%

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Sanction total count:

0 - No sanctions entered

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**DCS/CHP** 6
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**DCS/CHP** N/A
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**DCS/CHP** 0:0
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**DCS/CHP** N/A
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**DCS/CHP** 0:0
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**DCS/CHP** Makes some referrals to the SMA and others directly to the MFCU
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made to the SMA and the MFCU in aggregate.	**DCS/CHP** 0
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in	**DCS/CHP** 0:0

	indicator D1.I.2) as the denominator.	
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	**DCS/CHP** AZ DATA ENTRY NOTE: The State requested an extension on the submission of MACPAR in consideration of the unprecedented level of effort that is concurrently being invested in unwinding from the Continuous Enrollment Condition and the end of the Public Health Emergency. CMS denied that request in an email dated February 3, 2023 and instructed the State to submit what they are able. To that end, we are using this space to note incomplete data. We would like to note that the responses to the following questions may be incomplete: D1.X.2, D1.X.3, D1.X.4, D1.X.5, D1.X.9, D1.X.10.
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**DCS/CHP** Quarterly

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**AHCCCS** Not answered, optional
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**AHCCCS** Not answered, optional