Managed Care Program Annual Report (MCPAR) for Wisconsin: Medicaid SSI HMO

Due date	Last edited	Edited by	Status
06/29/2025	06/18/2025	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.	06/18/2025

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.	Medicaid SSI HMO

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	Anthem Blue Cross and Blue Shield Group Health Cooperative of Eau Claire Independent Care Health Plan (iCare) MHS Health Wisconsin My Choice Wisconsin (MCW)/Molina Network Health Plan Security Health Plan of Wisconsin United Healthcare Community Plan (UHC) Quartz

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	Maximus

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.	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.	"The state completed audits focused on capitation payments made after member date of death. In addition, the state reviewed COVID lab tests for accuracy, potential inappropriate billing of CPT codes 90837 and 90834, high utilization of optician CPT codes, and high utilization DME codes. The state continues to explore more opportunities for network provider audits which will include authority to recover overpayments from the plans as of 1/1/2025. The state reviewed data but chose not pursue the following audit areas due to bandwidth and ROI concerns: allergy testing, urine drug screening, abuse and neglect codes, and PCR tests. In addition to focused reviews by the state, plans are required to develop annual fraud, waste, and abuse strategic plans. The state annually reviews compliance and outcomes of the strategic plans. The plan reports issues of fraud, waste, and abuse to the state via quarterly program integrity reports. The state monitors the quarterly reports and partners with the plan to send referrals to the MFCU. The state also analyzes the quarterly program integrity reports for trends and concerns regarding fraud, waste, and abuse and follow up as appropriate."
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.	Allow plans to retain overpayments
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Article XII.M.9.a. and Article XII.M.11.f.i.
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain	The HMO recovers the overpayments and retains the funds for all overpayments identified by the HMO, provider or DHS OIG.

	overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The state collects all overpayment data on the Overpayment Recovery tab of the quarterly program integrity report. The report includes the date the overpayment was identified and the date the overpayment recovery was completed. The state reviews quarterly reports to ensure compliance with timely recoveries. The state provides technical assistance in monthly and quarterly meetings to address deficiencies.
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).	Daily MMIS cycle end-dates Medicaid eligibility and managed care enrollment effective the date of death. HMO capitation payments made for months after the date of death are adjusted in a weekly capitation payment adjustment cycle. Members can switch HMO plans prospectively, effective on the 1st of the next calendar month. Monthly capitation payments are made the first weekend of the calendar month. An HMO plan switch is therefore completed before capitation payments are generated for that month which eliminates the need to adjust capitation payments for this scenario.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes

BX.7c	**Changes in provider circumstances: Describe metric** Describe the metric or indicator that the state uses.	The state monitors terminations as reported on the quarterly program integrity reports and via email to DHSOIGManagedCare@dhs.wisconsin.gov. The plan is required to report for cause terminations within 24 hours of the date the provider was notified of their termination or suspension. The state monitors timeliness using quarterly program integrity report feedback and technical assistance meetings.
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 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/medicaid/hmo-info-medicaid.htm
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,	Encounter and Reporting (wi.gov)

		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.

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.	Contract for BadgerCare Plus and/or Medicaid SSI HMO Services Between the Wisconsin Department of Health Services and & [HMO]; January 1, 2023-December 31, 2023
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.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Contracts/Home.htm.spage
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Dental Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter “N/A” if not applicable.	The HMO capitated dental benefit is available in Milwaukee, Racine, Kenosha, Ozaukee, and Washington counties. Otherwise it is FFS in other HMO service areas. The HMO capitated emergency transportation is a benefit available in all services areas. Non-emergency transportation is a FFS benefit, unless not covered by the State vendor.
C1I.5	**Program enrollment**	53,638

	Enter the average number of individuals enrolled in this managed care program per 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.	Independent Care Health Plan expanded into 2 counties and Molina/MCW expanded into 9 counties and was decertified in 4 counties.

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).	Timeliness of initial data submissions Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Article XII Section E (Encounter Data Quality Criteria)

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.	Article XII Section E(2)
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.	No incentives awarded.
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter “The state did not experience any barriers to collecting or validating encounter data during the reporting year” as your response. “N/A” is not an acceptable response.	The state did not experience any barriers to collecting or validating encounter data during the reporting year.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident", as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	"Per 7.2.2 of the State's Member Grievances and Appeals Guide defines the 'Standard Resolution of Appeals' timeframe for a final written decision resolving the the appeal within 30 calendar days of receiving the appeal (oral or written).' "
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	"Per 7.2.3 of the State's Member Grievances and Appeals Guide defines the 'Expedited Resolution of Appeals' timeframe for a 'For expedited resolution of an appeal, the Health Plan must make reasonable effort to provide oral notice and issue a written disposition of an expedited hearing decision within 72 hours of receiving the verbal or written request for an expedited resolution.' "

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.	Per 7.2.1 of the State's Member Grievances and Appeals Guide defines the 'Standard Resolution of Grievances' timeframe for a 'final written decision resolving the appeal within 30 calendar days of receiving the appeal.'

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.	a. Network deficiencies are random and typically resolved within 6 months. No systemic deficiencies were identified. b. Wisconsin experienced 2 hospital closures. This resulted in 2 HMOs decertified in affected counties. Members were transferred to other HMOs with adequate network adequacy standard without disruptions in services. c. The Department is finalizing business analytics improvements, advancing the ability to analyze out-of-network utilization, grievances and appeals, % accepting new patients, language preferences, and physical access analysis. CMS Protocol 4 secret shopper methods are expected to take place this year through the EQR vendor as well as provider directory and wait time analysis. The encounter utilization provider capacity compared to enrolled providers is under consideration to resource and implement.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	"a. Network deficiencies are identified and reported to the HMOs with expectations to resolve within 6 months. In each instance the deficiencies are addressed, and confirmed until resolved. Solutions are typically applied within 6 months. If deficiencies persist, the State may take progressive action that ranges from freezing enrollment to decertify a service area and transferring members to a viable HMO. b. The State is developing HMO network provider data records' edits to improve the data completeness, accuracy, and data quality standards along with providing feedback to improve data quality."

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: 28

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 1 / 28

C2.V.2 Measure standard

15 minutes drive time/10 miles drive distance

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 2 / 28

C2.V.2 Measure standard

40 minutes drive time/30 miles drive distance

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member

enrollment, new member population, or composition of or payment to the provider network occur.

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 3 / 28

C2.V.2 Measure standard

45 minutes drive time/30 miles drive distance

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 4 / 28

C2.V.2 Measure standard

75 minutes drive time/60 miles drive distance

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member

enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

5 / 28

C2.V.2 Measure standard

15 minutes drive time/10 miles drive distance

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Urban	Adult and pediatric (age 12-17)

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

6 / 28

C2.V.2 Measure standard

45 minutes drive time/30 miles drive distance

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Rural	Adult and pediatric (age 12-17)

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 7 / 28

C2.V.2 Measure standard

45 minutes drive time/30 miles drive distance

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 8 / 28

C2.V.2 Measure standard

90 minutes drive time/75 miles drive distance

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 9 / 28

C2.V.2 Measure standard

45 minutes drive time/30 miles drive distance

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 10 / 28

C2.V.2 Measure standard

75 minutes drive time/60 miles drive distance

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

11 / 28

C2.V.2 Measure standard

45 minutes drive time/30 miles drive distance

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent Care Center	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

12 / 28

C2.V.2 Measure standard

75 minutes drive time/60 miles drive distance

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent Care Center	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 13 / 28

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Provider type in-network count/members' enrolled

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 14 / 28

C2.V.2 Measure standard

1:120

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Provider type in-network count/members' enrolled

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 15 / 28

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
Behavioral health	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Provider type in-network count/members' enrolled

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 16 / 28

C2.V.2 Measure standard

1:1100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Provider type in-network count/members' enrolled

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

17 / 28

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Urban	Adult and pediatric (age 12-17)

C2.V.7 Monitoring Methods

Provider type in-network count/members' enrolled

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

18 / 28

C2.V.2 Measure standard

1:120

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Rural	Adult and pediatric (age 12-17)

C2.V.7 Monitoring Methods

Provider type in-network count/members' enrolled

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

19 / 28

C2.V.2 Measure standard

1:1600

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Provider type in-network count/members' enrolled

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

20 / 28

C2.V.2 Measure standard

1:1900

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Provider type in-network count/members' enrolled

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

21 / 28

C2.V.2 Measure standard

Less than 30 days routine care

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

HMO attestation, provider surveys, site-visits, provider handbook and contractual terms.

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

22 / 28

C2.V.2 Measure standard

Less than 30 days routine care.

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

HMO attestation, provider surveys, site-visits, provider handbook and contractual terms.

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

23 / 28

C2.V.2 Measure standard

Less than 30 days routine care.

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

HMO attestation, provider surveys, site-visits, provider handbook and contractual terms.

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

24 / 28

C2.V.2 Measure standard

Less than 30 days routine care.

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

HMO attestation, provider surveys, site-visits, provider handbook and contractual terms.

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

25 / 28

C2.V.2 Measure standard

Less than 30 days routine care.

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Urban	Adult and pediatric (age 12-17)

C2.V.7 Monitoring Methods

HMO attestation, provider surveys, site-visits, provider handbook and contractual terms.

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

26 / 28

C2.V.2 Measure standard

Less than 30 days routine care.

C2.V.3 Standard type

Appointment wait time

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

OB/GYN	Rural	Adult and pediatric (age 12-17)

C2.V.7 Monitoring Methods

HMO attestation, provider surveys, site-visits, provider handbook and contractual terms.

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

27 / 28

C2.V.2 Measure standard

Routine < 90 days/Emergent < 24 hrs

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

HMO attestation, provider surveys, site-visits, provider handbook and contractual terms.

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

Complete

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

28 / 28

C2.V.2 Measure standard

Routine < 90 days/Emergent < 24 hrs

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

HMO attestation, provider surveys, site-visits, provider handbook and contractual terms.

C2.V.8 Frequency of oversight methods

A network analysis is conducted upon entering a contract with DHS, annually, a significant change in benefits, geographic service area, member enrollment, new member population, or composition of or payment to the provider network occur.

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://access.wisconsin.gov/access/
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.	Individuals may access benefits via phone, internet, in-person or by mail. HMO enrollment specialist are available via email to members for general questions at WIEBSMemberSupport@maximus.com. Also, in person enrollment counseling services are available to members upon request. An SSI managed care external consumer advocate is a person who provides advocacy services to SSI Medicaid HMO members with disabilites.
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).	Medicaid SSI HMO does not provide long-term services and supports.
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?	Monthly the BSS submits 10 Service Level Agreements that serve as an aspect to measure performance and is defined by the acceptable level of service, report content required and penalties. Annually DHS staff complete a Subrecipient Risk Assessment to evaluate a subrecipient's risk of non-compliance for every subaward. The risk assessment score will help determine the subrecipient's risk level and appropriate monitoring guidelines for each subrecipient to ensure the subrecipient is complying with federal statutes, regulations, and the terms and conditions of the subaward.

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).	01/01/2019
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.**	• Two organizations needed to submit cost analysis determined for each FRs and QTLs for M/S benefits within each classification • Two organizations needed to submit independent evaluation of AL and ADLs • 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	No

	may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	
C1XII.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).	**Anthem Blue Cross and Blue Shield** 7,221 **Group Health Cooperative of Eau Claire** 2,945 **Independent Care Health Plan (iCare)** 9,000 **MHS Health Wisconsin** 6,146 **My Choice Wisconsin (MCW)/Molina** 5,541 **Network Health Plan** 3,961 **Security Health Plan of Wisconsin** 615 **United Healthcare Community Plan (UHC)** 17,837 **Quartz** 384
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)	**Anthem Blue Cross and Blue Shield** 0.5% **Group Health Cooperative of Eau Claire** 0.2% **Independent Care Health Plan (iCare)** 0.7% **MHS Health Wisconsin** 0.5% **My Choice Wisconsin (MCW)/Molina** 0.4% **Network Health Plan** 0.3% **Security Health Plan of Wisconsin** 0%

United Healthcare Community Plan (UHC)

1.3%

Quartz

0%

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)	**Anthem Blue Cross and Blue Shield** 0.7% **Group Health Cooperative of Eau Claire** 0.3% **Independent Care Health Plan (iCare)** 0.9% **MHS Health Wisconsin** 0.6% **My Choice Wisconsin (MCW)/Molina** 0.6% **Network Health Plan** 0.4% **Security Health Plan of Wisconsin** 0.1% **United Healthcare Community Plan (UHC)** 1.8% **Quartz** 0%

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.	**Anthem Blue Cross and Blue Shield** 86% **Group Health Cooperative of Eau Claire** 84% **Independent Care Health Plan (iCare)** 86% **MHS Health Wisconsin** 87.5% **My Choice Wisconsin (MCW)/Molina** 87.6% **Network Health Plan** 86.1% **Security Health Plan of Wisconsin** 88% **United Healthcare Community Plan (UHC)** 86.4% **Quartz** 86.3%
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.	**Anthem Blue Cross and Blue Shield** Statewide all programs & populations **Group Health Cooperative of Eau Claire** Statewide all programs & populations **Independent Care Health Plan (iCare)** Statewide all programs & populations **MHS Health Wisconsin** Statewide all programs & populations **My Choice Wisconsin (MCW)/Molina** Statewide all programs & populations **Network Health Plan**

Statewide all programs & populations

Security Health Plan of Wisconsin

Statewide all programs & populations

United Healthcare Community Plan (UHC)

Statewide all programs & populations

Quartz

Statewide all programs & populations

D1II.2

Population specific MLR description

Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable.
See glossary for the regulatory definition of MLR.

Anthem Blue Cross and Blue Shield

BadgerCare Plus Standard, CLA, SSI Only, Dual Eligible

Group Health Cooperative of Eau Claire

BadgerCare Plus Standard, CLA, SSI Only, Dual Eligible

Independent Care Health Plan (iCare)

BadgerCare Plus Standard, CLA, SSI Only, Dual Eligible

MHS Health Wisconsin

BadgerCare Plus Standard, CLA, SSI Only, Dual Eligible

My Choice Wisconsin (MCW)/Molina

BadgerCare Plus Standard, CLA, SSI Only, Dual Eligible

Network Health Plan

BadgerCare Plus Standard, CLA, SSI Only, Dual Eligible

Security Health Plan of Wisconsin

BadgerCare Plus Standard, CLA, SSI Only, Dual Eligible

United Healthcare Community Plan (UHC)

BadgerCare Plus Standard, CLA, SSI Only, Dual Eligible

Quartz

BadgerCare Plus Standard, CLA, SSI Only, Dual Eligible

D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Anthem Blue Cross and Blue Shield** Yes **Group Health Cooperative of Eau Claire** Yes **Independent Care Health Plan (iCare)** Yes **MHS Health Wisconsin** Yes **My Choice Wisconsin (MCW)/Molina** Yes **Network Health Plan** Yes **Security Health Plan of Wisconsin** Yes **United Healthcare Community Plan (UHC)** Yes **Quartz** Yes
N/A	Enter the start date.	**Anthem Blue Cross and Blue Shield** 07/01/2022 **Group Health Cooperative of Eau Claire** 07/01/2022 **Independent Care Health Plan (iCare)** 07/01/2022 **MHS Health Wisconsin** 07/01/2022 **My Choice Wisconsin (MCW)/Molina** 07/01/2022

		Network Health Plan 07/01/2022 **Security Health Plan of Wisconsin** 07/01/2022 **United Healthcare Community Plan (UHC)** 07/01/2022 **Quartz** 07/01/2022
N/A	Enter the end date.	**Anthem Blue Cross and Blue Shield** 06/30/2023 **Group Health Cooperative of Eau Claire** 06/30/2023 **Independent Care Health Plan (iCare)** 06/30/2023 **MHS Health Wisconsin** 06/30/2023 **My Choice Wisconsin (MCW)/Molina** 06/30/2023 **Network Health Plan** 06/30/2023 **Security Health Plan of Wisconsin** 06/30/2023 **United Healthcare Community Plan (UHC)** 06/30/2023 **Quartz** 06/30/2023

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Anthem Blue Cross and Blue Shield** Within 120 days from the HMO date of payment to the provider **Group Health Cooperative of Eau Claire** Within 120 days from the HMO date of payment to the provider **Independent Care Health Plan (iCare)** Within 120 days from the HMO date of payment to the provider **MHS Health Wisconsin** Within 120 days from the HMO date of payment to the provider **My Choice Wisconsin (MCW)/Molina** Within 120 days from the HMO date of payment to the provider **Network Health Plan** Within 120 days from the HMO date of payment to the provider **Security Health Plan of Wisconsin** Within 120 days from the HMO date of payment to the provider **United Healthcare Community Plan (UHC)** Within 120 days from the HMO date of payment to the provider **Quartz** Within 120 days from the HMO date of payment to the provider.
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	**Anthem Blue Cross and Blue Shield** 97.4% **Group Health Cooperative of Eau Claire** 99.4% **Independent Care Health Plan (iCare)** 91.6% **MHS Health Wisconsin** 99.2%

	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.	**My Choice Wisconsin (MCW)/Molina** 93.6% **Network Health Plan** 99.1% **Security Health Plan of Wisconsin** 99.9% **United Healthcare Community Plan (UHC)** 99.3% **Quartz** 83.4%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**Anthem Blue Cross and Blue Shield** 94.8% **Group Health Cooperative of Eau Claire** 75.2% **Independent Care Health Plan (iCare)** 81% **MHS Health Wisconsin** 100% **My Choice Wisconsin (MCW)/Molina** 99.98% **Network Health Plan** 99.9% **Security Health Plan of Wisconsin** 99.99% **United Healthcare Community Plan (UHC)** 96.7% **Quartz** 78.9%

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.	**Anthem Blue Cross and Blue Shield** 76 **Group Health Cooperative of Eau Claire** 53 **Independent Care Health Plan (iCare)** 43 **MHS Health Wisconsin** 33 **My Choice Wisconsin (MCW)/Molina** 36 **Network Health Plan** 14 **Security Health Plan of Wisconsin** 11 **United Healthcare Community Plan (UHC)** 171 **Quartz** 6
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”.	**Anthem Blue Cross and Blue Shield** 39 **Group Health Cooperative of Eau Claire** 40 **Independent Care Health Plan (iCare)** 15 **MHS Health Wisconsin** 9 **My Choice Wisconsin (MCW)/Molina** 9 **Network Health Plan** 4 **Security Health Plan of Wisconsin** 2

United Healthcare Community Plan (UHC)

79

Quartz

2

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”.

Anthem Blue Cross and Blue Shield

2

Group Health Cooperative of Eau Claire

1

Independent Care Health Plan (iCare)

5

MHS Health Wisconsin

4

My Choice Wisconsin (MCW)/Molina

8

Network Health Plan

0

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

7

Quartz

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”.

Anthem Blue Cross and Blue Shield

26

Group Health Cooperative of Eau Claire

5

Independent Care Health Plan (iCare)

4

MHS Health Wisconsin

2

My Choice Wisconsin (MCW)/Molina

15

		Network Health Plan 0 **Security Health Plan of Wisconsin** 9 **United Healthcare Community Plan (UHC)** 65 **Quartz** 2
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Anthem Blue Cross and Blue Shield** 4 **Group Health Cooperative of Eau Claire** 2 **Independent Care Health Plan (iCare)** 10 **MHS Health Wisconsin** 2 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 3 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 12 **Quartz** 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	**Anthem Blue Cross and Blue Shield** N/A **Group Health Cooperative of Eau Claire** N/A **Independent Care Health Plan (iCare)** N/A **MHS Health Wisconsin**

	actively receiving LTSS at the time that the appeal was filed).	N/A **My Choice Wisconsin (MCW)/Molina** N/A **Network Health Plan** N/A **Security Health Plan of Wisconsin** N/A **United Healthcare Community Plan (UHC)** N/A **Quartz** N/A
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states	**Anthem Blue Cross and Blue Shield** N/A **Group Health Cooperative of Eau Claire** N/A **Independent Care Health Plan (iCare)** N/A **MHS Health Wisconsin** N/A **My Choice Wisconsin (MCW)/Molina** N/A **Network Health Plan** N/A **Security Health Plan of Wisconsin** N/A **United Healthcare Community Plan (UHC)** N/A **Quartz** N/A

	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.	**Anthem Blue Cross and Blue Shield** 75 **Group Health Cooperative of Eau Claire** 53 **Independent Care Health Plan (iCare)** 42 **MHS Health Wisconsin** 33 **My Choice Wisconsin (MCW)/Molina** 36 **Network Health Plan** 14 **Security Health Plan of Wisconsin** 11 **United Healthcare Community Plan (UHC)** 171 **Quartz** 6
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.	**Anthem Blue Cross and Blue Shield** 1 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 1 **MHS Health Wisconsin** 0 **My Choice Wisconsin (MCW)/Molina**

0

Network Health Plan

0

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

0

Quartz

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).

Anthem Blue Cross and Blue Shield

75

Group Health Cooperative of Eau Claire

53

Independent Care Health Plan (iCare)

36

MHS Health Wisconsin

23

My Choice Wisconsin (MCW)/Molina

34

Network Health Plan

11

Security Health Plan of Wisconsin

11

United Healthcare Community Plan (UHC)

140

Quartz

1

D1IV.6b

Resolved appeals related to reduction, suspension, or termination of a previously authorized service

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or

Anthem Blue Cross and Blue Shield

0

Group Health Cooperative of Eau Claire

0

Independent Care Health Plan (iCare)

4

	termination of a previously authorized service.	**MHS Health Wisconsin** 10 **My Choice Wisconsin (MCW)/Molina** 1 **Network Health Plan** 3 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 27 **Quartz** 0
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Anthem Blue Cross and Blue Shield** 0 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 0 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 4 **Quartz** 5
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan	**Anthem Blue Cross and Blue Shield** 0 **Group Health Cooperative of Eau Claire**

	during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	0 **Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 0 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 0 **Quartz** 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.	**Anthem Blue Cross and Blue Shield** 0 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 0 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 0 **Quartz** 0

D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Anthem Blue Cross and Blue Shield** 1 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 2 **MHS Health Wisconsin** 0 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 0 **Quartz** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Anthem Blue Cross and Blue Shield** 0 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 0 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)**

0

Quartz

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".	**Anthem Blue Cross and Blue Shield** 0 **Group Health Cooperative of Eau Claire** 1 **Independent Care Health Plan (iCare)** 1 **MHS Health Wisconsin** 0 **My Choice Wisconsin (MCW)/Molina** 3 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 19 **Quartz** 0
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Anthem Blue Cross and Blue Shield** 73 **Group Health Cooperative of Eau Claire** 51 **Independent Care Health Plan (iCare)** 41 **MHS Health Wisconsin** 5 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 1 **Security Health Plan of Wisconsin** 0

United Healthcare Community Plan (UHC)

0

Quartz

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”.

Anthem Blue Cross and Blue Shield

0

Group Health Cooperative of Eau Claire

0

Independent Care Health Plan (iCare)

1

MHS Health Wisconsin

0

My Choice Wisconsin (MCW)/Molina

0

Network Health Plan

0

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

1

Quartz

0

D1IV.7d

Resolved appeals related to outpatient behavioral health services

Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter “N/A”.

Anthem Blue Cross and Blue Shield

3

Group Health Cooperative of Eau Claire

1

Independent Care Health Plan (iCare)

0

MHS Health Wisconsin

1

My Choice Wisconsin (MCW)/Molina

2

Network Health Plan

0

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

0

Quartz

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”.

Anthem Blue Cross and Blue Shield

N/A

Group Health Cooperative of Eau Claire

N/A

Independent Care Health Plan (iCare)

N/A

MHS Health Wisconsin

N/A

My Choice Wisconsin (MCW)/Molina

3

Network Health Plan

0

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

11

Quartz

0

D1IV.7f

Resolved appeals related to skilled nursing facility (SNF) services

Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter “N/A”.

Anthem Blue Cross and Blue Shield

0

Group Health Cooperative of Eau Claire

0

Independent Care Health Plan (iCare)

0

MHS Health Wisconsin

		0 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 10 **Quartz** 0
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter “N/A”.	**Anthem Blue Cross and Blue Shield** N/A **Group Health Cooperative of Eau Claire** N/A **Independent Care Health Plan (iCare)** N/A **MHS Health Wisconsin** N/A **My Choice Wisconsin (MCW)/Molina** N/A **Network Health Plan** N/A **Security Health Plan of Wisconsin** N/A **United Healthcare Community Plan (UHC)** N/A **Quartz** N/A
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.	**Anthem Blue Cross and Blue Shield** 11 **Group Health Cooperative of Eau Claire** 1

	If the managed care plan does not cover dental services, enter “N/A”.	**Independent Care Health Plan (iCare)** 12 **MHS Health Wisconsin** 2 **My Choice Wisconsin (MCW)/Molina** 1 **Network Health Plan** 1 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 3 **Quartz** 0
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”.	**Anthem Blue Cross and Blue Shield** N/A **Group Health Cooperative of Eau Claire** N/A **Independent Care Health Plan (iCare)** N/A **MHS Health Wisconsin** N/A **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 0 **Quartz** 0

D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i paid primarily by Medicaid, enter “N/A”.	**Anthem Blue Cross and Blue Shield** 14 **Group Health Cooperative of Eau Claire** 19 **Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 8 **My Choice Wisconsin (MCW)/Molina** 8 **Network Health Plan** 7 **Security Health Plan of Wisconsin** 10 **United Healthcare Community Plan (UHC)** 43 **Quartz** 5

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.	**Anthem Blue Cross and Blue Shield** 5 **Group Health Cooperative of Eau Claire** 3 **Independent Care Health Plan (iCare)** 2 **MHS Health Wisconsin** 1 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 3 **Quartz** 0
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.	**Anthem Blue Cross and Blue Shield** 0 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 0 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0

United Healthcare Community Plan (UHC)

1

Quartz

0

D1IV.8c

State Fair Hearings resulting in an adverse decision for the enrollee

Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.

Anthem Blue Cross and Blue Shield

3

Group Health Cooperative of Eau Claire

2

Independent Care Health Plan (iCare)

1

MHS Health Wisconsin

0

My Choice Wisconsin (MCW)/Molina

0

Network Health Plan

0

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

0

Quartz

0

D1IV.8d

State Fair Hearings retracted prior to reaching a decision

Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.

Anthem Blue Cross and Blue Shield

0

Group Health Cooperative of Eau Claire

0

Independent Care Health Plan (iCare)

0

MHS Health Wisconsin

0

My Choice Wisconsin (MCW)/Molina

0

		Network Health Plan 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 0 **Quartz** 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 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).	**Anthem Blue Cross and Blue Shield** N/A **Group Health Cooperative of Eau Claire** N/A **Independent Care Health Plan (iCare)** N/A **MHS Health Wisconsin** N/A **My Choice Wisconsin (MCW)/Molina** N/A **Network Health Plan** N/A **Security Health Plan of Wisconsin** N/A **United Healthcare Community Plan (UHC)** N/A **Quartz** N/A
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your	**Anthem Blue Cross and Blue Shield** N/A **Group Health Cooperative of Eau Claire** N/A **Independent Care Health Plan (iCare)** N/A **MHS Health Wisconsin**

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).	N/A **My Choice Wisconsin (MCW)/Molina** N/A **Network Health Plan** N/A **Security Health Plan of Wisconsin** N/A **United Healthcare Community Plan (UHC)** N/A **Quartz** 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.	**Anthem Blue Cross and Blue Shield** 90 **Group Health Cooperative of Eau Claire** 2 **Independent Care Health Plan (iCare)** 27 **MHS Health Wisconsin** 100 **My Choice Wisconsin (MCW)/Molina** 211 **Network Health Plan** 61 **Security Health Plan of Wisconsin** 5 **United Healthcare Community Plan (UHC)** 76 **Quartz** 9
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.	**Anthem Blue Cross and Blue Shield** 1 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 5 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 3 **Security Health Plan of Wisconsin** 0

United Healthcare Community Plan (UHC)

12

Quartz

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.

Anthem Blue Cross and Blue Shield

N/A

Group Health Cooperative of Eau Claire

N/A

Independent Care Health Plan (iCare)

N/A

MHS Health Wisconsin

N/A

My Choice Wisconsin (MCW)/Molina

N/A

Network Health Plan

N/A

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

N/A

Quartz

N/A

D1IV.13

Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been

Anthem Blue Cross and Blue Shield

N/A

Group Health Cooperative of Eau Claire

N/A

Independent Care Health Plan (iCare)

N/A

MHS Health Wisconsin

N/A

My Choice Wisconsin (MCW)/Molina

N/A

	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.	**Network Health Plan** N/A **Security Health Plan of Wisconsin** N/A **United Healthcare Community Plan (UHC)** N/A **Quartz** N/A
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.	**Anthem Blue Cross and Blue Shield** 90 **Group Health Cooperative of Eau Claire** 2 **Independent Care Health Plan (iCare)** 27 **MHS Health Wisconsin** 95 **My Choice Wisconsin (MCW)/Molina** 210

Network Health Plan

61

Security Health Plan of Wisconsin

5

United Healthcare Community Plan (UHC)

76

Quartz

9

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".	**Anthem Blue Cross and Blue Shield** 12 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 9 **MHS Health Wisconsin** 2 **My Choice Wisconsin (MCW)/Molina** 7 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 4 **Quartz** 0
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem Blue Cross and Blue Shield** 48 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 14 **MHS Health Wisconsin** 54 **My Choice Wisconsin (MCW)/Molina** 47 **Network Health Plan** 38 **Security Health Plan of Wisconsin** 2

United Healthcare Community Plan (UHC)

51

Quartz

2

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".

Anthem Blue Cross and Blue Shield

0

Group Health Cooperative of Eau Claire

0

Independent Care Health Plan (iCare)

4

MHS Health Wisconsin

0

My Choice Wisconsin (MCW)/Molina

0

Network Health Plan

0

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

0

Quartz

0

D1IV.15d

Resolved grievances related to outpatient behavioral health services

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

Anthem Blue Cross and Blue Shield

4

Group Health Cooperative of Eau Claire

0

Independent Care Health Plan (iCare)

0

MHS Health Wisconsin

1

My Choice Wisconsin (MCW)/Molina

4

Network Health Plan

1

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

4

Quartz

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".

Anthem Blue Cross and Blue Shield

N/A

Group Health Cooperative of Eau Claire

N/A

Independent Care Health Plan (iCare)

N/A

MHS Health Wisconsin

N/A

My Choice Wisconsin (MCW)/Molina

4

Network Health Plan

0

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

1

Quartz

0

D1IV.15f

Resolved grievances related to skilled nursing facility (SNF) services

Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".

Anthem Blue Cross and Blue Shield

0

Group Health Cooperative of Eau Claire

0

Independent Care Health Plan (iCare)

1

MHS Health Wisconsin

		0 **My Choice Wisconsin (MCW)/Molina** 1 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 2 **Quartz** 0
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter “N/A”.	**Anthem Blue Cross and Blue Shield** N/A **Group Health Cooperative of Eau Claire** N/A **Independent Care Health Plan (iCare)** N/A **MHS Health Wisconsin** N/A **My Choice Wisconsin (MCW)/Molina** N/A **Network Health Plan** N/A **Security Health Plan of Wisconsin** N/A **United Healthcare Community Plan (UHC)** N/A **Quartz** N/A
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.	**Anthem Blue Cross and Blue Shield** 5 **Group Health Cooperative of Eau Claire** 0

If the managed care plan does not cover this type of service, enter “N/A”.

Independent Care Health Plan (iCare)

6

MHS Health Wisconsin

5

My Choice Wisconsin (MCW)/Molina

5

Network Health Plan

6

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

7

Quartz

0

D1IV.15i

Resolved grievances related to non-emergency medical transportation (NEMT)

Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter “N/A”.

Anthem Blue Cross and Blue Shield

N/A

Group Health Cooperative of Eau Claire

N/A

Independent Care Health Plan (iCare)

N/A

MHS Health Wisconsin

N/A

My Choice Wisconsin (MCW)/Molina

13

Network Health Plan

1

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

3

Quartz

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”.	**Anthem Blue Cross and Blue Shield** 36 **Group Health Cooperative of Eau Claire** 2 **Independent Care Health Plan (iCare)** 3 **MHS Health Wisconsin** 55 **My Choice Wisconsin (MCW)/Molina** 18 **Network Health Plan** 34 **Security Health Plan of Wisconsin** 2 **United Healthcare Community Plan (UHC)** 9 **Quartz** 3

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.	**Anthem Blue Cross and Blue Shield** 32 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 4 **MHS Health Wisconsin** 4 **My Choice Wisconsin (MCW)/Molina** 10 **Network Health Plan** 2 **Security Health Plan of Wisconsin** 1 **United Healthcare Community Plan (UHC)** 19 **Quartz** 1
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.	**Anthem Blue Cross and Blue Shield** 0 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 9 **My Choice Wisconsin (MCW)/Molina** 4 **Network Health Plan** 4 **Security Health Plan of Wisconsin** 0

United Healthcare Community Plan (UHC)

0

Quartz

0

D1IV.16c

Resolved grievances related to access to care/services from plan or provider

Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.

Anthem Blue Cross and Blue Shield

24

Group Health Cooperative of Eau Claire

0

Independent Care Health Plan (iCare)

8

MHS Health Wisconsin

22

My Choice Wisconsin (MCW)/Molina

83

Network Health Plan

9

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

6

Quartz

0

D1IV.16d

Resolved grievances related to quality of care

Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.

Anthem Blue Cross and Blue Shield

0

Group Health Cooperative of Eau Claire

2

Independent Care Health Plan (iCare)

15

MHS Health Wisconsin

2

My Choice Wisconsin (MCW)/Molina

1

Network Health Plan

0

Security Health Plan of Wisconsin

1

United Healthcare Community Plan (UHC)

42

Quartz

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.

Anthem Blue Cross and Blue Shield

4

Group Health Cooperative of Eau Claire

0

Independent Care Health Plan (iCare)

0

MHS Health Wisconsin

0

My Choice Wisconsin (MCW)/Molina

3

Network Health Plan

0

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

1

Quartz

0

D1IV.16f

Resolved grievances related to payment or billing issues

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.

Anthem Blue Cross and Blue Shield

29

Group Health Cooperative of Eau Claire

0

Independent Care Health Plan (iCare)

0

MHS Health Wisconsin

		55 **My Choice Wisconsin (MCW)/Molina** 51 **Network Health Plan** 44 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 18 **Quartz** 2
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.	**Anthem Blue Cross and Blue Shield** 0 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 2 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 0 **Quartz** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan	**Anthem Blue Cross and Blue Shield** 1 **Group Health Cooperative of Eau Claire** 0

	during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 2 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 0 **Quartz** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Anthem Blue Cross and Blue Shield** 1 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 0 **My Choice Wisconsin (MCW)/Molina** 1 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 0 **Quartz** 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.	**Anthem Blue Cross and Blue Shield** 0 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 0 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 0 **United Healthcare Community Plan (UHC)** 0 **Quartz** 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.	**Anthem Blue Cross and Blue Shield** 0 **Group Health Cooperative of Eau Claire** 0 **Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 4 **My Choice Wisconsin (MCW)/Molina** 58 **Network Health Plan** 5 **Security Health Plan of Wisconsin** 3 **United Healthcare Community Plan (UHC)**

2

Quartz

6

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: 19

Complete

D2.VII.1 Measure Name: Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET) - Engagement - Total, All Drugs

1 / 19

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

13.29%

Group Health Cooperative of Eau Claire

9.68%

Independent Care Health Plan (iCare)

14.48%

MHS Health Wisconsin

13.20%

My Choice Wisconsin (MCW)/Molina

9.64%

Network Health Plan

10.00%

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

9.90%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management (AMM) - Effective Acute Phase Treatment

D2.VII.2 Measure Domain

Behavioral health care

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

0105

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

70.09%

Group Health Cooperative of Eau Claire

56.00%

Independent Care Health Plan (iCare)

78.24%

MHS Health Wisconsin

74.00%

My Choice Wisconsin (MCW)/Molina

63.64%

Network Health Plan

75.79%

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

77.04%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management (AMM)- Effective Continuation Phase Treatment

D2.VII.2 Measure Domain

Behavioral health care

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

0105

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

49.53%

Group Health Cooperative of Eau Claire

40.00%

Independent Care Health Plan (iCare)

58.80%

MHS Health Wisconsin

57.33%

My Choice Wisconsin (MCW)/Molina

40.40%

Network Health Plan

62.11%

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

62.53%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)

D2.VII.2 Measure Domain

Behavioral health care

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

1932

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

84.18%

Group Health Cooperative of Eau Claire

81.25%

Independent Care Health Plan (iCare)

80.30%

MHS Health Wisconsin

80.35%

My Choice Wisconsin (MCW)/Molina

78.38%

Network Health Plan

78.33%

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

80.12%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)

D2.VII.2 Measure Domain

Behavioral health care

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

1879

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

70.45%

Group Health Cooperative of Eau Claire

72.73%

Independent Care Health Plan (iCare)

75.63%

MHS Health Wisconsin

74.79%

My Choice Wisconsin (MCW)/Molina

70.40%

Network Health Plan

81.40%

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

80.23%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure (CBP-AD)

6 / 19

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0018

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

69.34%

Group Health Cooperative of Eau Claire

71.07%

Independent Care Health Plan (iCare)

60.34%

MHS Health Wisconsin

67.64%

My Choice Wisconsin (MCW)/Molina

63.29%

Network Health Plan

69.59%

Security Health Plan of Wisconsin

77.59%

United Healthcare Community Plan (UHC)

71.78%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Plan All-Cause Readmissions (18-64) Observed/Expected Ratio

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

1768

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

0.9959

Group Health Cooperative of Eau Claire

0.8714

Independent Care Health Plan (iCare)

1.1355

MHS Health Wisconsin

1.0966

My Choice Wisconsin (MCW)/Molina

0.8143

Network Health Plan

0.8355

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

0.9483

Quartz

N/A

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

1800

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

63.29%

Group Health Cooperative of Eau Claire

73.02%

Independent Care Health Plan (iCare)

66.50%

MHS Health Wisconsin

75.00%

My Choice Wisconsin (MCW)/Molina

64.44%

Network Health Plan

63.16%

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

57.08%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Hemoglobin A1c Control for Patients with Diabetes - HBA1c Control (<8%)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0059

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

58.64%

Group Health Cooperative of Eau Claire

63.27%

Independent Care Health Plan (iCare)

56.69%

MHS Health Wisconsin

59.12%

My Choice Wisconsin (MCW)/Molina

61.54%

Network Health Plan

61.20%

Security Health Plan of Wisconsin

63.79%

United Healthcare Community Plan (UHC)

61.80%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening (CCS-AD)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0032

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

59.12%

Group Health Cooperative of Eau Claire

57.91%

Independent Care Health Plan (iCare)

56.93%

MHS Health Wisconsin

59.85%

My Choice Wisconsin (MCW)/Molina

60.25%

Network Health Plan

52.29%

Security Health Plan of Wisconsin

61.82%

United Healthcare Community Plan (UHC)

58.64%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Breast Cancer Screening (BCS-E-AD)

11 / 19

D2.VII.2 Measure Domain

Primary care access and preventative care

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

2372

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

52.35%

Group Health Cooperative of Eau Claire

52.90%

Independent Care Health Plan (iCare)

50.56%

MHS Health Wisconsin

57.34%

My Choice Wisconsin (MCW)/Molina

49.16%

Network Health Plan

54.66%

Security Health Plan of Wisconsin

70.97%

United Healthcare Community Plan (UHC)

55.54%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness (FUH)- 30 day follow-up, Total

D2.VII.2 Measure Domain

Behavioral health care

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

576

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

60.27%

Group Health Cooperative of Eau Claire

52.08%

Independent Care Health Plan (iCare)

78.29%

MHS Health Wisconsin

64.89%

My Choice Wisconsin (MCW)/Molina

65.28%

Network Health Plan

64.29%

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

52.16%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 30 day follow up (total) 13 / 19

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

42.14%

Group Health Cooperative of Eau Claire

38.10%

Independent Care Health Plan (iCare)

55.88%

MHS Health Wisconsin

40.38%

My Choice Wisconsin (MCW)/Molina

45.45%

Network Health Plan

47.46%

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

46.32%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 day follow-up (Total)

D2.VII.2 Measure Domain

Behavioral health care

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

3489

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

44.80%

Group Health Cooperative of Eau Claire

53.33%

Independent Care Health Plan (iCare)

52.90%

MHS Health Wisconsin

60.87%

My Choice Wisconsin (MCW)/Molina

60.24%

Network Health Plan

68.89%

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

48.61%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: Postpartum Care (PPC-AD) - Postpartum Care

15 / 19

D2.VII.2 Measure Domain

Maternal and perinatal health

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

1517

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

67.44%

Group Health Cooperative of Eau Claire

N/A

Independent Care Health Plan (iCare)

44.62%

MHS Health Wisconsin

51.16%

My Choice Wisconsin (MCW)/Molina

74.19%

Network Health Plan

50.00%

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

80.77%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: Postpartum Care (PPC-AD) - Timeliness of Prenatal Care

D2.VII.2 Measure Domain

Maternal and perinatal health

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

1517

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

83.72%

Group Health Cooperative of Eau Claire

N/A

Independent Care Health Plan (iCare)

53.85%

MHS Health Wisconsin

76.74%

My Choice Wisconsin (MCW)/Molina

80.65%

Network Health Plan

68.42%

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

79.49%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Colorectal Cancer Screening (COL-AD), Total 17 / 19

D2.VII.2 Measure Domain

Primary care access and preventative care

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

34

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

47.12%

Group Health Cooperative of Eau Claire

42.56%

Independent Care Health Plan (iCare)

42.56%

MHS Health Wisconsin

45.65%

My Choice Wisconsin (MCW)/Molina

41.59%

Network Health Plan

44.08%

Security Health Plan of Wisconsin

67.47%

United Healthcare Community Plan (UHC)

51.79%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women -Total (CHL-AD)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

33

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

53.64%

Group Health Cooperative of Eau Claire

N/A

Independent Care Health Plan (iCare)

64.42%

MHS Health Wisconsin

64.86%

My Choice Wisconsin (MCW)/Molina

72.58%

Network Health Plan

72.94%

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

51.59%

Quartz

N/A

Complete

D2.VII.1 Measure Name: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) Total

19 / 19

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

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Anthem Blue Cross and Blue Shield

40.74%

Group Health Cooperative of Eau Claire

N/A

Independent Care Health Plan (iCare)

38.71%

MHS Health Wisconsin

48.89%

My Choice Wisconsin (MCW)/Molina

N/A

Network Health Plan

N/A

Security Health Plan of Wisconsin

N/A

United Healthcare Community Plan (UHC)

43.48%

Quartz

N/A

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

Anthem Blue Cross and Blue Shield

D3.VIII.4 Reason for intervention

The plan did not meet contractual obligations related to policy, quality standards and performance criteria. There were issues related to claims processing, provider grievances, appeals, customer service and quality of reporting and communications sent to the Department

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

08/19/2024

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).	**Anthem Blue Cross and Blue Shield** 3.5 **Group Health Cooperative of Eau Claire** 1 **Independent Care Health Plan (iCare)** 4.04 **MHS Health Wisconsin** 1 **My Choice Wisconsin (MCW)/Molina** 3 **Network Health Plan** 1 **Security Health Plan of Wisconsin** 7 **United Healthcare Community Plan (UHC)** 4 **Quartz** 3
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Anthem Blue Cross and Blue Shield** 0 **Group Health Cooperative of Eau Claire** 22 **Independent Care Health Plan (iCare)** 0 **MHS Health Wisconsin** 0 **My Choice Wisconsin (MCW)/Molina** 0 **Network Health Plan** 0 **Security Health Plan of Wisconsin** 2

United Healthcare Community Plan (UHC)

0

Quartz

0

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.

Anthem Blue Cross and Blue Shield

0:1,000

Group Health Cooperative of Eau Claire

7.47:1,000

Independent Care Health Plan (iCare)

0:1,000

MHS Health Wisconsin

0:1,000

My Choice Wisconsin (MCW)/Molina

0:1,000

Network Health Plan

0:1,000

Security Health Plan of Wisconsin

3.25:1,000

United Healthcare Community Plan (UHC)

0:1,000

Quartz

0:1,000

D1X.4

Count of resolved program integrity investigations

How many program integrity investigations were resolved by the plan during the reporting year?

Anthem Blue Cross and Blue Shield

0

Group Health Cooperative of Eau Claire

22

Independent Care Health Plan (iCare)

0

MHS Health Wisconsin

0

My Choice Wisconsin (MCW)/Molina

0

Network Health Plan

0

Security Health Plan of Wisconsin

1

United Healthcare Community Plan (UHC)

0

Quartz

0

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.

Anthem Blue Cross and Blue Shield

0:1,000

Group Health Cooperative of Eau Claire

7.47:1,000

Independent Care Health Plan (iCare)

0:1,000

MHS Health Wisconsin

0:1,000

My Choice Wisconsin (MCW)/Molina

0:1,000

Network Health Plan

0:1,000

Security Health Plan of Wisconsin

1.63:1,000

United Healthcare Community Plan (UHC)

0:1,000

Quartz

0:1,000

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.

Anthem Blue Cross and Blue Shield

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

Group Health Cooperative of Eau Claire

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

Independent Care Health Plan (iCare)

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

MHS Health Wisconsin

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

My Choice Wisconsin (MCW)/Molina

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

Network Health Plan

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

Security Health Plan of Wisconsin

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

United Healthcare Community Plan (UHC)

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

Quartz

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.

Anthem Blue Cross and Blue Shield

0

Group Health Cooperative of Eau Claire

0

Independent Care Health Plan (iCare)

0

MHS Health Wisconsin

0

My Choice Wisconsin (MCW)/Molina

0

Network Health Plan

0

Security Health Plan of Wisconsin

0

United Healthcare Community Plan (UHC)

0

Quartz

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.

Anthem Blue Cross and Blue Shield

0:1,000

Group Health Cooperative of Eau Claire

0:1,000

Independent Care Health Plan (iCare)

0:1,000

MHS Health Wisconsin

0:1,000

My Choice Wisconsin (MCW)/Molina

0:1,000

Network Health Plan

0:1,000

Security Health Plan of Wisconsin

0:1,000

United Healthcare Community Plan (UHC)

0:1,000

Quartz

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?

Anthem Blue Cross and Blue Shield

01/01/2024

Group Health Cooperative of Eau Claire

01/01/2024

Independent Care Health Plan (iCare)

01/01/2024

MHS Health Wisconsin

01/01/2024

My Choice Wisconsin (MCW)/Molina

01/01/2024

Network Health Plan

01/01/2024

Security Health Plan of Wisconsin

01/01/2024

United Healthcare Community Plan (UHC)

01/01/2024

Quartz

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?

Anthem Blue Cross and Blue Shield

12/31/2024

Group Health Cooperative of Eau Claire

12/31/2024

Independent Care Health Plan (iCare)

12/31/2024

MHS Health Wisconsin

12/31/2024

My Choice Wisconsin (MCW)/Molina

12/31/2024

Network Health Plan

12/31/2024

Security Health Plan of Wisconsin

12/31/2024

United Healthcare Community Plan (UHC)

12/31/2024

Quartz

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?

Anthem Blue Cross and Blue Shield

$0

Group Health Cooperative of Eau Claire

$103.62

Independent Care Health Plan (iCare)

$87,010.64

MHS Health Wisconsin

$1,218,900.03

My Choice Wisconsin (MCW)/Molina

$286,660.09

Network Health Plan

$1,218,900.03

Security Health Plan of Wisconsin

$1,883.47

United Healthcare Community Plan (UHC)

$3,602,250.14

Quartz

$0

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))

Anthem Blue Cross and Blue Shield

$43,154,053.88

Group Health Cooperative of Eau Claire

$15,920,295.80

Independent Care Health Plan (iCare)

$54,118,912.62

MHS Health Wisconsin

$40,046,835.06

My Choice Wisconsin (MCW)/Molina

$32,909,036.71

Network Health Plan

$22,901,125.69

Security Health Plan of Wisconsin

$3,156,485.61

United Healthcare Community Plan (UHC)

$102,965,452.84

Quartz

$2,405,053.21

D1X.10

Changes in beneficiary circumstances

Select the frequency the plan reports changes in beneficiary

Anthem Blue Cross and Blue Shield

Weekly

circumstances to the state.

Group Health Cooperative of Eau Claire

Weekly

Independent Care Health Plan (iCare)

Weekly

MHS Health Wisconsin

Weekly

My Choice Wisconsin (MCW)/Molina

Weekly

Network Health Plan

Weekly

Security Health Plan of Wisconsin

Weekly

United Healthcare Community Plan (UHC)

Weekly

Quartz

Weekly

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.	**Anthem Blue Cross and Blue Shield** Not answered **Group Health Cooperative of Eau Claire** Not answered **Independent Care Health Plan (iCare)** Not answered **MHS Health Wisconsin** Not answered **My Choice Wisconsin (MCW)/Molina** Not answered **Network Health Plan** Not answered **Security Health Plan of Wisconsin** Not answered **United Healthcare Community Plan (UHC)** Not answered **Quartz** 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).	**Maximus** Enrollment Broker
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).	**Maximus** Enrollment Broker/Choice Counseling