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

Due date	Last edited	Edited by	Status
06/29/2025	06/27/2025	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

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Wisconsin
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Kimberly Schindler
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	Kimberly.Schindler@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.	06/27/2025

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2024
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2024
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.

	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.

Indicator	Response
BSS entity name	Multi-location ADRC

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

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

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

Indicator	Response
ILOS name	Not answered

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,364,098
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	977,134

Topic III. Encounter Data Report

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.	Capitation payments against date of death reviews are completed. EVV soft launch to allow home visit supportive home care and personal care worker time validation. Will not conduct actual audits until hard launch and vendor compliance requirements are in place. Other data analytics and reviews will be implemented after the DHS MLTSS system rewrite that is in process goes live. Once implemented there will be the ability to scrub the data for targeted anomalies.
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 has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Art. VIII.D.30, Art XIII.K.1.g, Art XIV.B.4, Art XIV.F. 5.c., Art XIV.C.6.g, XVII.B.4
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**	The SMA tracks satisfaction and timeliness of compliance with the reporting requirement.

	Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	
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	No

	PCCM entity through routine checks of Federal databases.	
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	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, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.	https://oci.wi.gov/Pages/Companies/FinExams.aspx

Topic XIII. Prior Authorization

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

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

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Family Care Contract between Wisconsin Department of Health Division of Medicaid Services and [MCO]. Amended October 2024
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2024
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-2024-contract-amend.pdf
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health 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 average number of individuals enrolled in this managed care program per	3,536

	month during the reporting year (i.e., average member months).	
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter “There were no major changes to the population or benefits during the reporting year” as your response. “N/A” is not an acceptable response.	There were no major changes to the population or benefits for the reporting year.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity 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 failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Art. XIV.B.6 and XVI.E.2.i(ii.)
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 year. If there were no barriers, please enter “The state did not experience any barriers to collecting or validating encounter data during the reporting year” as your response. “N/A” is not an acceptable response.	The state did not experience any barriers to collecting or validating encounter data during the reporting year.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident", as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	Member incidents that must be reported in AIRS include any of the following: i. Abuse as defined in Article I, including physical abuse, sexual abuse, emotional abuse, treatment without consent, and unreasonable confinement or restraint); ii. Neglect as defined in Article I; iii. Self-Neglect as defined in Article I; iv. Financial exploitation as defined in Article I; v. Exploitation. Taking advantage of a member for personal gain through the use of manipulation, intimidation, threats, or coercion. This could include, for example, human trafficking, forced labor, forced criminality, slavery, coercion, and sexual exploitation; vi. Medication error. Any time a member does not receive their medication as prescribed that resulted in a moderate or severe injury or illness. This includes wrong medication, wrong dosage, wrong timing, omission, wrong route, and wrong technique; a) moderate injury or illness is one that requires medical evaluation and treatment beyond basic first aid in any type of medical setting (for example, office visit, clinic, urgent care, emergency room, or hospital observation without admission). b) A severe injury or illness is one that has or could have the potential to have a major impact on one's life and well-being or that requires hospital admission for treatment and medical care, including life-threatening and fatal injuries. vii. Missing person. When a member's whereabouts are or were unknown and one or more of the following apply: a) The member has a legal decision maker; b) The member is under protective placement; c) The member lives in a residential facility; d) The member is considered vulnerable/high-risk; e) The MCO believes the member's health and safety is or was at risk; f) The area is experiencing potentially life-threatening weather conditions; or g) The member experienced injury or illness while missing; viii. Fall. An action where a member inadvertently descended to a lower level by losing control, losing balance, or collapsing that resulted in moderate to severe injury or illness directly related to the fall. A fall can be from a standing, sitting, or lying down position; ix. Emergency use of restraints or restrictive measures. When an Emergency use of restraints or restrictive measures. When an

		unanticipated situation has occurred where an individual suddenly engages in dangerous behavior, placing themselves or others at imminent, significant risk of physical injury. An emergency restrictive measure also applies to situations the IDT does not anticipate will occur again. This may include the appearance of a behavior that has not happened for years or has not been known to occur before or it could include current behaviors that suddenly and unexpectedly escalate to an intensity the team has not seen before; x. Unapproved use of restraints or restrictive measures. When there is a need for a restrictive measure and the IDT is gathering information for DHS approval or when approval for a restrictive measure has expired and is still being utilized; xi. Death due to any of the member incidents (i. through x.) of this list, as well as death due to accident, suicide, psychotropic medication(s), or unexplained, unusual, or suspicious circumstances; and Any other type of accident, injury, illness, death, or unplanned law enforcement involvement that is unexplained, unusual, or around which suspicious circumstances exist and resulted in a moderate or severe illness/injury.
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	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.

	MCO, PIHP or PAHP receives the appeal.	
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

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	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 provided explanations on similar services that can be provided to meet member needs. For the caregiver workforce shortage, there have been rate increases provided through state and federal assistance with ARPA. The state has also implemented 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.

Access Measures

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

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

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

Access measure total count: 47

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 1 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS assistive technology and communication aids	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 2 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

3 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
AODA services (excluding inpatient or physician provided)	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

4 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
AODA day treatment	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

5 / 47

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)	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

6 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

7 / 47

C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Day habilitation services	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

8 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

9 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

10 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

11 / 47

C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

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

Counseling and therapeutic resources	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

12 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

13 / 47

C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Supportive home care	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

16 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

17 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Occupational therapy	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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)	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

21 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

22 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

23 / 47

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)	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

24 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

25 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

26 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

27 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

28 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

29 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

30 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

31 / 47

C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Adult residential care – residential care apartment complex	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

32 / 47

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,	All counties	MLTSS

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

33 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Durable medical equipment (excluding hearing aids, prosthetics, and family planning supplies)	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

34 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Disposable medical supplies	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

35 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialized medical equipment and supplies	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

36 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Adaptive aids	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

37 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Personal emergency response systems services	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

38 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Environmental accessibility adaptations (home modifications)	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

39 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Daily living skills training	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

40 / 47

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	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

41 / 47

C2.V.2 Measure standard

No more than 60 business days from time of service approval

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Consumer education and training	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

42 / 47

C2.V.2 Measure standard

No more than 60 business days from time of service approval

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Housing counseling	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

43 / 47

C2.V.2 Measure standard

No more than 60 business days from time of service approval

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Training services for unpaid caregivers	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

44 / 47

C2.V.2 Measure standard

No more than 60 business days from time of service approval

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Relocation services	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

45 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Vocational futures planning and support	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

46 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 47 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Respiratory care	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	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. Written materials are accessible for screen readers and use plain language. ADRCs are required to have access to sign language interpreting services.
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 State ADRC regional quality specialists evaluate the quality, effectiveness, and efficiency of ADRC performance through a series of quality monitoring activities including; annual ADRC site visits, minimum of monthly contact with ADRC Directors, quarterly review of required reports and customer data regarding ADRC service delivery, ensure new staff complete and pass options counseling training and required post-test, verify each options counselor has their work observed for quality at least once annually by a peer or supervisor, ensure completion of annual quality improvement project for each ADRC, complete subrecipient risk assessments, review ADRC board meeting minutes, and individually 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

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

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	Yes
C1XII.5	**Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?** (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	**Did the State or MCOs complete the most recent parity analysis(es)?**	MCO
C1XII.7a	**Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?** (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	No
C1XII.8	**When was the last parity analysis(es) for this program completed?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	01/01/2017
C1XII.9	**When was the last parity analysis(es) for this program**	01/01/1900

	submitted to CMS? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	Yes
C1XII.10b	**In the last analysis(es) conducted, describe all deficiencies identified.**	"• One organization needed to supply analysis for FRs or QLTs and independent evaluation of AL and ADL. • Two organizations needed to submit NQTLs applicable to MH/SUD benefits and analysis. • Three organizations needed to submit medical necessity determination for MH/SUD benefits made available to members • Three organizations needed to submit reason for payment denials for MH/SUD "
C1XII.11a	**As of the end of this reporting period, have these deficiencies been resolved for all plans?**	Yes
C1XII.12a	**Has the state posted the current parity analysis(es) covering this program on its website?** The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity	No

	reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	
C1XII.12c	**When will the state post the current parity analysis(es) on its State Medicaid website in accordance with 42 CFR § 438.920(b)(1)?**	07/01/2026

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Community Care, Inc (CCI)** 711 **Independent Health Plan (iCare)** 1,522 **My Choice Wisconsin (MCW)** 1,303
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)** 0.1% **Independent Health Plan (iCare)** 0.1% **My Choice Wisconsin (MCW)** 0.1%
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)** 0.1% **Independent Health Plan (iCare)** 0.2% **My Choice Wisconsin (MCW)** 0.1%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Community Care, Inc (CCI)** 103.6% **Independent Health Plan (iCare)** 97.3% **My Choice Wisconsin (MCW)** 107.05%
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)** 01/01/2023 **Independent Health Plan (iCare)** 01/01/2023 **My Choice Wisconsin (MCW)** 01/01/2023
N/A	Enter the end date.	**Community Care, Inc (CCI)** 12/31/2023 **Independent Health Plan (iCare)** 12/31/2023 **My Choice Wisconsin (MCW)** 12/31/2023

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**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** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**Community Care, Inc (CCI)** 90% **Independent Health Plan (iCare)** 93.9% **My Choice Wisconsin (MCW)** 95.9%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were	**Community Care, Inc (CCI)** 86% **Independent Health Plan (iCare)** 99.997% **My Choice Wisconsin (MCW)** 99.7%

	compliant out of the proportion received from the managed care plan for the reporting year.

Topic IV. Appeals, State Fair Hearings & Grievances

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

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Community Care, Inc (CCI)** 17 **Independent Health Plan (iCare)** 47 **My Choice Wisconsin (MCW)** 84
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**Community Care, Inc (CCI)** 12 **Independent Health Plan (iCare)** 21 **My Choice Wisconsin (MCW)** 33
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 2 **My Choice Wisconsin (MCW)** 0
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 11 **My Choice Wisconsin (MCW)** 4
D1IV.2	**Active appeals**	**Community Care, Inc (CCI)** 0

	Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**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)** 17 **Independent Health Plan (iCare)** 47 **My Choice Wisconsin (MCW)** 84
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0

	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 within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Community Care, Inc (CCI)** 17 **Independent Health Plan (iCare)** 47 **My Choice Wisconsin (MCW)** 84
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Community Care, Inc (CCI)** 0 **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** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Community Care, Inc (CCI)** 2 **Independent Health Plan (iCare)** 33 **My Choice Wisconsin (MCW)** 54
D1IV.6b	**Resolved appeals related to reduction, suspension, or**	**Community Care, Inc (CCI)** 15

	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.	**Independent Health Plan (iCare)** 12 **My Choice Wisconsin (MCW)** 28
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)** 2
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** 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.	**Community Care, Inc (CCI)** 0 **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	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 1 **My Choice Wisconsin (MCW)** 0

	(only applicable to residents of rural areas with only one MCO).	
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 1 **My Choice Wisconsin (MCW)** 0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	**Community Care, Inc (CCI)** N/A **Independent Health Plan (iCare)** N/A **My Choice Wisconsin (MCW)** N/A
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.	**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)** N/A **Independent Health Plan (iCare)** N/A **My Choice Wisconsin (MCW)** N/A
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0

	were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter “N/A”.	**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)** N/A **Independent Health Plan (iCare)** N/A **My Choice Wisconsin (MCW)** N/A
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter “N/A”.	**Community Care, Inc (CCI)** 1 **Independent Health Plan (iCare)** 2 **My Choice Wisconsin (MCW)** 1
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)** 17 **Independent Health Plan (iCare)** 47 **My Choice Wisconsin (MCW)** 84

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

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Community Care, Inc (CCI)** 2 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 10
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)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 4
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)** 2 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 6
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **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 reporting year that were partially or fully favorable to the enrollee. If your state does	**Community Care, Inc (CCI)** N/A **Independent Health Plan (iCare)** N/A **My Choice Wisconsin (MCW)** N/A

	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).	
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

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Community Care, Inc (CCI)** 8 **Independent Health Plan (iCare)** 10 **My Choice Wisconsin (MCW)** 7
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Community Care, Inc (CCI)** 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)** 8 **Independent Health Plan (iCare)** 10 **My Choice Wisconsin (MCW)** 7
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0

	do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Community Care, Inc (CCI)** 8 **Independent Health Plan (iCare)** 10 **My Choice Wisconsin (MCW)** 7

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc (CCI)** N/A **Independent Health Plan (iCare)** N/A **My Choice Wisconsin (MCW)** N/A
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**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)** N/A **Independent Health Plan (iCare)** N/A **My Choice Wisconsin (MCW)** N/A
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)**

	substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	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)** N/A **Independent Health Plan (iCare)** N/A **My Choice Wisconsin (MCW)** N/A
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter “N/A”.	**Community Care, Inc (CCI)** 1 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 1
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)** 8 **Independent Health Plan (iCare)** 10 **My Choice Wisconsin (MCW)** 7
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter “N/A”.	**Community Care, Inc (CCI)** N/A **Independent Health Plan (iCare)** N/A **My Choice Wisconsin (MCW)** N/A
D1IV.15i	**Resolved grievances related to non-emergency medical**	**Community Care, Inc (CCI)** 0

	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”.	**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 paid primarily by Medicaid, enter “N/A”.	**Community Care, Inc (CCI)** 4 **Independent Health Plan (iCare)** 5 **My Choice Wisconsin (MCW)** 2

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Community Care, Inc (CCI)** 1 **Independent Health Plan (iCare)** 1 **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)** 1 **Independent Health Plan (iCare)** 5 **My Choice Wisconsin (MCW)** 3

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)** 1 **Independent Health Plan (iCare)** 3 **My Choice Wisconsin (MCW)** 1
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)** 1 **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)** 4 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 1

D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**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 by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**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)**	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)**

	Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Community Care, Inc (CCI)** 1 **Independent Health Plan (iCare)** 0 **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.

Quality & performance measure total count: 5

Complete

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

1 / 5

D2.VII.2 Measure Domain

Long-term services and supports

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

N/A

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

Cross-program rate: Family Care and Family Care Partnership

D2.VII.6 Measure Set

State-specific

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

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

D2.VII.8 Measure Description

% Increase in number of members in CIE from Q1 to Q4 of 2023

Measure results

Community Care, Inc (CCI)

5.53%

Independent Health Plan (iCare)

7.41%

My Choice Wisconsin (MCW)

18.07%

Complete

D2.VII.1 Measure Name: Pneumococcal Vaccination

2 / 5

D2.VII.2 Measure Domain

Primary care access and preventative care

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

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

D2.VII.8 Measure Description

Percentage of members during the measurement period who receive a pneumococcal immunization.

Measure results

Community Care, Inc (CCI)

90.70%

Independent Health Plan (iCare)

87.80%

My Choice Wisconsin (MCW)

94.60%

Complete

D2.VII.1 Measure Name: Influenza (Flu) Vaccination

3 / 5

D2.VII.2 Measure Domain

Primary care access and preventative care

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

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

D2.VII.8 Measure Description

Percentage of members during the measurement period who receive an influenza immunization.

Measure results

Community Care, Inc (CCI)

60.20%

Independent Health Plan (iCare)

51.90%

My Choice Wisconsin (MCW)

66.90%

Complete

D2.VII.1 Measure Name: Social Activities

4 / 5

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

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

D2.VII.8 Measure Description

Percentage of members who reported a positive level of satisfaction with the number of opportunities to participate in social activities.

Measure results

Community Care, Inc (CCI)

45.90%

Independent Health Plan (iCare)

59.10%

My Choice Wisconsin (MCW)

61.90%

Complete

D2.VII.1 Measure Name: Member Centered Care Planning

5 / 5

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

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

D2.VII.8 Measure Description

Percentage of comprehensive care plans reviewed and signed in accordance with the DHS-MCO contract requirement of every six months.

Measure results

Community Care, Inc (CCI)

70.60%

Independent Health Plan (iCare)

N/A

My Choice Wisconsin (MCW)

58.60%

Topic VIII. Sanctions

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

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

Sanction total count: 1

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 1

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Community Care, Inc (CCI)

D3.VIII.4 Reason for intervention

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

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/14/2023

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Community Care, Inc (CCI)** 1 **Independent Health Plan (iCare)** 4 **My Choice Wisconsin (MCW)** 0.69
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Community Care, Inc (CCI)** 25 **Independent Health Plan (iCare)** 24 **My Choice Wisconsin (MCW)** 7
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Community Care, Inc (CCI)** 35.16:1,000 **Independent Health Plan (iCare)** 15.77:1,000 **My Choice Wisconsin (MCW)** 5.37:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Community Care, Inc (CCI)** 23 **Independent Health Plan (iCare)** 11 **My Choice Wisconsin (MCW)** 5

D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Community Care, Inc (CCI)** 32.35:1,000 **Independent Health Plan (iCare)** 7.23:1,000 **My Choice Wisconsin (MCW)** 3.84:1,000
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)** 0 **Independent Health Plan (iCare)** 3 **My Choice Wisconsin (MCW)** 0
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	**Community Care, Inc (CCI)** 0:1,000 **Independent Health Plan (iCare)** 1.97:1,000 **My Choice Wisconsin (MCW)** 0:1,000

D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Community Care, Inc (CCI)** 01/01/2024 **Independent Health Plan (iCare)** 01/01/2024 **My Choice Wisconsin (MCW)** 01/01/2024
D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Community Care, Inc (CCI)** 12/31/2024 **Independent Health Plan (iCare)** 12/31/2024 **My Choice Wisconsin (MCW)** 12/31/2024
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount** From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**Community Care, Inc (CCI)** $167,682 **Independent Health Plan (iCare)** $227,305 **My Choice Wisconsin (MCW)** $158,643
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	**Community Care, Inc (CCI)** $61,523,461 **Independent Health Plan (iCare)** $116,685,469 **My Choice Wisconsin (MCW)** $108,987,835
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 XI: ILOS

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

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

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**Community Care, Inc (CCI)** Not answered **Independent Health Plan (iCare)** Not answered **My Choice Wisconsin (MCW)** Not answered

Topic XIII. Prior Authorization

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

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

Topic XIV. Patient Access API Usage

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

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

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**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