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

Due date	Last edited	Edited by	Status
03/29/2025	03/28/2025	Maxwell Seifer	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.	Maxwell Seifer
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	maxwell.seifer@azahcccs.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Maxwell Seifer
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	maxwell.seifer@azahcccs.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	03/28/2025

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	10/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	09/30/2024
A6	**Program name** Auto-populated from report dashboard.	Comprehensive Health Plan (CHP)

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	CHP: 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

Add In Lieu of Services and Settings (A.9)

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

	Indicator	Response
	ILOS name	

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	2,168,516
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,896,734

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. If no PI activities were performed, enter “No PI activities were performed during the reporting period” as your response. “N/A” is not an acceptable response.	1) Behavioral Health Fraud focus; specifically 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 (CAF) Payment Suspensions, terminations, and case partnerships with the MFCU and other law enforcement agencies. Additionally, there has been sharing of pre pay review code unit limits and filters with MCOs for awareness. Due to large scale of CAFs, we have established a civil remedy process to finalize these investigations, the results of which have outcomes posted online (i.e. exclusion lists MCOs can use). AHCCCS has spent considerable time ensuring member safety and fallout provisions such as housing, crisis services, care coordination, etc. were established in response to the large amount of BH fraud. 2) Habilitation and attendant care providers, along with billing for respite, have become a focus. OIG has initiated a dedicated effort to review and investigate these provider types and billing. Additionally, our previous in depth analysis on respite coincides with an increase in referrals. 3) CMS communicated significant hospice concerns to AZ as a result of the moratorium in California. OIG, in conjunction with independent review from the MCOs, also reviewed and verified there were no current hospice concerns identified in any of the billing data. This topic has been set for a biannual review cadence to ensure items are closely monitored. This review occurred again and there have been no AZ Medicaid hospice concerns identified by the MCOs. 4) OIG continues to facilitate rolling annual audits, such as those examining billing for services after date of death and billing for outpatient services while a member is inpatient. 5) OIG provided analyses on allergy testing and immunotherapy utilization for MCO and FFS populations, as well as the over 21 and under 21 populations. 6) OIG, in partnership with OGC, created NDA agreements so MCOs will come to the table to discuss FWA schemes.

		These are currently in the process of being updated to meet the new HIPAA requirements. 7) Review of members incorrectly enrolled in the AIHP program, removing those who were ineligible for it. There was in response to an influx of members who had their enrollment switched to AIHP in order to facilitate various fraud schemes. 8) In FFY24 the following audits were initiated by OIG - 23 Deficit Reduction Act (DRA) Audits; 2 Provider Compliance Audits; 22 American Rescue Plan (ARP) Audits; and 3 Targeted Investments (TI) Audits. In FFY24 the following audits were completed by OIG - 21 Deficit Reduction Act (DRA) Audits; 121 Member Date of Death Audits; 71 Targeted Investments (TI) Audits; 53 Inpatient Care Audits; 1 Federally Qualified Healthcare Center (FQHC) Audit; 5 American Rescue Plan (ARP) Audits. 9) Qlarant (AHCCCS UPIC contractor) looking at Laboratories, ABA providers, and Hospice providers. Our current use of Qlarant assists with the oversight of a variety of provider types.
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 plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	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 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 topics (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).	To the extent that AHCCCS OIG has a finding from an FWA case, our findings are communicated to DMPS and/or DES for the changes to occur to the enrollment files. The state ensures timely and accurate reconciliation between the state and plans using daily HIPAA 834 files to communicate member health plan and enrollment changes. Also, the state sends monthly HIPAA 834 files as a "roster" file for the plans to confirm their enrollment as of the 1st of the month. Capitation payments are calculated based upon the number of days a member is enrolled in a plan.
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.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? 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 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.	No
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of	No

	individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	
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, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.	No such audits were conducted during the reporting year.

Topic XIII. Prior Authorization

> ⚠ **Beginning June 2026, Indicators B.XIII.1a-b–2a-b must be completed. Submission of this data before June 2026 is optional.**

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?**	Not reporting data

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 Comprehensive Health Plan
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	10/01/2023
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/CMDP/CHP_AMD22_EFF100123.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 average number of individuals enrolled in this managed care program per	9,076

	month during the reporting year (i.e., average member months).	
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. If there were no major changes, please enter “There were no major changes to the population or benefits during the reporting year” as your response. “N/A” is not an acceptable response.	There were no major changes to the population or benefits during the reporting year.

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
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 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.	Section 60 of the CHP Contract outlines Encounter Data Reporting for the MCO.

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.	Section 60 of the CHP Contract outlines Encounter Data Reporting for the MCO.
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.	N/A
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 experienced during the reporting year. If there were no barriers, please enter “The state did not experience any barriers to collecting or validating encounter data during the reporting year” as your response. “N/A” is not an acceptable response.	The state did not experience any barriers to collecting or validating encounter data during the reporting year.

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 ten business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. [42 CFR 457.1260, 42 CFR 438.408(a), 42 CFR 438.408(b)(1) and (3)].

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 access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	Primarily Dentists and Pharmacies in La Paz County.
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, when an MCO is not meeting time and distance standards for a provider type in a county, the MCO providers an explanation of its efforts to close the gap. AHCCCS also provides a list of registered providers in the county and in neighboring counties who are not contracted with the plan in order to assist in network building.

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
Hospital

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

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
Hospital

C2.V.5 Region
All Other Counties

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

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
Dentist

C2.V.5 Region
Maricopa and Pima County

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

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	C2.V.5 Region	C2.V.6 Population
Cardiologist	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

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	C2.V.5 Region	C2.V.6 Population
Behavioral Health Residential 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

20 / 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
Behavioral Health Residential 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

21 / 29

C2.V.2 Measure standard

90% of members within 15min/10mi

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	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

22 / 29

C2.V.2 Measure standard

90% of members within 60 miles

C2.V.3 Standard type

Maximum time or distance

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

Behavioral health Outpatient and Integrated Clinic

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

23 / 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

24 / 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

25 / 29

C2.V.2 Measure standard

Urgent Appts no later than 3 Business Days Routine Appts within 45 Calendar Days (CHP - Routine appointments within 30 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

26 / 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 27 / 29

C2.V.2 Measure standard

Urgent Appts no later than 24 hours Routine Appts within 7 Calendar days for initial assessment. Adults - 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 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

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

When entering out of home placement, rapid response within 72 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	CHP -Foster Care only

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(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	No website or email address
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.	Phone, Internet, In Person and auxillary aids are available when requested
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).	LTSS data is a shared responsibility throughout the AHCCCS agency. Information received by a BSS is shared with the appropriate AHCCCS division and handled on an individual basis.
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?	Regular quality assurance reviews are complete on the BSS staff which evaluates the overall effectiveness and efficiency of these workers.

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).	No

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	Yes
C1XII.5	**Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?** (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	No
C1XII.6	**Did the State or MCOs complete the most recent parity analysis(es)?**	MCO
C1XII.7a	**Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?** (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	No
C1XII.8	**When was the last parity analysis(es) for this program completed?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	08/15/2024
C1XII.9	**When was the last parity analysis(es) for this program**	10/02/2017

	submitted to CMS? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	Yes
C1XII.10b	**In the last analysis(es) conducted, describe all deficiencies identified.**	Deficiencies were identified with Respite, Physical and Occupational Therapy, and for Institution for Mental Diseases (IMD).
C1XII.11a	**As of the end of this reporting period, have these deficiencies been resolved for all plans?**	No
C1XII.11b	**If deficiencies have not been resolved, select all that apply.**	Other, specify – Currently, there is an Arizona state statute that limits and allows for a specific number of hours for Respite, PT, and OT.
C1XII.12a	**Has the state posted the current parity analysis(es) covering this program on its website?** The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO	Yes

	may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	
C1XII.12b	**Provide the URL link(s).** Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.	https://www.azahcccs.gov/Resources/GovernmentalOversight/Mental_Health_Parity.html

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**CHP: DCS/CHP** 9,043
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)	**CHP: DCS/CHP** 0.4%
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)	**CHP: DCS/CHP** 0.5%

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. Write MLR as a percentage: for example, write 92% rather than 0.92.	**CHP: DCS/CHP** 93.6%
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.	**CHP: 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.	**CHP: 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?	**CHP: DCS/CHP** Yes
N/A	Enter the start date.	**CHP: DCS/CHP**

		10/01/2022
N/A	Enter the end date.	**CHP: DCS/CHP** 09/30/2023

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.	**CHP: DCS/CHP** Professional, Institutional, and Dental Encounters not involving services eligible for Federal Drug Rebate processing shall be received by AHCCCS 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. Failure to submit encounters within 210 days may result in sanctions as specified in the AHCCCS Encounter Manual.
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 year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year 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 year.	**CHP: DCS/CHP** 94.31%

D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) 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 year.	**CHP: DCS/CHP** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

> ⚠ **Beginning June 2025, Indicators D1.IV.1a-c must be completed. Submission of this data before June 2025 is optional; if you choose not to respond prior to June 2025, enter "N/A".**

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during 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.	**CHP: DCS/CHP** 74
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**CHP: DCS/CHP** 59
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**CHP: DCS/CHP** 3
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**CHP: DCS/CHP** 12
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**CHP: DCS/CHP** 4

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).	**CHP: DCS/CHP** N/A
D1IV.4	**Number of critical incidents filed during the reporting year 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 year 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 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	**CHP: DCS/CHP** N/A

	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 within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**CHP: DCS/CHP** 33
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 within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**CHP: 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).	**CHP: DCS/CHP** 73

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.	**CHP: DCS/CHP** 1
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.	**CHP: DCS/CHP** 0
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).	**CHP: DCS/CHP** 0
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.	**CHP: DCS/CHP** 0
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	**CHP: DCS/CHP** 0

	services outside the network (only applicable to residents of rural areas with only one MCO).	
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.	**CHP: DCS/CHP** 0

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”.	**CHP: DCS/CHP** 0
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”.	**CHP: DCS/CHP** 5
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”.	**CHP: DCS/CHP** 8
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	**CHP: DCS/CHP** 41

	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”.	
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”.	**CHP: DCS/CHP** 4
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”.	**CHP: DCS/CHP** 0
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”.	**CHP: DCS/CHP** 0
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”.	**CHP: DCS/CHP** 15

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”.	**CHP: DCS/CHP** 0
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 paid primarily by Medicaid, enter “N/A”.	**CHP: DCS/CHP** 1

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**CHP: 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.	**CHP: 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.	**CHP: 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) during the reporting year prior to reaching a decision.	**CHP: DCS/CHP** 1
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).	**CHP: 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).	**CHP: 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.	**CHP: DCS/CHP** 38
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**CHP: DCS/CHP** 0
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.	**CHP: 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 year 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	**CHP: DCS/CHP** N/A

	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 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 year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**CHP: DCS/CHP** 36

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”.	**CHP: DCS/CHP** 1
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”.	**CHP: DCS/CHP** 3
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”.	**CHP: DCS/CHP** 4
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	**CHP: DCS/CHP** 12

	substance use services. If the managed care plan does not cover this type of service, enter "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".	**CHP: DCS/CHP** 0
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".	**CHP: DCS/CHP** 0
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".	**CHP: DCS/CHP** 0
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".	**CHP: DCS/CHP** 2

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”.	**CHP: DCS/CHP** 15
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 paid primarily by Medicaid, enter “N/A”.	**CHP: DCS/CHP** 1

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.	**CHP: DCS/CHP** 3
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.	**CHP: DCS/CHP** 0

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.	**CHP: DCS/CHP** 0
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.	**CHP: DCS/CHP** 5
D1IV.16e	**Resolved grievances related to plan communications** 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.	**CHP: DCS/CHP** 0

D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**CHP: DCS/CHP** 1
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan 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.	**CHP: DCS/CHP** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**CHP: DCS/CHP** 0
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 by the plan during the reporting year that were filed due to a lack of	**CHP: DCS/CHP** 0

	timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan 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.	**CHP: DCS/CHP** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**CHP: DCS/CHP** 29

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: 4

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (WCV)

1 / 4

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1516

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, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

CHP: DCS/CHP

77.14

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio (AMR) - Total

2 / 4

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

1800

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, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

CHP: DCS/CHP

82.93

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness (FUM): 7 Days - Total

3 / 4

D2.VII.2 Measure Domain

Behavioral health care

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

3489

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, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

CHP: DCS/CHP

86.6

Complete

D2.VII.1 Measure Name: Oral Evaluation, Dental Services (OEV)

4 / 4

D2.VII.2 Measure Domain

Dental and oral health services

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

2517

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

CHP: DCS/CHP

71.92

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: 2

Complete

D3.VIII.1 Intervention type: Compliance letter

1 / 2

D3.VIII.2 Plan performance issue

Results of secret shopper calls validating provider network.

D3.VIII.3 Plan name

CHP: DCS/CHP

D3.VIII.4 Reason for intervention

Data on the MCO's website regarding ASD providers was inaccurate.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

02/23/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 05/25/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

2 / 2

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

CHP: DCS/CHP

D3.VIII.4 Reason for intervention

Failure to submit Performance Improvement Projects (PIPs) deliverables timely.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

11/27/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

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).	**CHP: DCS/CHP** 1
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**CHP: 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 to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**CHP: DCS/CHP** 0:0
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**CHP: 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 to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**CHP: DCS/CHP** 0:0
D1X.6	**Referral path for program integrity referrals to the state**	**CHP: DCS/CHP** Makes referrals to the State Medicaid Agency

	What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	(SMA) only
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.	**CHP: DCS/CHP** 0
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	**CHP: DCS/CHP** 0:1,000
D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**CHP: DCS/CHP** 10/01/2023
D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**CHP: DCS/CHP** 09/30/2024
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount** From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**CHP: DCS/CHP** N/A
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of premium revenue for the	**CHP: DCS/CHP** N/A

	corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**CHP: DCS/CHP** Daily

Topic XI: ILOS

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if "Yes", which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter "0" for utilization.

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**CHP: DCS/CHP** No ILOSs were offered by this plan

Topic XIII. Prior Authorization

> ⚠ **Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".**

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage

> ⚠ **Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".**

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Not reporting data

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 performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**AHCCCS** State Government Entity
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** Other, specify – Choice counseling, LTSS Complain Access Point and information on LTSS grievance/appeals filing process is provided by the BSS role in the state government. Other functions specific to the LTSS grievance/appeals filing process and other LTSS activities are performed by other divisions within same the state government agency with information received from the BSS agent.