Managed Care Program Annual Report (MCPAR) for Arizona: Long Term Care (LTC)

Due date	Last edited	Edited by	Status
03/28/2024	06/21/2024	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.	06/24/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	10/01/2022
A5b	**Reporting period end date** Auto-populated from report dashboard.	09/30/2023
A6	**Program name** Auto-populated from report dashboard.	Long Term Care (LTC)

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	LTC: Banner University Family Care
	LTC: Mercy Care
	LTC: APIPA dba UnitedHealthcare Community Plan
	LTC: DES/DDD

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 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.	2,264,547
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.	1,910,748

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; 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. OIG has also provided several data reports to AHCCCS for review on different codes, such as by rport code H0015. AHCCCS has reviewed these reports and implemented measures. Code H0015 had a rate set. OIG has participated in several joint agency meetings on the BH Fraud plaguing Arizona. 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) 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. 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) Respite codes have also become a newer focus with OIG providing indepth analysis of codes. 7) OIG recently provided analyses on partial hospitalization codes and data scenarios to AHCCCS for review to ensure policy and claims edits appropriately align. 8) OIG, in partnership with OGC, has created NDA agreements so MCOs will come to the table to disucss FWA schemes. These are currently in the process of being reviewed and signed by each MCO.9) OIG has onboarded the RAC with a focus on facility claims overpayments for DRG services. Process flows have been mapped, concept briefs approved, file layouts transfers have occurred, and we are close to full implementation of the start of the project.
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.1

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 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.	Yes
BX.7c	**Changes in provider circumstances: Describe metric** Describe the metric or indicator that the state uses.	Data is not available at this time.
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 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).	No

BX.10	**Periodic audits**	Data Validation audits are conducted annually, and results are posted on the website. Results for data validation audits are under each line of business, the individual health plan, and the 'Sanctions' section of the following link. https://azahcccs.gov/Resources/OversightOfHealthPlans/AdministrativeActions/
	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.	

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 Long Term Care System Elderly and/or Physically Disabled
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	10/1/2022 - 9/30/2023
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/ALTCS/ALTCSCYE2020/ALTCS_EPD_ContractAmendment12(YH18-0001).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 month during the reporting year (i.e., average member months).	66,892

| C1I.6 | **Changes to enrollment or benefits** | N/A |
| | 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. | |

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)).	Other, specify – Evaluate Health Care Quality, Evaluate contractor performance, develop and evaluate capitation rates, develop FFS payment rates, Determine risk sharing payments, process reconciliations and risk adjustments.
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 68 of the LTC 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 68 of the LTC 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	N/A

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.

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.	An allegation that any aspect of care, or treatment, utilization of behavioral health services or utilization of physical health care services that caused or could have caused an acute medical or psychiatric condition or an exacerbation of a chronic medical or psychiatric condition and may ultimately cause the risk of harm to an AHCCCS member. Also, IADs as outlined in AMPM Policy 961. https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/961.pdf
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 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.	Low provider and member population density in rural areas. The low population limits member volume while credentialing and contracting costs do not change. This is particularly challenging in getting dental providers. Also, in areas with a high portion of tribal/I.H.S. providers these providers face challenges in contracting.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	MCPs get lists of non-par providers registered with the state but but not in network to assist recruitment. MCPs have to develop plans for addressing network gaps. For appointment standards, plans typically reach out and educate non-compliant providers and resurvey after education. State is also requiring plans to get NCQA certification.

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

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

C2.V.3 Standard type
Maximum time or distance

C2.V.4 Provider
Primary care

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

C2.V.2 Measure standard
90% of members within 40min/30mi

C2.V.3 Standard type
Maximum time or distance

C2.V.4 Provider
Primary care

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

C2.V.2 Measure standard
90% of members within 12min/8mi

C2.V.3 Standard type
Maximum time or distance

C2.V.4 Provider
Primary care

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

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

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

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

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

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

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

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

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

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

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 - Crisis Stabilization 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

C2.V.2 Measure standard
90% of members within 45 miles

C2.V.3 Standard type
Maximum distance to travel

C2.V.4 Provider
Behavioral health - Crisis Stabilization Facility

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

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

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

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

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

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

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

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

C2.V.3 Standard type

Maximum distance to travel

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

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

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
Primary care

C2.V.5 Region
All Counties

C2.V.6 Population
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
Specialty Provider

C2.V.5 Region
All Counties

C2.V.6 Population
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**

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**

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

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

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

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(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	Data is not available at the time of submission.
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.	Data is not available at the time of submission.
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).	Data is not available at the time of submission.
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?	Data is not available at the time of submission.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure**	No
	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).	

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).	**LTC: Banner University Family Care** 6,905 **LTC: Mercy Care** 10,528 **LTC: APIPA dba UnitedHealthcare Community Plan** 8,659 **LTC: DES/DDD** 40,800
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)	**LTC: Banner University Family Care** 0.3% **LTC: Mercy Care** 0.5% **LTC: APIPA dba UnitedHealthcare Community Plan** 0.4% **LTC: DES/DDD** 1.8%
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)	**LTC: Banner University Family Care** 0.4% **LTC: Mercy Care** 0.6% **LTC: APIPA dba UnitedHealthcare Community Plan** 0.5% **LTC: DES/DDD** 2.1%

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.	**LTC: Banner University Family Care** 92.6% **LTC: Mercy Care** 94.6% **LTC: APIPA dba UnitedHealthcare Community Plan** 96.5% **LTC: DES/DDD** 89.5%
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.	**LTC: Banner University Family Care** Statewide all programs & populations **LTC: Mercy Care** Statewide all programs & populations **LTC: APIPA dba UnitedHealthcare Community Plan** Statewide all programs & populations **LTC: DES/DDD** Statewide all programs & populations
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.	**LTC: Banner University Family Care** N/A **LTC: Mercy Care** N/A **LTC: APIPA dba UnitedHealthcare Community Plan** N/A **LTC: DES/DDD** 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?	**LTC: Banner University Family Care** Yes **LTC: Mercy Care** Yes **LTC: APIPA dba UnitedHealthcare Community Plan** Yes **LTC: DES/DDD**

Yes

N/A	Enter the start date.	LTC: Banner University Family Care
		10/01/2021
		LTC: Mercy Care
		10/01/2021
		LTC: APIPA dba UnitedHealthcare Community Plan
		10/10/2021
		LTC: DES/DDD
		10/01/2021
N/A	Enter the end date.	LTC: Banner University Family Care
		09/30/2022
		LTC: Mercy Care
		09/30/2022
		LTC: APIPA dba UnitedHealthcare Community Plan
		09/30/2022
		LTC: DES/DDD
		09/30/2022

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.	**LTC: Banner University Family Care** 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. **LTC: Mercy Care** 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. **LTC: APIPA dba UnitedHealthcare Community Plan** 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. **LTC: DES/DDD** 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	**LTC: Banner University Family Care** 80.82% **LTC: Mercy Care** 98.22% **LTC: APIPA dba UnitedHealthcare Community Plan** 98.55% **LTC: DES/DDD**

	compliant out of the file submissions it has received from the managed care plan for the reporting year.	99.38%
D1III.3	**Share of encounter data submissions that were HIPAA compliant**	**LTC: Banner University Family Care** 100%
	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.	**LTC: Mercy Care** 100% **LTC: APIPA dba UnitedHealthcare Community Plan** 100% **LTC: DES/DDD** 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 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.	**LTC: Banner University Family Care** 91 **LTC: Mercy Care** 124 **LTC: APIPA dba UnitedHealthcare Community Plan** 76 **LTC: DES/DDD** 478
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.	**LTC: Banner University Family Care** 2 **LTC: Mercy Care** 2 **LTC: APIPA dba UnitedHealthcare Community Plan** 4 **LTC: DES/DDD** 26
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).	**LTC: Banner University Family Care** 116 **LTC: Mercy Care** 129 **LTC: APIPA dba UnitedHealthcare Community Plan** 79 **LTC: DES/DDD** 526
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	**LTC: Banner University Family Care** 1 **LTC: Mercy Care** 10 **LTC: APIPA dba UnitedHealthcare Community Plan** 1 **LTC: DES/DDD**

	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 enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	2
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.	**LTC: Banner University Family Care** 87 **LTC: Mercy Care** 110 **LTC: APIPA dba UnitedHealthcare Community Plan** 61 **LTC: DES/DDD** 423
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.	**LTC: Banner University Family Care** 2 **LTC: Mercy Care** 5 **LTC: APIPA dba UnitedHealthcare Community Plan** 7 **LTC: DES/DDD** 49
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	**LTC: Banner University Family Care** 90 **LTC: Mercy Care**

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).

124

**LTC: APIPA dba UnitedHealthcare
Community Plan**

79

LTC: DES/DDD

388

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.

LTC: Banner University Family Care

6

LTC: Mercy Care

0

**LTC: APIPA dba UnitedHealthcare
Community Plan**

0

LTC: DES/DDD

17

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.

LTC: Banner University Family Care

20

LTC: Mercy Care

4

**LTC: APIPA dba UnitedHealthcare
Community Plan**

0

LTC: DES/DDD

3

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).

LTC: Banner University Family Care

0

LTC: Mercy Care

1

**LTC: APIPA dba UnitedHealthcare
Community Plan**

0

LTC: DES/DDD

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

LTC: Banner University Family Care

0

LTC: Mercy Care

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.

0

LTC: APIPA dba UnitedHealthcare Community Plan

0

LTC: DES/DDD

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 services outside the network (only applicable to residents of rural areas with only one MCO).

LTC: Banner University Family Care

0

LTC: Mercy Care

0

LTC: APIPA dba UnitedHealthcare Community Plan

0

LTC: DES/DDD

0

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.

LTC: Banner University Family Care

0

LTC: Mercy Care

0

LTC: APIPA dba UnitedHealthcare Community Plan

0

LTC: DES/DDD

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".	**LTC: Banner University Family Care** 2 **LTC: Mercy Care** 3 **LTC: APIPA dba UnitedHealthcare Community Plan** 1 **LTC: DES/DDD** 1
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".	**LTC: Banner University Family Care** 37 **LTC: Mercy Care** 48 **LTC: APIPA dba UnitedHealthcare Community Plan** 7 **LTC: DES/DDD** 99
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".	**LTC: Banner University Family Care** 0 **LTC: Mercy Care** 0 **LTC: APIPA dba UnitedHealthcare Community Plan** 1 **LTC: DES/DDD** 5
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".	**LTC: Banner University Family Care** 0 **LTC: Mercy Care** 0 **LTC: APIPA dba UnitedHealthcare Community Plan** 0 **LTC: DES/DDD**

32

D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs**	**LTC: Banner University Family Care**
		7
	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".	**LTC: Mercy Care**
		21
		LTC: APIPA dba UnitedHealthcare Community Plan
		12
		LTC: DES/DDD
		75

D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services**	**LTC: Banner University Family Care**
		0
	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".	**LTC: Mercy Care**
		1
		LTC: APIPA dba UnitedHealthcare Community Plan
		1
		LTC: DES/DDD
		4

D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)**	**LTC: Banner University Family Care**
		19
	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".	**LTC: Mercy Care**
		5
		LTC: APIPA dba UnitedHealthcare Community Plan
		0
		LTC: DES/DDD
		2

D1IV.7h	**Resolved appeals related to dental services**	**LTC: Banner University Family Care**
		1
	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".	**LTC: Mercy Care**
		11
		LTC: APIPA dba UnitedHealthcare Community Plan
		3
		LTC: DES/DDD

D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)**	**LTC: Banner University Family Care**
		0
	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".	**LTC: Mercy Care**
		1
		LTC: APIPA dba UnitedHealthcare Community Plan
		0
		LTC: DES/DDD
		0

D1IV.7j	**Resolved appeals related to other service types**	**LTC: Banner University Family Care**
		32
	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".	**LTC: Mercy Care**
		39
		LTC: APIPA dba UnitedHealthcare Community Plan
		54
		LTC: DES/DDD
		147

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.	**LTC: Banner University Family Care** 6 **LTC: Mercy Care** 5 **LTC: APIPA dba UnitedHealthcare Community Plan** 1 **LTC: DES/DDD** 37
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.	**LTC: Banner University Family Care** 0 **LTC: Mercy Care** 0 **LTC: APIPA dba UnitedHealthcare Community Plan** 0 **LTC: DES/DDD** 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.	**LTC: Banner University Family Care** 1 **LTC: Mercy Care** 1 **LTC: APIPA dba UnitedHealthcare Community Plan** 3 **LTC: DES/DDD** 8
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.	**LTC: Banner University Family Care** 4 **LTC: Mercy Care** 4 **LTC: APIPA dba UnitedHealthcare Community Plan** 0 **LTC: DES/DDD**

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).

LTC: Banner University Family Care

N/A

LTC: Mercy Care

N/A

LTC: APIPA dba UnitedHealthcare Community Plan

N/A

LTC: DES/DDD

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).

LTC: Banner University Family Care

N/A

LTC: Mercy Care

N/A

LTC: APIPA dba UnitedHealthcare Community Plan

N/A

LTC: DES/DDD

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.	**LTC: Banner University Family Care** 586 **LTC: Mercy Care** 974 **LTC: APIPA dba UnitedHealthcare Community Plan** 968 **LTC: DES/DDD** 1,426
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.	**LTC: Banner University Family Care** 0 **LTC: Mercy Care** 18 **LTC: APIPA dba UnitedHealthcare Community Plan** 9 **LTC: DES/DDD** 3
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.	**LTC: Banner University Family Care** 636 **LTC: Mercy Care** 892 **LTC: APIPA dba UnitedHealthcare Community Plan** 977 **LTC: DES/DDD** 1,410
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 -	**LTC: Banner University Family Care** 21 **LTC: Mercy Care** 203 **LTC: APIPA dba UnitedHealthcare Community Plan** 301 **LTC: DES/DDD**

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 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.

209

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.

LTC: Banner University Family Care

585

LTC: Mercy Care

973

LTC: APIPA dba UnitedHealthcare Community Plan

968

LTC: DES/DDD

1,418

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".	**LTC: Banner University Family Care** 6 **LTC: Mercy Care** 2 **LTC: APIPA dba UnitedHealthcare Community Plan** 1 **LTC: DES/DDD** 5
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".	**LTC: Banner University Family Care** 9 **LTC: Mercy Care** 5 **LTC: APIPA dba UnitedHealthcare Community Plan** 7 **LTC: DES/DDD** 77
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".	**LTC: Banner University Family Care** 0 **LTC: Mercy Care** 0 **LTC: APIPA dba UnitedHealthcare Community Plan** 1 **LTC: DES/DDD** 6
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".	**LTC: Banner University Family Care** 3 **LTC: Mercy Care** 2 **LTC: APIPA dba UnitedHealthcare Community Plan** 0 **LTC: DES/DDD**

52

D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs**	**LTC: Banner University Family Care**
		3

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".

LTC: Mercy Care

1

LTC: APIPA dba UnitedHealthcare Community Plan

13

LTC: DES/DDD

51

D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services**	**LTC: Banner University Family Care**
		3

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".

LTC: Mercy Care

13

LTC: APIPA dba UnitedHealthcare Community Plan

1

LTC: DES/DDD

1

D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)**	**LTC: Banner University Family Care**
		82

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".

LTC: Mercy Care

23

LTC: APIPA dba UnitedHealthcare Community Plan

0

LTC: DES/DDD

717

D1IV.15h	**Resolved grievances related to dental services**	**LTC: Banner University Family Care**
		2

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".

LTC: Mercy Care

0

LTC: APIPA dba UnitedHealthcare Community Plan

3

LTC: DES/DDD

14

D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)**	**LTC: Banner University Family Care**
		496
	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".	**LTC: Mercy Care**
		35
		LTC: APIPA dba UnitedHealthcare Community Plan
		0
		LTC: DES/DDD
		68

D1IV.15j	**Resolved grievances related to other service types**	**LTC: Banner University Family Care**
		32
	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".	**LTC: Mercy Care**
		4
		LTC: APIPA dba UnitedHealthcare Community Plan
		55
		LTC: DES/DDD
		130

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.	**LTC: Banner University Family Care** 21 **LTC: Mercy Care** 14 **LTC: APIPA dba UnitedHealthcare Community Plan** 10 **LTC: DES/DDD** 162
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.	**LTC: Banner University Family Care** 14 **LTC: Mercy Care** 21 **LTC: APIPA dba UnitedHealthcare Community Plan** 20 **LTC: DES/DDD** 578
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.	**LTC: Banner University Family Care** 29 **LTC: Mercy Care** 1 **LTC: APIPA dba UnitedHealthcare Community Plan** 0 **LTC: DES/DDD** 6

D1IV.16d	**Resolved grievances related to quality of care**	**LTC: Banner University Family Care**
		39
	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.	**LTC: Mercy Care**
		107
		LTC: APIPA dba UnitedHealthcare Community Plan
		611
		LTC: DES/DDD
		199

D1IV.16e	**Resolved grievances related to plan communications**	**LTC: Banner University Family Care**
		4
	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.	**LTC: Mercy Care**
		1
		LTC: APIPA dba UnitedHealthcare Community Plan
		1
		LTC: DES/DDD
		49

D1IV.16f	**Resolved grievances related to payment or billing issues**	**LTC: Banner University Family Care**
		13
	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.	**LTC: Mercy Care**
		29
		LTC: APIPA dba UnitedHealthcare Community Plan
		11
		LTC: DES/DDD
		77

D1IV.16g	**Resolved grievances related to suspected fraud**	**LTC: Banner University Family Care**
		0
	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	**LTC: Mercy Care**
		1
		LTC: APIPA dba UnitedHealthcare Community Plan
		0
		LTC: DES/DDD
		4

		to another entity, such as a state Ombudsman or Office of the Inspector General.

D1IV.16h | **Resolved grievances related to abuse, neglect or exploitation** | **LTC: Banner University Family Care**

13

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.

LTC: Mercy Care

13

LTC: APIPA dba UnitedHealthcare Community Plan

0

LTC: DES/DDD

174

D1IV.16i | **Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** | **LTC: Banner University Family Care**

1

Enter the total number of grievances resolved by the plan 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).

LTC: Mercy Care

0

LTC: APIPA dba UnitedHealthcare Community Plan

0

LTC: DES/DDD

1

D1IV.16j | **Resolved grievances related to plan denial of expedited appeal** | **LTC: Banner University Family Care**

0

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.

LTC: Mercy Care

1

LTC: APIPA dba UnitedHealthcare Community Plan

0

LTC: DES/DDD

1

D1IV.16k | **Resolved grievances filed for other reasons** | **LTC: Banner University Family Care**

502

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.

LTC: Mercy Care

635

LTC: APIPA dba UnitedHealthcare Community Plan

324

LTC: DES/DDD

159

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: 5

✓ Complete

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

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description
N/A

Measure results

LTC: Banner University Family Care
34.0

LTC: Mercy Care
44.3

LTC: APIPA dba UnitedHealthcare Community Plan
44.8

LTC: DES/DDD
54.4

✓ Complete

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

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description
N/A

Measure results

LTC: Banner University Family Care
N/A

LTC: Mercy Care
64.0

LTC: APIPA dba UnitedHealthcare Community Plan

N/A

LTC: DES/DDD

77.8

✅ Complete

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

3 / 5

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

LTC: Banner University Family Care

N/A

LTC: Mercy Care

N/A

LTC: APIPA dba UnitedHealthcare Community Plan

N/A

LTC: DES/DDD

63.3

✅ Complete

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

4 / 5

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

LTC: Banner University Family Care

N/A

LTC: Mercy Care

N/A

LTC: APIPA dba UnitedHealthcare Community Plan

42.7

LTC: DES/DDD

49.9

✓ Complete

D2.VII.1 Measure Name: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)   5 / 5

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number	**D2.VII.4 Measure Reporting and D2.VII.5 Programs**
0059	Program-specific rate

D2.VII.6 Measure Set	**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**
HEDIS	No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

LTC: Banner University Family Care

37.0

LTC: Mercy Care

23.4

LTC: APIPA dba UnitedHealthcare Community Plan

27.0

LTC: DES/DDD

20.6

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: 1

✅ **Complete**

D3.VIII.1 Intervention type: Civil monetary penalty   1 / 1

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

LTC: Mercy Care

D3.VIII.4 Reason for intervention

Aged Pended Encounters

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$355

D3.VIII.7 Date assessed

11/28/2022

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

No, no remediation

D3.VIII.9 Corrective action plan

No

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).	**LTC: Banner University Family Care** 1 **LTC: Mercy Care** 1 **LTC: APIPA dba UnitedHealthcare Community Plan** 1 **LTC: DES/DDD** 1
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**LTC: Banner University Family Care** N/A **LTC: Mercy Care** N/A **LTC: APIPA dba UnitedHealthcare Community Plan** N/A **LTC: DES/DDD** 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.	**LTC: Banner University Family Care** 0:0 **LTC: Mercy Care** 0:0 **LTC: APIPA dba UnitedHealthcare Community Plan** 0:0 **LTC: DES/DDD** 0:0
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**LTC: Banner University Family Care** N/A **LTC: Mercy Care** N/A **LTC: APIPA dba UnitedHealthcare Community Plan** N/A **LTC: DES/DDD**

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.

LTC: Banner University Family Care

0:0

LTC: Mercy Care

0:0

LTC: APIPA dba UnitedHealthcare Community Plan

0:0

LTC: DES/DDD

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.

LTC: Banner University Family Care

Makes some referrals to the SMA and others directly to the MFCU

LTC: Mercy Care

Makes some referrals to the SMA and others directly to the MFCU

LTC: APIPA dba UnitedHealthcare Community Plan

Makes some referrals to the SMA and others directly to the MFCU

LTC: DES/DDD

Makes some referrals to the SMA and others directly to the MFCU

D1X.7 | **Count of program integrity referrals to the state**

Enter the total number of program integrity referrals made during the reporting year.

LTC: Banner University Family Care

0

LTC: Mercy Care

3

LTC: APIPA dba UnitedHealthcare Community Plan

15

LTC: DES/DDD

66

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).

LTC: Banner University Family Care

0:0

LTC: Mercy Care

1:3,509

LTC: APIPA dba UnitedHealthcare Community Plan

	Express this as a ratio per 1,000 beneficiaries.	1:577
		LTC: DES/DDD 1:618

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, at minimum, 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 42 CFR 438.8(f)(2).	**LTC: Banner University Family Care** Data is not available at this time. **LTC: Mercy Care** Data is not available at this time. **LTC: APIPA dba UnitedHealthcare Community Plan** Data is not available at this time **LTC: DES/DDD** Data is not available at this time.

D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**LTC: Banner University Family Care** Daily **LTC: Mercy Care** Daily **LTC: APIPA dba UnitedHealthcare Community Plan** Daily **LTC: DES/DDD** Daily

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** Other, specify – Data is not available at this time.
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 – Data is not available at this time.