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

Due date	Last edited	Edited by	Status
06/29/2023	06/20/2023	Kimberly Schindler	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

Point of Contact

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Wisconsin
A2a	**Contact name** First and last name of the contact person.	Kimberly Schindler

	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.	
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	DHSDMSLTC@dhs.wisconsin.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Kimberly Schindler
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	Kimberly.Schindler@dhs.wisconsin.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/20/2023

Reporting Period

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2022
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2022
A6	**Program name** Auto-populated from report dashboard.	Family Care Partnership

Add plans (A.7)

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

Find in the Excel Workbook
A_Program_Info

Indicator	Response
Plan name	Community Care, Inc (CCI)
	Independent Health Plan (iCare)
	My Choice Wisconsin (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 Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Find in the Excel Workbook
A_Program_Info

Indicator	Response
BSS entity name	Multi-location ADRC

Topic I. Program Characteristics and Enrollment

Find in the Excel Workbook
B_State

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,637,616
BI.2	**Statewide Medicaid managed care enrollment** Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.	1,192,574

Topic III. Encounter Data Report

Find in the Excel Workbook
B_State

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	State Medicaid agency staff Other third-party vendor

		Glossary in Excel Workbook for more information.

Topic X: Program Integrity

Find in the Excel Workbook
B_State

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.	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 anomilies.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State requires the return of overpayments
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in	Art III.D.30, Art III.K.1.g, Art.XIV.C.4, Article XIV.C.5.g

	plan contracts, as required by 42 CFR 438.608(d)(1)(i).	
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.	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.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The SMA tracks satisfaction and timeliness of compliance with the reporting requirement.
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).	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 programed 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.

BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and 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).	Yes

BX.9b	**Website posting of 5 percent or more ownership control: Link** What is the link to the website? Refer to 42 CFR 602(g)(3).	https://www.dhs.wisconsin.gov/familycare/mcocontacts.pdf
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	https://oci.wi.gov/Pages/Companies/FinExams.aspx

Topic I: Program Characteristics

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1I.1	**Program contract** 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 <>. Issued January 1, 2022
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2022
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.dhs.wisconsin.gov/familycare/mcos/fc-fcp-2022-generic-final.pdf
C1I.3	**Program type**	Managed Care Organization (MCO)

	What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	
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 Long-term services and supports (LTSS) Dental Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1I.5	**Program enrollment** Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	3710
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	No major changes.

Topic III: Encounter Data Report

Find in the Excel Workbook

C1_Program_Set

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	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.	Art. XIV.B
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	Art. XIV.B.5 and XVI.E.2

	failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	
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.	Incentives are not awarded to managed care plans for encouter data quality.
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	None.

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
C1_Program_Set

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.	Member's whereabouts are not known for 24 hours or more, under any of the following circumstances: i. The member is under guardianship/protective placement; ii. The member has been identified as a vulnerable/high risk member as defined under Article I.139; iii. The MCO has reason to believe that the member's health or safety is at risk; iv. The member is a potential threat to the community or self; v. The member has a significant medical condition that would deteriorate without medications/care; vi. The member lives in a residential facility; or vii. The area is experiencing potentially life-threatening weather conditions. Member has died under any of the following circumstances: i. Death involving unexplained, unusual, or suspicious circumstances; ii. Death involving apparent abuse or neglect; iii. Apparent homicide; iv.

		Apparent suicide; v. Apparent poisoning; vi. Apparent accident, whether the resulting injury is or is not the primary cause of death; or vii. When a physician refuses to sign the death certificate. Member has suffered or caused an injury or accident related to any of the following circumstances: i. When unexplained, unusual, or suspicious circumstances exist; ii. When physical abuse, sexual abuse, or neglect exist; iii. When the member has been poisoned; or iv. When law enforcement or a court of law have investigated and/or are involved;
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.	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.
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 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.
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 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.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	Two of the main challenges are limited numbers of providers in rural regions/counties, and the caregiver workforce shortage.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	MCPs report on counties served, rather than counties the providers are located in. MCPs also provide 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 and HCBS rates. 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.

Topic V. Availability, Accessibility and Network Adequacy

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.

Find in the Excel Workbook
C2_Program_State

Access measure total count: 99

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 1 / 99

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	C2.V.5 Region	C2.V.6 Population
LTSS assistive technology	Urban	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 / 99

C2.V.2 Measure standard

1:225

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-adult day care	Urban	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 / 99

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
AODA services (excluding inpatient or physician provided)	Urban	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 / 99

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

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

AODA day treatment	Urban	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 / 99

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Mental health services (excluding inpatient, physician-provided, or comprehensive community services)	Urban	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 / 99

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

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

Mental health day treatment

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 / 99

C2.V.2 Measure standard

1:275

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Day habilitation services	Urban	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 / 99

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
Supported employment – small group employment support	Urban	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 / 99

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
Prevocational services	Urban	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 / 99

C2.V.2 Measure standard

1:1500

C2.V.3 Standard type

Provider to enrollee ratios

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

Community support program	Urban	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 / 99

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	Urban	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

12 / 99

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Home health services	Urban	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 / 99

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Supportive home care	Urban	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

14 / 99

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Personal care	Urban	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 / 99

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Self-directed personal care	Urban	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 / 99

C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Respite	Urban	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 / 99

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
Occupational therapy	Urban	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 / 99

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
Physical therapy	Urban	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 / 99

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Skilled nursing services registered nurse/licensed practical nurse	Urban	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 / 99

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Nursing (including intermittent and private duty)	Urban	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 / 99

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
Supported employment – individual employment support	Urban	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 / 99

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Transportation (specialized transportation) – other transportation	Urban	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 / 99

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Transportation (excluding ambulance)	Urban	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 / 99

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Transportation (specialized transportation) – community transportation	Urban	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 / 99

C2.V.2 Measure standard

1:1200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Home-delivered meals	Urban	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 / 99

C2.V.2 Measure standard

1:900

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Financial management services	Urban	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 / 99

C2.V.2 Measure standard

1:900

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Consumer-directed supports (self-directed supports) broker	Urban	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 / 99

C2.V.2 Measure standard

1:50

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Adult residential care – 1-2 bed adult family homes	Urban	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 / 99

C2.V.2 Measure standard

1:50

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Adult residential care – 3-4 bed adult family homes	Urban	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 / 99

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 – community-based residential facility	Urban	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

31 / 99

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

Adult residential care – residential care apartment complex	Urban	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

32 / 99

C2.V.2 Measure standard

1:350

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Nursing home stays (nursing home, institute for mental disease, and immediate care facility for individuals with intellectual disabilities)	Urban	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

33 / 99

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	C2.V.5 Region	C2.V.6 Population
Durable medical equipment (excluding hearing aids, prosthetics, and family planning supplies)	Urban	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 / 99

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	C2.V.5 Region	C2.V.6 Population
Disposable medical supplies	Urban	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 / 99

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	C2.V.5 Region	C2.V.6 Population
Specialized medical equipment and supplies	Urban	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 / 99

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	C2.V.5 Region	C2.V.6 Population
Adaptive aids	Urban	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 / 99

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	C2.V.5 Region	C2.V.6 Population
Personal emergency response systems services	Urban	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 / 99

C2.V.2 Measure standard

No more than 60 - 90 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
Environmental accessibility adaptations (home modifications)	Urban	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 / 99

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
Daily living skills training	Urban	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 / 99

C2.V.2 Measure standard

No more than 60 business days from time of service approval if the service is not provided internally by the MCO

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Consultative clinical and therapeutic services for caregivers	Urban	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 / 99

C2.V.2 Measure standard

No more than 60 business days from time of service approval if the service is not provided internally by the MCO

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Consumer education and training	Urban	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 / 99

C2.V.2 Measure standard

No more than 60 business days from time of service approval if the service is not provided internally by the MCO

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Housing counseling	Urban	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

43 / 99

C2.V.2 Measure standard

No more than 60 business days from time of service approval if the service is not provided internally by the MCO

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Training services for unpaid caregivers	Urban	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 / 99

C2.V.2 Measure standard

No more than 60 business days from time of service approval if the service is not provided internally by the MCO

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Relocation services	Urban	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 / 99

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	C2.V.5 Region	C2.V.6 Population
Vocational futures planning and	Urban	MLTSS

support

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 / 99

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

47 / 99

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
Respiratory care	Urban	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

48 / 99

C2.V.2 Measure standard

No greater than 1 case manager per 50 members, if service is not provided internally by the MCO.

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Case management	Urban	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

49 / 99

C2.V.2 Measure standard

No greater than 1 case manager per 50 members, if service is not provided internally by the MCO.

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Care management	Urban	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 50 / 99

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	C2.V.5 Region	C2.V.6 Population
LTSS assistive technology	Rural	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 51 / 99

C2.V.2 Measure standard

1:350

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-adult day care	Rural	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

52 / 99

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
AODA services (excluding inpatient or physician provided)	Rural	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

53 / 99

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
AODA day treatment	Rural	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

54 / 99

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Mental health services (excluding inpatient, physician-provided, or comprehensive community services)	Rural	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

55 / 99

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Mental health day treatment	Rural	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

56 / 99

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
Day habilitation services	Rural	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

57 / 99

C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Supported employment – small group employment support	Rural	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

58 / 99

C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Prevocational services	Rural	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

59 / 99

C2.V.2 Measure standard

1:350

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Community support program	Rural	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

60 / 99

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	Rural	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

61 / 99

C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Home health services	Rural	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

62 / 99

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
Supportive home care	Rural	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

63 / 99

C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Personal care	Rural	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

64 / 99

C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Self-directed personal care	Rural	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

65 / 99

C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

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

66 / 99

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Occupational therapy	Rural	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

67 / 99

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physical therapy	Rural	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

68 / 99

C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Skilled nursing services registered nurse/licensed practical nurse	Rural	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

69 / 99

C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Nursing (including intermittent and private duty)	Rural	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

70 / 99

C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Supported employment – individual employment support	Rural	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

71 / 99

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Transportation (specialized transportation) – other transportation	Rural	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

72 / 99

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Transportation (excluding ambulance)	Rural	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

73 / 99

C2.V.2 Measure standard

Transportation (specialized transportation) – community transportation

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ransportation (specialized transportation) – community transportation	Rural	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

74 / 99

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
Home-delivered meals	Rural	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

75 / 99

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
Financial management services	Rural	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

76 / 99

C2.V.2 Measure standard

1:900

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Consumer-directed supports (self-directed supports) broker	Rural	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

77 / 99

C2.V.2 Measure standard

1:75

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Adult residential care – 1-2 bed adult family homes	Rural	Adult and pediatric

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

78 / 99

C2.V.2 Measure standard

1:75

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Adult residential care – 1-2 bed adult family homes	Rural	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

79 / 99

C2.V.2 Measure standard

1:75

C2.V.3 Standard type

Provider to enrollee ratios

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

Adult residential care – 3-4 bed adult family homes	Rural	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

80 / 99

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Adult residential care – community-based residential facility	Rural	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

81 / 99

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 – residential care	Rural	MLTSS

apartment complex

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

82 / 99

C2.V.2 Measure standard

1:125

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Nursing home stays (nursing home, institute for mental disease, and immediate care facility for individuals with intellectual disabilities)	Rural	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

83 / 99

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	C2.V.5 Region	C2.V.6 Population
Durable medical equipment (excluding hearing aids, prosthetics, and family planning supplies)	Rural	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

84 / 99

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	C2.V.5 Region	C2.V.6 Population
Disposable medical supplies	Rural	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

85 / 99

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	C2.V.5 Region	C2.V.6 Population
Specialized medical equipment and supplies	Rural	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

86 / 99

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	C2.V.5 Region	C2.V.6 Population
Adaptive aids	Rural	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

87 / 99

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	C2.V.5 Region	C2.V.6 Population
Personal emergency response systems services	Rural	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

88 / 99

C2.V.2 Measure standard

No more than 60 - 90 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
Environmental accessibility adaptations (home modifications)	Rural	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

89 / 99

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Daily living skills training	Rural	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

90 / 99

C2.V.2 Measure standard

No more than 60 business days from time of service approval if the service is not provided internally by the MCO

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Consultative clinical and therapeutic services for caregivers	Rural	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

91 / 99

C2.V.2 Measure standard

No more than 60 business days from time of service approval if the service is not provided internally by the MCO

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Consumer education and training	Rural	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

92 / 99

C2.V.2 Measure standard

No more than 60 business days from time of service approval if the service is not provided internally by the MCO

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Housing counseling	Rural	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

93 / 99

C2.V.2 Measure standard

No more than 60 business days from time of service approval if the service is not provided internally by the MCO

C2.V.3 Standard type

Service fulfillment

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

Training services for unpaid caregivers

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

94 / 99

C2.V.2 Measure standard

No more than 60 business days from time of service approval if the service is not provided internally by the MCO

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Relocation services	Rural	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

95 / 99

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	C2.V.5 Region	C2.V.6 Population
Vocational futures planning and support	Rural	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

96 / 99

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Speech and language pathology services (except in inpatient and hospital settings)	Rural	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

97 / 99

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Respiratory care	Rural	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

98 / 99

C2.V.2 Measure standard

No greater than 1 case manager per 50 members, if service is not provided internally by the MCO.

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Care Management	Rural	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

99 / 99

C2.V.2 Measure standard

No greater than 1 case manager per 50 members, if service is not provided internally by the MCO.

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Care Management	Rural	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.dhs.wisconsin.gov/adrc/index.htm
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.	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	**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).	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	**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?	The SMA's 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, policy development and corrective action as needed.

Topic X: Program Integrity

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic I. Program Characteristics & Enrollment

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**Community Care, Inc (CCI)** 779 **Independent Health Plan (iCare)** 1463 **My Choice Wisconsin (MCW)**

1469

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)	**Community Care, Inc (CCI)** 0.05% **Independent Health Plan (iCare)** 0.09% **My Choice Wisconsin (MCW)** 0.09%
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)	**Community Care, Inc (CCI)** 0.07% **Independent Health Plan (iCare)** 0.12% **My Choice Wisconsin (MCW)** 0.12%

Topic II. Financial Performance

Find in the Excel Workbook
D1_Plan_Set

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	**Community Care, Inc (CCI)** 98.3% **Independent Health Plan (iCare)** 98.9% **My Choice Wisconsin (MCW)** 99.2%

	in Excel Workbook for the regulatory definition of MLR.	
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.	**Community Care, Inc (CCI)** Program-specific regional **Independent Health Plan (iCare)** Program-specific regional **My Choice Wisconsin (MCW)** Program-specific regional
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.	**Community Care, Inc (CCI)** N/A **Independent Health Plan (iCare)** N/A **My Choice Wisconsin (MCW)** 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?	**Community Care, Inc (CCI)** Yes **Independent Health Plan (iCare)** Yes **My Choice Wisconsin (MCW)** Yes
N/A	Enter the start date.	**Community Care, Inc (CCI)** 01/01/2021 **Independent Health Plan (iCare)** 01/01/2021 **My Choice Wisconsin (MCW)**

		01/01/2021
N/A	Enter the end date.	**Community Care, Inc (CCI)** 12/31/2021 **Independent Health Plan (iCare)** 12/31/2021 **My Choice Wisconsin (MCW)** 12/31/2021

Topic III. Encounter Data

Find in the Excel Workbook
D1_Plan_Set

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.	**Community Care, Inc (CCI)** Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter. **Independent Health Plan (iCare)** Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter. **My Choice Wisconsin (MCW)** 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	**Share of encounter data submissions that met state's timely submission requirements**	**Community Care, Inc (CCI)** 100% **Independent Health Plan (iCare)**

	What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	90.36% **My Choice Wisconsin (MCW)** 54.72%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**Community Care, Inc (CCI)** 96.94% **Independent Health Plan (iCare)** 77.53% **My Choice Wisconsin (MCW)** 86.31%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or	**Community Care, Inc (CCI)** 10 **Independent Health Plan (iCare)** 23 **My Choice Wisconsin (MCW)**

	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.	10
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
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).	**Community Care, Inc (CCI)** 10 **Independent Health Plan (iCare)** 23 **My Choice Wisconsin (MCW)** 10
D1IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0

	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.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Community Care, Inc (CCI)** 10 **Independent Health Plan (iCare)** 23 **My Choice Wisconsin (MCW)** 10
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service**	**Community Care, Inc (CCI)** 10

	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).	**Independent Health Plan (iCare)** 16 **My Choice Wisconsin (MCW)** 10
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)** 0 **Independent Health Plan (iCare)** 7 **My Choice Wisconsin (MCW)** 0
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.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance**	**Community Care, Inc (CCI)** 0

	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.	**Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 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).	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 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.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0

Topic IV. Appeals, State Fair Hearings & Grievances

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.

Find in the Excel Workbook
D1_Plan_Set

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".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 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".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
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".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 5 **My Choice Wisconsin (MCW)** 0
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	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)**

	mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	0 **My Choice Wisconsin (MCW)** 0
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Community Care, Inc (CCI)** 2 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Community Care, Inc (CCI)** 8 **Independent Health Plan (iCare)** 15 **My Choice Wisconsin (MCW)** 4
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that	**Community Care, Inc (CCI)** 0

	were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 1
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 2 **My Choice Wisconsin (MCW)** 1
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 1 **My Choice Wisconsin (MCW)** 3

Topic IV. Appeals, State Fair Hearings & Grievances

State Fair Hearings

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**Community Care, Inc (CCI)** 2 **Independent Health Plan (iCare)**

		2 **My Choice Wisconsin (MCW)** 2
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.	**Community Care, Inc (CCI)** 1 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 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.	**Community Care, Inc (CCI)** 1 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 1 **My Choice Wisconsin (MCW)** 0
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the	**Community Care, Inc (CCI)** N/A **Independent Health Plan (iCare)** N/A

	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).	**My Choice Wisconsin (MCW)** 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).	**Community Care, Inc (CCI)** N/A **Independent Health Plan (iCare)** N/A **My Choice Wisconsin (MCW)** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances Overview

Find in the Excel Workbook
D1_Plan_Set

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.	**Community Care, Inc (CCI)** 7 **Independent Health Plan (iCare)** 162 **My Choice Wisconsin (MCW)** 2
D1IV.11	**Active grievances**	**Community Care, Inc (CCI)**

	Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Community Care, Inc (CCI)** 7 **Independent Health Plan (iCare)** 162 **My Choice Wisconsin (MCW)** 2
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0

	service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Community Care, Inc (CCI)** 7 **Independent Health Plan (iCare)** 162 **My Choice Wisconsin (MCW)** 2

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Service

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

Find in the Excel Workbook
D1_Plan_Set

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".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
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".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
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".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.15d	**Resolved grievances related to outpatient behavioral**	**Community Care, Inc (CCI)**

	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".	0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc (CCI)** 7 **Independent Health Plan (iCare)** 162 **My Choice Wisconsin (MCW)** 2
D1IV.15h	**Resolved grievances related to dental services**	**Community Care, Inc (CCI)**

	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".	0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Reason

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

Find in the Excel Workbook
D1_Plan_Set

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.	**Community Care, Inc (CCI)** 2 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
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.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 89 **My Choice Wisconsin (MCW)** 0
D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 58 **My Choice Wisconsin (MCW)** 0

D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 14 **My Choice Wisconsin (MCW)** 0
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Community Care, Inc (CCI)** 3 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0

	financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**My Choice Wisconsin (MCW)** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved 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).	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0

	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.	
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**Community Care, Inc (CCI)** 2 **Independent Health Plan (iCare)** 1 **My Choice Wisconsin (MCW)** 2

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.

Find in the Excel Workbook
D2_Plan_Measures

Quality & performance measure total count: 1

Complete

D2.VII.1 Measure Name: Competitive Integrated Employment (CIS) 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
Program-specific rate

D2.VII.6 Measure Set
State-specific

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

D2.VII.8 Measure Description

% Increase in number of members in CIE from Q1 to Q4 of 2021

Measure results

Community Care, Inc (CCI)

15%

Independent Health Plan (iCare)

79%

My Choice Wisconsin (MCW)

13%

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.

Find in the Excel Workbook
D3_Plan_Sanctions

Sanction total count: 1

Complete

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

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

My Choice Wisconsin (MCW)

D3.VIII.4 Reason for intervention

Failure to meet the quality standards regarding monitoring and collecting evidence that providers continuously meet required licensure, certification, or other standards and expectations (Article X11.C.5.a).

Sanction details

D3.VIII.5 Instances of non-compliance

70

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

08/19/2021

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

Yes 04/01/2022

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Find in the Excel Workbook
D1_Plan_Set

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).	**Community Care, Inc (CCI)** 1 **Independent Health Plan (iCare)** 1 **My Choice Wisconsin (MCW)** 1
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**Community Care, Inc (CCI)** 1 **Independent Health Plan (iCare)** 1 **My Choice Wisconsin (MCW)** 1
D1X.3	**Ratio of opened program integrity investigations to**	**Community Care, Inc (CCI)**

	enrollees What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	1:29 **Independent Health Plan (iCare)** 0:69 **My Choice Wisconsin (MCW)** 0:56
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**Community Care, Inc (CCI)** 1 **Independent Health Plan (iCare)** 1 **My Choice Wisconsin (MCW)** 1
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**Community Care, Inc (CCI)** 1:29 **Independent Health Plan (iCare)** 0:69 **My Choice Wisconsin (MCW)** 0:26
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.	**Community Care, Inc (CCI)** Makes some referrals to the SMA and others directly to the MFCU **Independent Health Plan (iCare)** Makes some referrals to the SMA and others directly to the MFCU **My Choice Wisconsin (MCW)** Makes some referrals to the SMA and others directly to the MFCU

D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made to the SMA and the MFCU in aggregate.	**Community Care, Inc (CCI)** 1 **Independent Health Plan (iCare)** 1 **My Choice Wisconsin (MCW)** 3
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.2) as the denominator.	**Community Care, Inc (CCI)** 1:29 **Independent Health Plan (iCare)** 0:69 **My Choice Wisconsin (MCW)** 0:20
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	**Community Care, Inc (CCI)** 1/1/22-12/31/22 $69,309 Recovered Ratio = 0.0011 **Independent Health Plan (iCare)** 1/1/22-12/31/22 $261,830 Recovered Ratio = 0.0027 **My Choice Wisconsin (MCW)** 1/1/22-12/31/22 $1,340,186 Recovered Ratio = 0.0124
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Community Care, Inc (CCI)** Daily **Independent Health Plan (iCare)** Daily **My Choice Wisconsin (MCW)**

Daily

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.

Find in the Excel Workbook
E_BSS_Entities

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Multi-location ADRC** Aging and Disability Resource Network (ADRN)
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).	**Multi-location ADRC** Enrollment Broker/Choice Counseling