

# Managed Care Program Annual Report (MCPAR) for Wisconsin: Family Care

Due date	Last edited	Edited by	Status
06/29/2024	05/14/2024	Kimberly Schindler	Submitted

Indicator	Response
<b>Exclusion of CHIP from MCPAR</b>  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	<b>State name</b> Auto-populated from your account profile.	Wisconsin
A2a	<b>Contact name</b> 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.	Kimberly Schindler
A2b	<b>Contact email address</b> Enter email address. Department or program-wide email addresses ok.	DHSDMSLTC@dhs.wisconsin.gov
A3a	<b>Submitter name</b> CMS receives this data upon submission of this MCPAR report.	Kimberly Schindler
A3b	<b>Submitter email address</b> CMS receives this data upon submission of this MCPAR report.	Kimberly.Schindler@dhs.wisconsin.gov
A4	<b>Date of report submission</b> CMS receives this date upon submission of this MCPAR report.	06/24/2024

## Reporting Period

Number	Indicator	Response
A5a	<b>Reporting period start date</b> Auto-populated from report dashboard.	01/01/2023
A5b	<b>Reporting period end date</b> Auto-populated from report dashboard.	01/01/2024
A6	<b>Program name</b> Auto-populated from report dashboard.	Family Care

## 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	Community Care, Inc. (CCI)  Inclusa, Inc.  Lakeland Care, Inc.  My Choice Wisconsin, Inc. (MCW)

## 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 Independent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	Multi-location ADRC

## Section B: State-Level Indicators

### Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	<b>Statewide Medicaid enrollment</b>  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.	1,467,489
BI.2	<b>Statewide Medicaid managed care enrollment</b>  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.	1,095,234

## Topic III. Encounter Data Report

Number	Indicator	Response
<b>BIII.1</b>	<p><b>Data validation entity</b></p> <p>Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs.</p> <p>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.</p>	Other third-party vendor

## Topic X: Program Integrity

Number	Indicator	Response
<b>BX.1</b>	<p><b>Payment risks between the state and plans</b></p> <p>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.</p>	<p>Capitation payments against date of death reviews are completed. EVV soft launch to allow home visit supportive home care and personal care worker time validation. Will not conduct actual audits until hard launch and vendor compliance requirements are in place. Other data analytics and reviews will be implemented after the DHS MLTSS system rewrite that is in process goes live. Once implemented there will be the ability to scrub the data for targeted anomalies.</p>
<b>BX.2</b>	<p><b>Contract standard for overpayments</b></p> <p>Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.</p>	<p>State requires the return of overpayments</p>
<b>BX.3</b>	<p><b>Location of contract provision stating overpayment standard</b></p> <p>Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).</p>	<p>Art III.D.30, Art III.K.1.g, Art.XIV.C.4, Article XIV.C.5.g</p>
<b>BX.4</b>	<p><b>Description of overpayment contract standard</b></p> <p>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.</p>	<p>Include in Program Integrity Quarterly Reporting overpayments recovered and retained by MCO versus those returned to the SMA because the plan is not permitted to retain them, and identify those due to potential fraud</p>
<b>BX.5</b>	<p><b>State overpayment reporting monitoring</b></p>	<p>The SMA tracks satisfaction and timeliness of compliance with the reporting requirements.</p>

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.

<b>BX.6</b>	<b>Changes in beneficiary circumstances</b>  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).	This is an automated function in the Forward Health System and used to produce the monthly capitation. The plan reports enrollment changes such as deaths, incarcerations, and disenrollments to the local income maintenance agency. The data is updated in the system which then updates the SMA MMIS program to produce Capitation payments and capitation adjustments. Updates to the enrollee's functional screen and annual financial eligibility reviews or as required updates are used to maintain accurate enrollment records in the SMA MMIS
<b>BX.7a</b>	<b>Changes in provider circumstances: Monitoring plans</b>  Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	No
<b>BX.8a</b>	<b>Federal database checks: Excluded person or entities</b>  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	No



PCCM entity through routine checks of Federal databases.

<b>BX.9a</b>	<b>Website posting of 5 percent or more ownership control</b>  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).	Yes
<b>BX.9b</b>	<b>Website posting of 5 percent or more ownership control: Link</b>  What is the link to the website? Refer to 42 CFR 602(g)(3).	<a href="https://www.dhs.wisconsin.gov/familycare/mco/contacts.pdf">https://www.dhs.wisconsin.gov/familycare/mco/contacts.pdf</a>
<b>BX.10</b>	<b>Periodic audits</b>  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.	<a href="https://oci.wi.gov/Pages/Companies/FinExams.aspx">https://oci.wi.gov/Pages/Companies/FinExams.aspx</a>

## Section C: Program-Level Indicators

### Topic I: Program Characteristics

Number	Indicator	Response
C11.1	<b>Program contract</b> Enter the title of the contract between the state and plans participating in the managed care program.	Family Care Contract between Wisconsin Department of Health Division of Medicaid Services and & >; Amended January 1, 2023
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	1/1/2023
C11.2	<b>Contract URL</b> Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	<a href="https://www.dhs.wisconsin.gov/familycare/mcos/fc-fcp-2022-generic-final.pdf">https://www.dhs.wisconsin.gov/familycare/mcos/fc-fcp-2022-generic-final.pdf</a>
C11.3	<b>Program type</b> What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Prepaid Inpatient Health Plan (PIHP)
C11.4a	<b>Special program benefits</b> 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  Long-term services and supports (LTSS)  Transportation
C11.4b	<b>Variation in special benefits</b> 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
C11.5	<b>Program enrollment</b> Enter the average number of individuals enrolled in this managed care program per	53,415

month during the reporting year (i.e., average member months).

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**C1I.6**

**Changes to enrollment or benefits**

There were no major changes to the population or benefits during the reporting year.

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.

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## Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	<p><b>Uses of encounter data</b></p> <p>For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more.</p> <p>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)).</p>	<p>Rate setting</p> <p>Quality/performance measurement</p> <p>Monitoring and reporting</p> <p>Contract oversight</p> <p>Program integrity</p> <p>Policy making and decision support</p>
C1III.2	<p><b>Criteria/measures to evaluate MCP performance</b></p> <p>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.</p> <p>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).</p>	<p>Overall data accuracy (as determined through data validation)</p>
C1III.3	<p><b>Encounter data performance criteria contract language</b></p> <p>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.</p>	<p>Art. XIV.B</p>
C1III.4	<p><b>Financial penalties contract language</b></p> <p>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</p>	<p>Art. XIV.B.5 and XVI.G</p>

standards. Use contract section references, not page numbers.

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<b>C1III.5</b>	<b>Incentives for encounter data quality</b>  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
<b>C1III.6</b>	<b>Barriers to collecting/validating encounter data</b>  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.

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## Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	<p><b>State's definition of "critical incident," as used for reporting purposes in its MLTSS program</b></p> <p>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.</p>	<p>The MCO is required to report immediately to its DHS Member Care Quality Specialist any of the following: Upon learning a member's whereabouts are not known for 24 hours or more, under any of the following circumstances: The member is under guardianship/protective placement; The member has been identified as a vulnerable/high risk member as defined under Article I.144; The MCO has reason to believe that the member's health or safety is at risk; The member is a potential threat to the community or self; The member has a significant medical condition that would deteriorate without medications/care; The member lives in a residential facility; or The area is experiencing potentially life-threatening weather conditions. Upon learning a member has died under any of the following circumstances: Death involving unexplained, unusual, or suspicious circumstances; Death involving apparent abuse or neglect; Apparent homicide; Apparent suicide; Apparent poisoning; Contract for &amp; Program between the Wisconsin Department of Health Services, Division of Medicaid Services and &amp; Article V, Care Management Page 93 Apparent accident, whether the resulting injury is or is not the primary cause of death; or When a physician refuses to sign the death certificate. Upon learning a member has suffered or caused an injury or accident related to any of the following circumstances: When unexplained, unusual, or suspicious circumstances exist; When physical abuse, sexual abuse, or neglect exist; When the member has been poisoned; or When law enforcement, Adult Protective Services (APS), or a court of law have investigated and/or are involved; Upon learning a member has been admitted to a state IMD or Intensive Treatment Program (ITP). A list of both county and privately operated IMDs in Wisconsin can be found in section 27.11 of the Medicaid Eligibility Handbook. Upon learning that an Emergency Restrictive Measure, as defined in Wis. Stat. § 46.90(1)(i), was used on a member regardless of injury.</p>

<b>C1IV.2</b>	<p><b>State definition of "timely" resolution for standard appeals</b></p> <p>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.</p>	<p>Unless the member requests expedited resolution, for Family Care and Partnership the MCO must mail or hand-deliver a written decision on the appeal no later than thirty (30) calendar days after the date of receipt of the appeal.</p>
<b>C1IV.3</b>	<p><b>State definition of "timely" resolution for expedited appeals</b></p> <p>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.</p>	<p>The MCO must make reasonable efforts to give the member prompt oral notice of approval or denial of the request for expedited resolution and a written notice within two (2) calendar days.</p>
<b>C1IV.4</b>	<p><b>State definition of "timely" resolution for grievances</b></p> <p>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.</p>	<p>The MCO grievance and appeal committee for Family Care and Partnership Medicaid-only must mail or hand-deliver a written decision on a grievance to the member and the member's legal decision maker, if applicable, as expeditiously as the member's situation and health condition require, but no later than ninety (90) calendar days after the date of receipt of the grievance.</p>

## Topic V. Availability, Accessibility and Network Adequacy

### Network Adequacy

Number	Indicator	Response
C1V.1	<p><b>Gaps/challenges in network adequacy</b></p> <p>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.</p>	Two of the main challenges are limited numbers of providers in rural regions/counties, and the caregiver workforce shortage.
C1V.2	<p><b>State response to gaps in network adequacy</b></p> <p>How does the state work with MCPs to address gaps in network adequacy?</p>	<p>MCPs provided explanations on similar services that can be provided to meet member needs. For the caregiver workforce shortage, there have been rate increases provided through state and federal assistance with ARPA. The state is also implementing the Wiscaregiver career program which prepares job seekers to enter the caregiving workforce. The program teaches essential skills that direct care workers can use from one employer to another without the need for re-training. This will help employers officially recognize workers' skills and will help professionalize their career. The goal is to certify at least 10,000 new workers in the profession of direct care.</p>



## **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.



Complete

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

1 / 47

**C2.V.2 Measure standard**

For general equipment or supplies, no more than 30 business days from the time of service order. For highly specialized equipment and supplies, no more than 120 business days from the time of service order.

**C2.V.3 Standard type**

Service fulfillment

**C2.V.4 Provider**

LTSS assistive  
technology and  
communication aids

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

2 / 47

**C2.V.2 Measure standard**

1:225

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

LTSS-adult day care

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

3 / 47

### C2.V.2 Measure standard

1:200

### C2.V.3 Standard type

Provider to enrollee ratios

#### C2.V.4 Provider

AODA services  
(excluding inpatient  
or physician  
provided)

#### C2.V.5 Region

All counties

#### C2.V.6 Population

MLTSS

### C2.V.7 Monitoring Methods

Plan provider roster review

### C2.V.8 Frequency of oversight methods

Annually



Complete

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

4 / 47

### C2.V.2 Measure standard

1:200

### C2.V.3 Standard type

Provider to enrollee ratios

#### C2.V.4 Provider

AODA day treatment

#### C2.V.5 Region

All counties

#### C2.V.6 Population

MLTSS

### C2.V.7 Monitoring Methods

Plan provider roster review

### C2.V.8 Frequency of oversight methods

Annually



Complete

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

5 / 47

**C2.V.2 Measure standard**

1:150

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Mental health services (excluding inpatient, physician-provided, or comprehensive community services)

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

6 / 47

**C2.V.2 Measure standard**

1:150

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Mental health day treatment

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

7 / 47

**C2.V.2 Measure standard**

1:300

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Day habilitation  
services

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

8 / 47

**C2.V.2 Measure standard**

1:250

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Supported  
employment – small  
group employment  
support

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

9 / 47

**C2.V.2 Measure standard**

1:250

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Prevocational  
services

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

10 / 47

**C2.V.2 Measure standard**

1:350

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Community support  
program

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

11 / 47

**C2.V.2 Measure standard**

1:300

**C2.V.3 Standard type**

Provider to enrollee ratios

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

Counseling and  
therapeutic  
resources

All counties

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

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**C2.V.2 Measure standard**

1:250

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Home health  
services

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

13 / 47

**C2.V.2 Measure standard**

1:100

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Supportive home  
care

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

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**C2.V.2 Measure standard**

1:775

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Personal care

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

15 / 47

**C2.V.2 Measure standard**

1:775

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Self-directed  
personal care

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**



Annually



Complete

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

16 / 47

**C2.V.2 Measure standard**

1:400

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Respite

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

17 / 47

**C2.V.2 Measure standard**

1:200

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Occupational  
therapy

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

18 / 47

### **C2.V.2 Measure standard**

1:200

### **C2.V.3 Standard type**

Provider to enrollee ratios

#### **C2.V.4 Provider**

Physical therapy

#### **C2.V.5 Region**

All counties

#### **C2.V.6 Population**

MLTSS

### **C2.V.7 Monitoring Methods**

Plan provider roster review

### **C2.V.8 Frequency of oversight methods**

Annually



Complete

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

19 / 47

### **C2.V.2 Measure standard**

1:775

### **C2.V.3 Standard type**

Provider to enrollee ratios

#### **C2.V.4 Provider**

Skilled nursing  
services registered  
nurse/licensed  
practical nurse

#### **C2.V.5 Region**

All counties

#### **C2.V.6 Population**

MLTSS

### **C2.V.7 Monitoring Methods**

Plan provider roster review

### **C2.V.8 Frequency of oversight methods**

Annually



Complete

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

20 / 47

**C2.V.2 Measure standard**

1:775

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**Nursing (including  
intermittent and  
private duty)**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

21 / 47

**C2.V.2 Measure standard**

1:250

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**Supported  
employment –  
individual  
employment support**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

22 / 47

**C2.V.2 Measure standard**

1:150

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Transportation  
(specialized  
transportation) –  
other transportation

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

23 / 47

**C2.V.2 Measure standard**

1:150

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Transportation  
(excluding  
ambulance)

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

24 / 47

**C2.V.2 Measure standard**

1:150

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Transportation  
(specialized  
transportation) –  
community  
transportation

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

25 / 47

**C2.V.2 Measure standard**

1:1200

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Home-delivered  
meals

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

26 / 47

**C2.V.2 Measure standard**

1:900

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Financial  
management  
services

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

27 / 47

**C2.V.2 Measure standard**

1:900

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Consumer-directed  
supports (self-  
directed supports)  
broker

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

28 / 47

**C2.V.2 Measure standard**

1:75

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Adult residential care  
– 1-2 bed adult  
family homes

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

29 / 47

**C2.V.2 Measure standard**

1:75

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Adult residential care  
– 3-4 bed adult  
family homes

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

30 / 47

**C2.V.2 Measure standard**

1:200

**C2.V.3 Standard type**

Provider to enrollee ratios

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

Adult residential care   All counties   MLTSS  
– community-based  
residential facility

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



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

31 / 47

**C2.V.2 Measure standard**

1:300

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Adult residential care  
– residential care  
apartment complex

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



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

32 / 47

**C2.V.2 Measure standard**

1:350

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Nursing home stays  
(nursing home,

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS



institute for mental  
disease, and  
immediate care  
facility for individuals  
with intellectual  
disabilities)

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

33 / 47

**C2.V.2 Measure standard**

For general equipment or supplies, no more than 30 business days from the time of service order. For highly specialized equipment and supplies, no more than 120 business days from the time of service order.

**C2.V.3 Standard type**

Service fulfillment

**C2.V.4 Provider**

Durable medical  
equipment  
(excluding hearing  
aids, prosthetics, and  
family planning  
supplies)

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

34 / 47

**C2.V.2 Measure standard**

For general equipment or supplies, no more than 30 business days from the time of service order. For highly specialized equipment and supplies, no more than 120 business days from the time of service order.

### **C2.V.3 Standard type**

Service fulfillment

#### **C2.V.4 Provider**

Disposable medical  
supplies

#### **C2.V.5 Region**

All counties

#### **C2.V.6 Population**

MLTSS

### **C2.V.7 Monitoring Methods**

Plan provider roster review

### **C2.V.8 Frequency of oversight methods**

Annually



Complete

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

35 / 47

### **C2.V.2 Measure standard**

For general equipment or supplies, no more than 30 business days from the time of service order. For highly specialized equipment and supplies, no more than 120 business days from the time of service order.

### **C2.V.3 Standard type**

Service fulfillment

#### **C2.V.4 Provider**

Specialized medical  
equipment and  
supplies

#### **C2.V.5 Region**

All counties

#### **C2.V.6 Population**

MLTSS

### **C2.V.7 Monitoring Methods**

Plan provider roster review

### **C2.V.8 Frequency of oversight methods**

Annually



Complete

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

36 / 47

**C2.V.2 Measure standard**

For general equipment or supplies, no more than 30 business days from the time of service order. For highly specialized equipment and supplies, no more than 120 business days from the time of service order.

**C2.V.3 Standard type**

Service fulfillment

**C2.V.4 Provider**

Adaptive aids

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

37 / 47

**C2.V.2 Measure standard**

No more than 30 business days from time of service order.

**C2.V.3 Standard type**

Service fulfillment

**C2.V.4 Provider**

Personal emergency  
response systems  
services

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

38 / 47

**C2.V.2 Measure standard**

No more than 60 business days from time of service approval.

**C2.V.3 Standard type**

Service fulfillment

**C2.V.4 Provider**

Environmental  
accessibility  
adaptations (home  
modifications)

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

39 / 47

**C2.V.2 Measure standard**

1:200

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Daily living skills  
training

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

40 / 47

**C2.V.2 Measure standard**

No more than 60 business days from time of service approval

**C2.V.3 Standard type**

Service fulfillment

**C2.V.4 Provider**

Consultative clinical  
and therapeutic  
services for  
caregivers

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

41 / 47

**C2.V.2 Measure standard**

No more than 60 business days from time of service approval

**C2.V.3 Standard type**

Service fulfillment

**C2.V.4 Provider**

Consumer education  
and training

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

42 / 47

**C2.V.2 Measure standard**

No more than 60 business days from time of service approval

**C2.V.3 Standard type**

Service fulfillment

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

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

43 / 47

**C2.V.2 Measure standard**

No more than 60 business days from time of service approval

**C2.V.3 Standard type**

Service fulfillment

**C2.V.4 Provider**

Training services for  
unpaid caregivers

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

44 / 47

**C2.V.2 Measure standard**

No more than 60 business days from time of service approval

**C2.V.3 Standard type**

Service fulfillment

**C2.V.4 Provider**

Relocation services

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

45 / 47

**C2.V.2 Measure standard**

No more than 30 business days from time of service approval.

**C2.V.3 Standard type**

Service fulfillment

**C2.V.4 Provider**

Vocational futures  
planning and  
support

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

46 / 47

**C2.V.2 Measure standard**

1:200

**C2.V.3 Standard type**

Provider to enrollee ratios

**C2.V.4 Provider**

Speech and  
language pathology  
services (except in  
inpatient and  
hospital settings)

**C2.V.5 Region**

All counties

**C2.V.6 Population**

MLTSS

**C2.V.7 Monitoring Methods**

Plan provider roster review

**C2.V.8 Frequency of oversight methods**  
Annually



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

47 / 47

**C2.V.2 Measure standard**  
1:200

**C2.V.3 Standard type**  
Provider to enrollee ratios

**C2.V.4 Provider**  
Respiratory care

**C2.V.5 Region**  
All counties

**C2.V.6 Population**  
MLTSS

**C2.V.7 Monitoring Methods**  
Plan provider roster review

**C2.V.8 Frequency of oversight methods**  
Annually

**Topic IX: Beneficiary Support System (BSS)**



Number	Indicator	Response
C1IX.1	<b>BSS website</b>  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.	<a href="https://www.dhs.wisconsin.gov/adrc/index.htm">https://www.dhs.wisconsin.gov/adrc/index.htm</a>
C1IX.2	<b>BSS auxiliary aids and services</b>  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)? 42 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.	The ADRC must provide information and assistance to members of the target populations and their families, friends, caregivers, advocates and others who ask for assistance on their behalf. Information and assistance must be provided in a manner convenient to the customer including, but not limited to, being provided in-person in the customer's home or at the ADRC office as an appointment or walk-in, over the telephone, virtually, via email, or through written correspondence.
C1IX.3	<b>BSS LTSS program data</b>  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).	ADRCs identify the unmet needs of their customer populations, including unserved or underserved subgroups within the customer populations, and the types of services, facilities, or funding sources that are in short supply.
C1IX.4	<b>State evaluation of BSS entity performance</b>  What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	The State ADRC regional quality specialists evaluate the quality, effectiveness and efficiency of ADRC performance through a series of quality monitoring activities including; annual ADRC site visits, monthly contact with ADRC Directors, quarterly review of review required reports and customer data regarding ADRC service delivery, assuring new staff complete and pass options counseling training and required post-test, verify each options counselor has been observed at least once annually by a peer or supervisor, regularly review ADRC board meeting agendas, minutes, and supporting documents and individually reviewing, investigating and responding to ADRC complaints. The ADRC regional quality team identifies trends, issues, concerns, and best practices through these activities and addresses quality concerns through the provision of technical assistance, training,

## Topic X: Program Integrity

Number	Indicator	Response
C1X.3	<b>Prohibited affiliation disclosure</b>  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

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## Section D: Plan-Level Indicators

### Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	<b>Plan enrollment</b>  Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	<b>Community Care, Inc. (CCI)</b>
		13,952
		<b>Inclusa, Inc.</b>
		17,153
		<b>Lakeland Care, Inc.</b>
		7,331
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		14,979
D1I.2	<b>Plan share of Medicaid</b>  What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? <ul style="list-style-type: none"> <li>• Numerator: Plan enrollment (D1.I.1)</li> <li>• Denominator: Statewide Medicaid enrollment (B.I.1)</li> </ul>	<b>Community Care, Inc. (CCI)</b>
		1%
		<b>Inclusa, Inc.</b>
		1.2%
		<b>Lakeland Care, Inc.</b>
		0.5%
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		1%

<b>D1I.3</b>	<b>Plan share of any Medicaid managed care</b>	<b>Community Care, Inc. (CCI)</b>
	What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?	1.3%
	• Numerator: Plan enrollment (D1.I.1)	<b>Inclusa, Inc.</b>
	• Denominator: Statewide Medicaid managed care enrollment (B.I.2)	1.6%
		<b>Lakeland Care, Inc.</b>
		0.7%
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		1.4%

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## Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	<b>Medical Loss Ratio (MLR)</b>  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.	<b>Community Care, Inc. (CCI)</b>
		95%
		<b>Inclusa, Inc.</b>
		98%
		<b>Lakeland Care, Inc.</b>
		96%
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		95%
D1II.1b	<b>Level of aggregation</b>  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.	<b>Community Care, Inc. (CCI)</b>
		Program-specific regional
		<b>Inclusa, Inc.</b>
		Program-specific regional
		<b>Lakeland Care, Inc.</b>
		Program-specific regional
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		Program-specific regional
D1II.2	<b>Population specific MLR description</b>  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.	<b>Community Care, Inc. (CCI)</b>
		N/A
		<b>Inclusa, Inc.</b>
		N/A
		<b>Lakeland Care, Inc.</b>
		N/A
		<b>My Choice Wisconsin, Inc. (MCW)</b>

N/A

<b>D1II.3</b>	<b>MLR reporting period discrepancies</b>  Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	<b>Community Care, Inc. (CCI)</b> Yes
		<b>Inclusa, Inc.</b> Yes
		<b>Lakeland Care, Inc.</b> Yes
		<b>My Choice Wisconsin, Inc. (MCW)</b> Yes
<b>N/A</b>	Enter the start date.	<b>Community Care, Inc. (CCI)</b> 01/01/2022
		<b>Inclusa, Inc.</b> 01/01/2022
		<b>Lakeland Care, Inc.</b> 01/01/2022
		<b>My Choice Wisconsin, Inc. (MCW)</b> 01/01/2022
<b>N/A</b>	Enter the end date.	<b>Community Care, Inc. (CCI)</b> 12/31/2022
		<b>Inclusa, Inc.</b> 12/31/2022
		<b>Lakeland Care, Inc.</b> 12/31/2022
		<b>My Choice Wisconsin, Inc. (MCW)</b> 12/31/2022

**Topic III. Encounter Data**

Number	Indicator	Response
D1III.1	<b>Definition of timely encounter data submissions</b>  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.	<b>Community Care, Inc. (CCI)</b>  Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter.
		<b>Inclusa, Inc.</b>  Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter.
		<b>Lakeland Care, Inc.</b>  Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter.
		<b>My Choice Wisconsin, Inc. (MCW)</b>  Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter.
D1III.2	<b>Share of encounter data submissions that met state's timely submission requirements</b>  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.	<b>Community Care, Inc. (CCI)</b>  100%
		<b>Inclusa, Inc.</b>  94%
		<b>Lakeland Care, Inc.</b>  100%
		<b>My Choice Wisconsin, Inc. (MCW)</b>  81%
D1III.3	<b>Share of encounter data submissions that were HIPAA compliant</b>	<b>Community Care, Inc. (CCI)</b>  96%



What percent of the plan's encounter data submissions

**Inclusa, Inc.**

(submitted during the reporting year) met state requirements

99%

for HIPAA compliance?

If the state has not yet received encounter data submissions for

**Lakeland Care, Inc.**

the entire contract period when it submits this report, enter

97%

here percentage of encounter data submissions that were

**My Choice Wisconsin, Inc. (MCW)**

compliant out of the proportion received from the managed

95%

care plan for the reporting year.

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## Topic IV. Appeals, State Fair Hearings & Grievances

### Appeals Overview

Number	Indicator	Response
D1IV.1	<b>Appeals resolved (at the plan level)</b>	<b>Community Care, Inc. (CCI)</b>
	Enter the total number of appeals resolved during the reporting year.	73
	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.	<b>Inclusa, Inc.</b>
		20
		<b>Lakeland Care, Inc.</b>
		8
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		47
D1IV.2	<b>Active appeals</b>	<b>Community Care, Inc. (CCI)</b>
	Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	2
		<b>Inclusa, Inc.</b>
		4
		<b>Lakeland Care, Inc.</b>
		0
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		2
D1IV.3	<b>Appeals filed on behalf of LTSS users</b>	<b>Community Care, Inc. (CCI)</b>
	Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable.	75
	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).	<b>Inclusa, Inc.</b>
		24
		<b>Lakeland Care, Inc.</b>
		8
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		49

<b>D1IV.4</b>	<b>Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal</b>	<p><b>Community Care, Inc. (CCI)</b></p> <p>0</p> <p><b>Inclusa, Inc.</b></p> <p>0</p> <p><b>Lakeland Care, Inc.</b></p> <p>0</p> <p><b>My Choice Wisconsin, Inc. (MCW)</b></p> <p>0</p>
	<p>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".</p> <p>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".</p> <p>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.</p> <p>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.</p>	

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<b>D1IV.5a</b>	<b>Standard appeals for which timely resolution was provided</b>	<p><b>Community Care, Inc. (CCI)</b></p> <p>73</p> <p><b>Inclusa, Inc.</b></p> <p>20</p>
	<p>Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year.</p> <p>See 42 CFR §438.408(b)(2) for</p>	

requirements related to timely resolution of standard appeals.

**Lakeland Care, Inc.**

8

**My Choice Wisconsin, Inc. (MCW)**

47

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**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.

**Community Care, Inc. (CCI)**

0

**Inclusa, Inc.**

0

**Lakeland Care, Inc.**

0

**My Choice Wisconsin, Inc. (MCW)**

0

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**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).

**Community Care, Inc. (CCI)**

15

**Inclusa, Inc.**

7

**Lakeland Care, Inc.**

1

**My Choice Wisconsin, Inc. (MCW)**

7

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**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.

**Community Care, Inc. (CCI)**

45

**Inclusa, Inc.**

11

**Lakeland Care, Inc.**

2

<b>D1IV.6c</b>	<b>Resolved appeals related to payment denial</b>  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.	<b>Community Care, Inc. (CCI)</b>  0  <b>Inclusa, Inc.</b>  0  <b>Lakeland Care, Inc.</b>  0  <b>My Choice Wisconsin, Inc. (MCW)</b>  0
<b>D1IV.6d</b>	<b>Resolved appeals related to service timeliness</b>  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).	<b>Community Care, Inc. (CCI)</b>  0  <b>Inclusa, Inc.</b>  0  <b>Lakeland Care, Inc.</b>  0  <b>My Choice Wisconsin, Inc. (MCW)</b>  0
<b>D1IV.6e</b>	<b>Resolved appeals related to lack of timely plan response to an appeal or grievance</b>  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.	<b>Community Care, Inc. (CCI)</b>  0  <b>Inclusa, Inc.</b>  0  <b>Lakeland Care, Inc.</b>  0  <b>My Choice Wisconsin, Inc. (MCW)</b>

<b>D1IV.6f</b>	<b>Resolved appeals related to plan denial of an enrollee's right to request out-of-network care</b>	<b>Community Care, Inc. (CCI)</b>
		0
	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).	<b>Inclusa, Inc.</b>
		0
		<b>Lakeland Care, Inc.</b>
		0
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		0
<b>D1IV.6g</b>	<b>Resolved appeals related to denial of an enrollee's request to dispute financial liability</b>	<b>Community Care, Inc. (CCI)</b>
		13
	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.	<b>Inclusa, Inc.</b>
		1
		<b>Lakeland Care, Inc.</b>
		1
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		3

## 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	<b>Resolved appeals related to general inpatient services</b>  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".	<b>Community Care, Inc. (CCI)</b>
		N/A
		<b>Inclusa, Inc.</b>
		N/A
		<b>Lakeland Care, Inc.</b>
D1IV.7b	<b>Resolved appeals related to general outpatient services</b>  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".	<b>Community Care, Inc. (CCI)</b>
		0
		<b>Inclusa, Inc.</b>
		0
		<b>Lakeland Care, Inc.</b>
D1IV.7c	<b>Resolved appeals related to inpatient behavioral health services</b>  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".	<b>Community Care, Inc. (CCI)</b>
		N/A
		<b>Inclusa, Inc.</b>
		N/A
		<b>Lakeland Care, Inc.</b>
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		N/A

<b>D1IV.7d</b>	<p><b>Resolved appeals related to outpatient behavioral health services</b></p> <p>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".</p>	<p><b>Community Care, Inc. (CCI)</b></p> <p>0</p> <p><b>Inclusa, Inc.</b></p> <p>0</p> <p><b>Lakeland Care, Inc.</b></p> <p>0</p> <p><b>My Choice Wisconsin, Inc. (MCW)</b></p> <p>0</p>
<b>D1IV.7e</b>	<p><b>Resolved appeals related to covered outpatient prescription drugs</b></p> <p>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".</p>	<p><b>Community Care, Inc. (CCI)</b></p> <p>N/A</p> <p><b>Inclusa, Inc.</b></p> <p>N/A</p> <p><b>Lakeland Care, Inc.</b></p> <p>N/A</p> <p><b>My Choice Wisconsin, Inc. (MCW)</b></p> <p>N/A</p>
<b>D1IV.7f</b>	<p><b>Resolved appeals related to skilled nursing facility (SNF) services</b></p> <p>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".</p>	<p><b>Community Care, Inc. (CCI)</b></p> <p>4</p> <p><b>Inclusa, Inc.</b></p> <p>5</p> <p><b>Lakeland Care, Inc.</b></p> <p>0</p> <p><b>My Choice Wisconsin, Inc. (MCW)</b></p> <p>7</p>
<b>D1IV.7g</b>	<p><b>Resolved appeals related to long-term services and</b></p>	<p><b>Community Care, Inc. (CCI)</b></p>



	<b>supports (LTSS)</b>  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".	7  <b>Inclusa, Inc.</b> 11  <b>Lakeland Care, Inc.</b> 2  <b>My Choice Wisconsin, Inc. (MCW)</b> 9
<b>D1IV.7h</b>	<b>Resolved appeals related to dental services</b>  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".	<b>Community Care, Inc. (CCI)</b> N/A  <b>Inclusa, Inc.</b> N/A  <b>Lakeland Care, Inc.</b> N/A  <b>My Choice Wisconsin, Inc. (MCW)</b> N/A
<b>D1IV.7i</b>	<b>Resolved appeals related to non-emergency medical transportation (NEMT)</b>  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".	<b>Community Care, Inc. (CCI)</b> N/A  <b>Inclusa, Inc.</b> N/A  <b>Lakeland Care, Inc.</b> N/A  <b>My Choice Wisconsin, Inc. (MCW)</b> N/A
<b>D1IV.7j</b>	<b>Resolved appeals related to other service types</b>  Enter the total number of appeals resolved by the plan during the reporting year that	<b>Community Care, Inc. (CCI)</b> 0

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".

**Inclusa, Inc.**

2

**Lakeland Care, Inc.**

1

**My Choice Wisconsin, Inc. (MCW)**

4

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## State Fair Hearings

Number	Indicator	Response
<b>D1IV.8a</b>	<b>State Fair Hearing requests</b>  Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	<b>Community Care, Inc. (CCI)</b>  16
		<b>Inclusa, Inc.</b>  11
		<b>Lakeland Care, Inc.</b>  7
		<b>My Choice Wisconsin, Inc. (MCW)</b>  38
<b>D1IV.8b</b>	<b>State Fair Hearings resulting in a favorable decision for the enrollee</b>  Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	<b>Community Care, Inc. (CCI)</b>  2
		<b>Inclusa, Inc.</b>  2
		<b>Lakeland Care, Inc.</b>  1
		<b>My Choice Wisconsin, Inc. (MCW)</b>  5
<b>D1IV.8c</b>	<b>State Fair Hearings resulting in an adverse decision for the enrollee</b>  Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	<b>Community Care, Inc. (CCI)</b>  6
		<b>Inclusa, Inc.</b>  8
		<b>Lakeland Care, Inc.</b>  4
		<b>My Choice Wisconsin, Inc. (MCW)</b>  10

<b>D1IV.8d</b>	<p><b>State Fair Hearings retracted prior to reaching a decision</b></p> <p>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.</p>	<p><b>Community Care, Inc. (CCI)</b></p> <p>8</p> <p><b>Inclusa, Inc.</b></p> <p>1</p> <p><b>Lakeland Care, Inc.</b></p> <p>2</p> <p><b>My Choice Wisconsin, Inc. (MCW)</b></p> <p>23</p>
<b>D1IV.9a</b>	<p><b>External Medical Reviews resulting in a favorable decision for the enrollee</b></p> <p>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).</p>	<p><b>Community Care, Inc. (CCI)</b></p> <p>N/A</p> <p><b>Inclusa, Inc.</b></p> <p>N/A</p> <p><b>Lakeland Care, Inc.</b></p> <p>N/A</p> <p><b>My Choice Wisconsin, Inc. (MCW)</b></p> <p>N/A</p>
<b>D1IV.9b</b>	<p><b>External Medical Reviews resulting in an adverse decision for the enrollee</b></p> <p>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).</p>	<p><b>Community Care, Inc. (CCI)</b></p> <p>N/A</p> <p><b>Inclusa, Inc.</b></p> <p>N/A</p> <p><b>Lakeland Care, Inc.</b></p> <p>N/A</p> <p><b>My Choice Wisconsin, Inc. (MCW)</b></p> <p>N/A</p>

# Grievances Overview

Number	Indicator	Response
D1IV.10	<b>Grievances resolved</b>  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.	<b>Community Care, Inc. (CCI)</b>
		51
		<b>Inclusa, Inc.</b>
		37
		<b>Lakeland Care, Inc.</b>
		17
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		32
D1IV.11	<b>Active grievances</b>  Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	<b>Community Care, Inc. (CCI)</b>
		0
		<b>Inclusa, Inc.</b>
		1
		<b>Lakeland Care, Inc.</b>
		0
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		0
D1IV.12	<b>Grievances filed on behalf of LTSS users</b>  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.	<b>Community Care, Inc. (CCI)</b>
		51
		<b>Inclusa, Inc.</b>
		38
		<b>Lakeland Care, Inc.</b>
		17
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		32

<b>D1IV.13</b>	<b>Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance</b>	<b>Community Care, Inc. (CCI)</b>
		0
		<b>Inclusa, Inc.</b>
		0
		<b>Lakeland Care, Inc.</b>
		0
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		0

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 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.

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**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.

**Community Care, Inc. (CCI)**

51

**Inclusa, Inc.**

37

**Lakeland Care, Inc.**

17

**My Choice Wisconsin, Inc. (MCW)**

32

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## Grievances by Service

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



Number	Indicator	Response
D1IV.15a	<b>Resolved grievances related to general inpatient services</b>  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".	<b>Community Care, Inc. (CCI)</b> N/A
		<b>Inclusa, Inc.</b> N/A
		<b>Lakeland Care, Inc.</b> N/A
		<b>My Choice Wisconsin, Inc. (MCW)</b> N/A
D1IV.15b	<b>Resolved grievances related to general outpatient services</b>  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".	<b>Community Care, Inc. (CCI)</b> 0
		<b>Inclusa, Inc.</b> 0
		<b>Lakeland Care, Inc.</b> 0
		<b>My Choice Wisconsin, Inc. (MCW)</b> 0
D1IV.15c	<b>Resolved grievances related to inpatient behavioral health services</b>  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".	<b>Community Care, Inc. (CCI)</b> N/A
		<b>Inclusa, Inc.</b> N/A
		<b>Lakeland Care, Inc.</b> N/A
		<b>My Choice Wisconsin, Inc. (MCW)</b> N/A

<b>D1IV.15d</b>	<b>Resolved grievances related to outpatient behavioral health services</b>  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".	<b>Community Care, Inc. (CCI)</b>  0  <b>Inclusa, Inc.</b>  0  <b>Lakeland Care, Inc.</b>  0  <b>My Choice Wisconsin, Inc. (MCW)</b>  1
<b>D1IV.15e</b>	<b>Resolved grievances related to coverage of outpatient prescription drugs</b>  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".	<b>Community Care, Inc. (CCI)</b>  N/A  <b>Inclusa, Inc.</b>  N/A  <b>Lakeland Care, Inc.</b>  N/A  <b>My Choice Wisconsin, Inc. (MCW)</b>  N/A
<b>D1IV.15f</b>	<b>Resolved grievances related to skilled nursing facility (SNF) services</b>  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".	<b>Community Care, Inc. (CCI)</b>  0  <b>Inclusa, Inc.</b>  7  <b>Lakeland Care, Inc.</b>  1  <b>My Choice Wisconsin, Inc. (MCW)</b>  4
<b>D1IV.15g</b>	<b>Resolved grievances related to long-term services and</b>	<b>Community Care, Inc. (CCI)</b>

	<b>supports (LTSS)</b>  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".	46  <b>Inclusa, Inc.</b> 25  <b>Lakeland Care, Inc.</b> 16  <b>My Choice Wisconsin, Inc. (MCW)</b> 27
<b>D1IV.15h</b>	<b>Resolved grievances related to dental services</b>  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".	<b>Community Care, Inc. (CCI)</b> N/A  <b>Inclusa, Inc.</b> N/A  <b>Lakeland Care, Inc.</b> N/A  <b>My Choice Wisconsin, Inc. (MCW)</b> N/A
<b>D1IV.15i</b>	<b>Resolved grievances related to non-emergency medical transportation (NEMT)</b>  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".	<b>Community Care, Inc. (CCI)</b> 0  <b>Inclusa, Inc.</b> 0  <b>Lakeland Care, Inc.</b> 0  <b>My Choice Wisconsin, Inc. (MCW)</b> 0
<b>D1IV.15j</b>	<b>Resolved grievances related to other service types</b>  Enter the total number of grievances resolved by the plan during the reporting year that	<b>Community Care, Inc. (CCI)</b> 5

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".

**Inclusa, Inc.**

5

**Lakeland Care, Inc.**

0

**My Choice Wisconsin, Inc. (MCW)**

0

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## Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	<b>Resolved grievances related to plan or provider customer service</b>	<b>Community Care, Inc. (CCI)</b> 35
	Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service.	<b>Inclusa, Inc.</b> 15
	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.	<b>Lakeland Care, Inc.</b> 2
		<b>My Choice Wisconsin, Inc. (MCW)</b> 16
D1IV.16b	<b>Resolved grievances related to plan or provider care management/case management</b>	<b>Community Care, Inc. (CCI)</b> 10
	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.	<b>Inclusa, Inc.</b> 5
	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.	<b>Lakeland Care, Inc.</b> 11
		<b>My Choice Wisconsin, Inc. (MCW)</b> 7

<b>D1IV.16c</b>	<p><b>Resolved grievances related to access to care/services from plan or provider</b></p> <p>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.</p>	<p><b>Community Care, Inc. (CCI)</b></p> <p>2</p> <p><b>Inclusa, Inc.</b></p> <p>5</p> <p><b>Lakeland Care, Inc.</b></p> <p>1</p> <p><b>My Choice Wisconsin, Inc. (MCW)</b></p> <p>1</p>
<b>D1IV.16d</b>	<p><b>Resolved grievances related to quality of care</b></p> <p>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.</p>	<p><b>Community Care, Inc. (CCI)</b></p> <p>11</p> <p><b>Inclusa, Inc.</b></p> <p>5</p> <p><b>Lakeland Care, Inc.</b></p> <p>3</p> <p><b>My Choice Wisconsin, Inc. (MCW)</b></p> <p>5</p>
<b>D1IV.16e</b>	<p><b>Resolved grievances related to plan communications</b></p> <p>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.</p>	<p><b>Community Care, Inc. (CCI)</b></p> <p>15</p> <p><b>Inclusa, Inc.</b></p> <p>0</p> <p><b>Lakeland Care, Inc.</b></p> <p>0</p> <p><b>My Choice Wisconsin, Inc. (MCW)</b></p> <p>3</p>

<b>D1IV.16f</b>	<b>Resolved grievances related to payment or billing issues</b>  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.	<b>Community Care, Inc. (CCI)</b> 0  <b>Inclusa, Inc.</b> 7  <b>Lakeland Care, Inc.</b> 0  <b>My Choice Wisconsin, Inc. (MCW)</b> 0
<b>D1IV.16g</b>	<b>Resolved grievances related to suspected fraud</b>  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 perpetrated 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.	<b>Community Care, Inc. (CCI)</b> 0  <b>Inclusa, Inc.</b> 0  <b>Lakeland Care, Inc.</b> 0  <b>My Choice Wisconsin, Inc. (MCW)</b> 0
<b>D1IV.16h</b>	<b>Resolved grievances related to abuse, neglect or exploitation</b>  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.	<b>Community Care, Inc. (CCI)</b> 0  <b>Inclusa, Inc.</b> 0  <b>Lakeland Care, Inc.</b> 0  <b>My Choice Wisconsin, Inc. (MCW)</b>

<b>D1IV.16i</b>	<b>Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)</b>	<b>Community Care, Inc. (CCI)</b> 0  <b>Inclusa, Inc.</b> 0  <b>Lakeland Care, Inc.</b> 0  <b>My Choice Wisconsin, Inc. (MCW)</b> 0
<b>D1IV.16j</b>	<b>Resolved grievances related to plan denial of expedited appeal</b>	<b>Community Care, Inc. (CCI)</b> 1  <b>Inclusa, Inc.</b> 5  <b>Lakeland Care, Inc.</b> 3  <b>My Choice Wisconsin, Inc. (MCW)</b> 1
<b>D1IV.16k</b>	<b>Resolved grievances filed for other reasons</b>	<b>Community Care, Inc. (CCI)</b> 0  <b>Inclusa, Inc.</b> 0  <b>Lakeland Care, Inc.</b> 0



## **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.



Complete

## D2.VII.1 Measure Name: Competitive Integrated Employment (CIE)

1 / 1

### D2.VII.2 Measure Domain

Long-term services and supports

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

N/A

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

Cross-program rate: Family Care, Family Care Partnership

### D2.VII.6 Measure Set

State-specific

### 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

% Increase in number of members in CIE from Q1 to Q4 of 2022

### Measure results

#### Community Care, Inc. (CCI)

6.94%

#### Inclusa, Inc.

11.20%

#### Lakeland Care, Inc.

17.16%

#### My Choice Wisconsin, Inc. (MCW)

15.17%

## 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.



Complete

**D3.VIII.1 Intervention type: Corrective action plan**

1 / 2

**D3.VIII.2 Intervention topic**      **D3.VIII.3 Plan name**

Performance  
improvement

Inclusa, Inc.

**D3.VIII.4 Reason for intervention**

Failure to meet quality standards and performance criteria under Article V.J. of the contract and under Inclusa's DHS approved Member Safety and Risk Policy and Procedure. These failures resulted in member's exposure to substantial risk of harm.

**Sanction details****D3.VIII.5 Instances of non-compliance**

1

**D3.VIII.6 Sanction amount**

N/A

**D3.VIII.7 Date assessed**

03/24/2023

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

Remediation in progress

**D3.VIII.9 Corrective action plan**

Yes



Complete

**D3.VIII.1 Intervention type: Corrective action plan**

2 / 2

**D3.VIII.2 Intervention topic**      **D3.VIII.3 Plan name**

Performance  
improvement

Community Care, Inc. (CCI)

**D3.VIII.4 Reason for intervention**

Failure to meet quality standards and performance criteria under Article V.J. of the contract and under Inclusa's DHS approved Member Safety and Risk Policy and Procedure. These failures resulted in member's exposure to substantial risk of harm.

**Sanction details****D3.VIII.5 Instances of non-compliance**

1

**D3.VIII.6 Sanction amount**

N/A

**D3.VIII.7 Date assessed**

12/14/2023

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

Remediation in progress

**D3.VIII.9 Corrective action plan**

No

## Topic X. Program Integrity

Number	Indicator	Response
D1X.1	<b>Dedicated program integrity staff</b>  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).	<b>Community Care, Inc. (CCI)</b>  1
		<b>Inclusa, Inc.</b>  5
		<b>Lakeland Care, Inc.</b>  3
		<b>My Choice Wisconsin, Inc. (MCW)</b>  1
D1X.2	<b>Count of opened program integrity investigations</b>  How many program integrity investigations were opened by the plan during the reporting year?	<b>Community Care, Inc. (CCI)</b>  25
		<b>Inclusa, Inc.</b>  46
		<b>Lakeland Care, Inc.</b>  3
		<b>My Choice Wisconsin, Inc. (MCW)</b>  5
D1X.3	<b>Ratio of opened program integrity investigations to enrollees</b>  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.	<b>Community Care, Inc. (CCI)</b>  1.79:1,000
		<b>Inclusa, Inc.</b>  2.68:1,000
		<b>Lakeland Care, Inc.</b>  0.41:1,000
		<b>My Choice Wisconsin, Inc. (MCW)</b>  0.33:1,000

<b>D1X.4</b>	<b>Count of resolved program integrity investigations</b>  How many program integrity investigations were resolved by the plan during the reporting year?	<b>Community Care, Inc. (CCI)</b>  22
		<b>Inclusa, Inc.</b>  15
		<b>Lakeland Care, Inc.</b>  20
		<b>My Choice Wisconsin, Inc. (MCW)</b>  5
<b>D1X.5</b>	<b>Ratio of resolved program integrity investigations to enrollees</b>  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.	<b>Community Care, Inc. (CCI)</b>  1.58:1,000
		<b>Inclusa, Inc.</b>  0.87:1,000
		<b>Lakeland Care, Inc.</b>  2.73:1,000
		<b>My Choice Wisconsin, Inc. (MCW)</b>  0.33:1,000
<b>D1X.6</b>	<b>Referral path for program integrity referrals to the state</b>  What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	<b>Community Care, Inc. (CCI)</b>  Makes some referrals to the SMA and others directly to the MFCU
		<b>Inclusa, Inc.</b>  Makes some referrals to the SMA and others directly to the MFCU
		<b>Lakeland Care, Inc.</b>  Makes some referrals to the SMA and others directly to the MFCU
		<b>My Choice Wisconsin, Inc. (MCW)</b>

<b>D1X.7</b>	<b>Count of program integrity referrals to the state</b>	<b>Community Care, Inc. (CCI)</b>
	Enter the total number of program integrity referrals made during the reporting year.	2
		<b>Inclusa, Inc.</b>
		2
		<b>Lakeland Care, Inc.</b>
		22
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		0
<b>D1X.8</b>	<b>Ratio of program integrity referral to the state</b>	<b>Community Care, Inc. (CCI)</b>
	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.	0.14:1,000
		<b>Inclusa, Inc.</b>
		0.12:1,000
		<b>Lakeland Care, Inc.</b>
		3:1,000
		<b>My Choice Wisconsin, Inc. (MCW)</b>
		0:1,000
<b>D1X.9</b>	<b>Plan overpayment reporting to the state</b>	<b>Community Care, Inc. (CCI)</b>
	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: <ul style="list-style-type: none"><li>• The date of the report (rating period or calendar year).</li><li>• The dollar amount of overpayments recovered.</li><li>• 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).</li></ul>	""1/1/23-12/31/23 \$644,207,369 Recovered Ratio = 0.0003""
		<b>Inclusa, Inc.</b>
		""1/1/22-12/31/22 \$1,662,345 Recovered Ratio = 0.0022""
		<b>Lakeland Care, Inc.</b>
		""1/1/23-12/31/23 \$4,017,087 Recovered Ratio = 0.0120""



**My Choice Wisconsin, Inc. (MCW)**

""1/1/23-12/31/23 \$2,269,708 Recovered Ratio  
= 0.0033""

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**D1X.10**

**Changes in beneficiary  
circumstances**

Select the frequency the plan  
reports changes in beneficiary  
circumstances to the state.

**Community Care, Inc. (CCI)**

Daily

**Inclusa, Inc.**

Daily

**Lakeland Care, Inc.**

Daily

**My Choice Wisconsin, Inc. (MCW)**

Daily

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## **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
<b>EIX.1</b>	<b>BSS entity type</b>  What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	<b>Multi-location ADRC</b>  Aging and Disability Resource Network (ADRN)
<b>EIX.2</b>	<b>BSS entity role</b>  What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	<b>Multi-location ADRC</b>  Enrollment Broker/Choice Counseling