WISCONSIN DEPARTMENT of HEALTH SERVICES

Managed Care Program Annual Report

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Background

Managed Care Program Annual Report (MCPAR)

- CMS regulations at 42 CFR § 438.66(e) require states to submit a MCPAR.

- MCPARs are due annually, no later than 180 days after the end of each program's contract year. For the adult managed care programs, the contract year is from January through December 31 and the MCPAR is due the following June.

Managed Care Program Annual Report (MCPAR)

- The MCPAR is a program-specific report, and states must submit one MCPAR for each program.

- DHS submits reports for Family Care (FC), Family Care Partnership (FCP), BadgerCare Plus (BC+), and Medicaid SSI HMO, and Care4Kids (C4K).

Managed Care Program Annual Report (MCPAR)

- CMS is undertaking efforts to improve transparency by publicly posting MCPARs in the next year on a regular basis on Medicaid.gov.
- States are required to post MCPARs to their websites to support transparency and plan accountability.

Managed Care Program Annual Report (MCPAR)

- States must also:
  - Provide MCPARs to their Medical Care Advisory Committee (Medicaid Advisory Committee)
  - If the program includes long-term services and supports (LTSS), provide the MCPAR to the stakeholder consultation groups specified in 42 CFR 438.70. For FC and FCP, this is the Long-Term Care Advisory Committee.

MCPAR Categories

MCPAR Data

- The MCPAR includes state level, program level, and plan level data that describes the program's integrity and quality of care for members.

State-Level Indicators

- Enrollment
- Program integrity activities
- Overpayment monitoring
- Federal database checks and monitoring

Program-Level Indicators

- Enrollment
- Encounter data
- Appeals, fair hearings, and grievances
- Network adequacy
- Member support systems (ADRCs, enrollment broker)

Plan-Level Indicators

- Enrollment and share of total enrollment
- Medical loss ratio
- Timely and HIPAA-compliant encounter submissions
- Quality measures
- Program integrity staffing, investigations, and overpayment reporting
- Appeals, grievances, and fair hearings

Data Analysis

Strengths

- Program Integrity
  - MCOs submitted quarterly program integrity activities in a DHS template, including required specific investigation data, number of complaints, number of program integrity employees, results of provider audits and recoveries. DHS was able to report on all program integrity data elements.
  - MCOs submitted preliminary Medical Loss Ratio (MLR) reporting with their annual financial audits due June 1 of the calendar year. The 2022 preliminary results were included in the 2023 MCPAR reporting. Final resubmissions will be made if there are final 2022 risk corridor retro adjustments.

Areas for Improvement

- Program Integrity
  - The DHS template will have updates to enhance instructions and support consistency of reporting between MCOs.
  - MCO experience and skill projecting the risk corridor estimate can produce immaterial retro adjustments and should eliminate the need for a final resolution.

Strengths

- Appeal and Grievances
  - CMS reporting requirements for the MCPAR were more robust than required by the managed care rule. As a result, standardized quarterly appeal and grievance logs/instructions were created to account for all reporting included in the MCPAR. MCOs began quarterly reporting with the updated logs in 2023 and DHS was able to report on all appeal and grievance data elements with the 2023 MCPAR.

Areas for Improvement

- Appeals and Grievances
  - Opportunities for enhancing quality and consistency of submitted appeal and grievance data.

CMS Feedback

- The structured data captured by this system will allow CMS to generate and analyze state-specific and nationwide data across the universe of managed care programs and requirements. This data analysis will allow CMS to identify areas of technical assistance and to target efforts to assist states in improving their managed care programs while also ensuring compliance with managed care statutes and regulations, such as ensuring access to care.
- CMS may develop standardized feedback for all MCPARs in the future to continue advancing data quality.

WISCONSIN DEPARTMENT *of* HEALTH SERVICES

Thank you!

Questions?

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

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

	Indicator	Response
	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.	DHSDMSLTC@dhs.wisconsin.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Kimberly Schindler
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	Kimberly.Schindler@dhs.wisconsin.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/24/2024

Reporting Period

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

Add plans (A.7)

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

	Indicator	Response
	Plan name	Community Care, Inc. (CCI) Inclusa, Inc. Lakeland Care, Inc. My Choice Wisconsin, Inc. (MCW)

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

	Indicator	Response
	BSS entity name	Multi-location ADRC

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.	1,467,489
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,095,234

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

	Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	This is an automated function in the Forward Health System and used to produce the monthly capitation. The plan reports enrollment changes such as deaths, incarcerations, and disenrollments to the local income maintenance agency. The data is updated in the system which then updates the SMA MMIS program to produce Capitation payments and capitation adjustments. Updates to the enrollee's functional screen and annual financial eligibility reviews or as required updates are used to maintain accurate enrollment records in the SMA MMIS
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or	No

	PCCM entity through routine checks of Federal databases.	
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	Yes
BX.9b	**Website posting of 5 percent or more ownership control: Link** What is the link to the website? Refer to 42 CFR 602(g)(3).	https://www.dhs.wisconsin.gov/familycare/mcocontacts.pdf
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter 'No such audits were conducted during the reporting year' as your response. 'N/A' is not an acceptable response.	https://oci.wi.gov/Pages/Companies/FinExams.aspx

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Family Care Contract between Wisconsin Department of Health Division of Medicaid Services and <>; Amended January 1, 2023
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	1/1/2023
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.dhs.wisconsin.gov/familycare/mcos/fc-fcp-2022-generic-final.pdf
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Prepaid Inpatient Health Plan (PIHP)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per	53,415

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

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Art. XIV.B
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality	Art. XIV.B.5 and XVI.G

	standards. Use contract section references, not page numbers.	
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has 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.	The MCO is required to report immediately to its DHS Member Care Quality Specialist any of the following: Upon learning a member's whereabouts are not known for 24 hours or more, under any of the following circumstances: The member is under guardianship/protective placement; The member has been identified as a vulnerable/high risk member as defined under Article I.144; The MCO has reason to believe that the member's health or safety is at risk; The member is a potential threat to the community or self; The member has a significant medical condition that would deteriorate without medications/care; The member lives in a residential facility; or The area is experiencing potentially life-threatening weather conditions. Upon learning a member has died under any of the following circumstances: Death involving unexplained, unusual, or suspicious circumstances; Death involving apparent abuse or neglect; Apparent homicide; Apparent suicide; Apparent poisoning; Contract for <> Program between the Wisconsin Department of Health Services, Division of Medicaid Services and <> Article V, Care Management Page 93 Apparent accident, whether the resulting injury is or is not the primary cause of death; or When a physician refuses to sign the death certificate. Upon learning a member has suffered or caused an injury or accident related to any of the following circumstances: When unexplained, unusual, or suspicious circumstances exist; When physical abuse, sexual abuse, or neglect exist; When the member has been poisoned; or When law enforcement, Adult Protective Services (APS), or a court of law have investigated and/or are involved; Upon learning a member has been admitted to a state IMD or Intensive Treatment Program (ITP). A list of both county and privately operated IMDs in Wisconsin can be found in section 27.11 of the Medicaid Eligibility Handbook. Upon learning that an Emergency Restrictive Measure, as defined in Wis. Stat. § 46.90(1)(i), was used on a member regardless of injury.

C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	Unless the member requests expedited resolution, for Family Care and Partnership the MCO must mail or hand-deliver a written decision on the appeal no later than thirty (30) calendar days after the date of receipt of the appeal.
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	The MCO must make reasonable efforts to give the member prompt oral notice of approval or denial of the request for expedited resolution and a written notice within two (2) calendar days.
C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	The MCO grievance and appeal committee for Family Care and Partnership Medicaid-only must mail or hand-deliver a written decision on a grievance to the member and the member's legal decision maker, if applicable, as expeditiously as the member's situation and health condition require, but no later than ninety (90) calendar days after the date of receipt of the grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter 'No challenges were encountered' as your response. 'N/A' is not an acceptable response.	Two of the main challenges are limited numbers of providers in rural regions/counties, and the caregiver workforce shortage.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	MCPs provided explanations on similar services that can be provided to meet member needs. For the caregiver workforce shortage, there have been rate increases provided through state and federal assistance with ARPA. The state is also implementing the Wiscaregiver career program which prepares job seekers to enter the caregiving workforce. The program teaches essential skills that direct care workers can use from one employer to another without the need for re-training. This will help employers officially recognize workers' skills and will help professionalize their career. The goal is to certify at least 10,000 new workers in the profession of direct care.

Access Measures

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

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

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

Access measure total count: 47

Complete

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

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

1:225

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-adult day care	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

3 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

8 / 47

C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Supported employment – small group employment support	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:350

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Community support program	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

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

Counseling and therapeutic resources	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Self-directed personal care	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

21 / 47

C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Supported employment – individual employment support	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

22 / 47

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

23 / 47

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Transportation (excluding ambulance)	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

24 / 47

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Transportation (specialized transportation) – community transportation	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

25 / 47

C2.V.2 Measure standard

1:1200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Home-delivered meals	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

26 / 47

C2.V.2 Measure standard

1:900

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

27 / 47

C2.V.2 Measure standard

1:900

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

28 / 47

C2.V.2 Measure standard

1:75

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

29 / 47

C2.V.2 Measure standard

1:75

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Adult residential care – 3-4 bed adult family homes	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

30 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

31 / 47

C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

32 / 47

C2.V.2 Measure standard

1:350

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Nursing home stays (nursing home,	All counties	MLTSS

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

33 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

34 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

35 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

36 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

37 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

38 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

39 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

40 / 47

C2.V.2 Measure standard

No more than 60 business days from time of service approval

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Consultative clinical and therapeutic services for caregivers

C2.V.5 Region

All counties

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

41 / 47

C2.V.2 Measure standard

No more than 60 business days from time of service approval

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Consumer education and training

C2.V.5 Region

All counties

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

42 / 47

C2.V.2 Measure standard

No more than 60 business days from time of service approval

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

C2.V.5 Region

C2.V.6 Population

Housing counseling	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

43 / 47

C2.V.2 Measure standard

No more than 60 business days from time of service approval

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

44 / 47

C2.V.2 Measure standard

No more than 60 business days from time of service approval

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

45 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

46 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

47 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.dhs.wisconsin.gov/adrc/index.htm
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	The ADRC must provide information and assistance to members of the target populations and their families, friends, caregivers, advocates and others who ask for assistance on their behalf. Information and assistance must be provided in a manner convenient to the customer including, but not limited to, being provided in-person in the customer's home or at the ADRC office as an appointment or walk-in, over the telephone, virtually, via email, or through written correspondence.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	ADRCs identify the unmet needs of their customer populations, including unserved or underserved subgroups within the customer populations, and the types of services, facilities, or funding sources that are in short supply.
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	The State ADRC regional quality specialists evaluate the quality, effectiveness and efficiency of ADRC performance through a series of quality monitoring activities including; annual ADRC site visits, monthly contact with ADRC Directors, quarterly review of review required reports and customer data regarding ADRC service delivery, assuring new staff complete and pass options counseling training and required post-test, verify each options counselor has been observed at least once annually by a peer or supervisor, regularly review ADRC board meeting agendas, minutes, and supporting documents and individually reviewing, investigating and responding to ADRC complaints. The ADRC regional quality team identifies trends, issues, concerns, and best practices through these activities and addresses quality concerns through the provision of technical assistance, training,

		policy development and corrective action as needed.

Topic X: Program Integrity

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

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Community Care, Inc. (CCI)** 13,952 **Inclusa, Inc.** 17,153 **Lakeland Care, Inc.** 7,331 **My Choice Wisconsin, Inc. (MCW)** 14,979
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Community Care, Inc. (CCI)** 1% **Inclusa, Inc.** 1.2% **Lakeland Care, Inc.** 0.5% **My Choice Wisconsin, Inc. (MCW)** 1%

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

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Community Care, Inc. (CCI)** 95% **Inclusa, Inc.** 98% **Lakeland Care, Inc.** 96% **My Choice Wisconsin, Inc. (MCW)** 95%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Community Care, Inc. (CCI)** Program-specific regional **Inclusa, Inc.** Program-specific regional **Lakeland Care, Inc.** Program-specific regional **My Choice Wisconsin, Inc. (MCW)** Program-specific regional
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Community Care, Inc. (CCI)** N/A **Inclusa, Inc.** N/A **Lakeland Care, Inc.** N/A **My Choice Wisconsin, Inc. (MCW)**

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

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Community Care, Inc. (CCI)** Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter. **Inclusa, Inc.** Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter. **Lakeland Care, Inc.** Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter. **My Choice Wisconsin, Inc. (MCW)** Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**Community Care, Inc. (CCI)** 100% **Inclusa, Inc.** 94% **Lakeland Care, Inc.** 100% **My Choice Wisconsin, Inc. (MCW)** 81%
D1III.3	**Share of encounter data submissions that were HIPAA compliant**	**Community Care, Inc. (CCI)** 96%

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.	**Inclusa, Inc.** 99% **Lakeland Care, Inc.** 97% **My Choice Wisconsin, Inc. (MCW)** 95%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Community Care, Inc. (CCI)** 73 **Inclusa, Inc.** 20 **Lakeland Care, Inc.** 8 **My Choice Wisconsin, Inc. (MCW)** 47
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.	**Community Care, Inc. (CCI)** 2 **Inclusa, Inc.** 4 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 2
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Community Care, Inc. (CCI)** 75 **Inclusa, Inc.** 24 **Lakeland Care, Inc.** 8 **My Choice Wisconsin, Inc. (MCW)** 49

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 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.	**Community Care, Inc. (CCI)** 0 **Inclusa, Inc.** 0 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 0
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	**Community Care, Inc. (CCI)** 73 **Inclusa, Inc.** 20

requirements related to timely resolution of standard appeals.

Lakeland Care, Inc.

8

My Choice Wisconsin, Inc. (MCW)

47

D1IV.5b

Expedited appeals for which timely resolution was provided

Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year.
See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.

Community Care, Inc. (CCI)

0

Inclusa, Inc.

0

Lakeland Care, Inc.

0

My Choice Wisconsin, Inc. (MCW)

0

D1IV.6a

Resolved appeals related to denial of authorization or limited authorization of a service

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service.
(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).

Community Care, Inc. (CCI)

15

Inclusa, Inc.

7

Lakeland Care, Inc.

1

My Choice Wisconsin, Inc. (MCW)

7

D1IV.6b

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

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.

Community Care, Inc. (CCI)

45

Inclusa, Inc.

11

Lakeland Care, Inc.

2

My Choice Wisconsin, Inc. (MCW)

13

D1IV.6c

Resolved appeals related to payment denial

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.

Community Care, Inc. (CCI)

0

Inclusa, Inc.

0

Lakeland Care, Inc.

0

My Choice Wisconsin, Inc. (MCW)

0

D1IV.6d

Resolved appeals related to service timeliness

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).

Community Care, Inc. (CCI)

0

Inclusa, Inc.

0

Lakeland Care, Inc.

0

My Choice Wisconsin, Inc. (MCW)

0

D1IV.6e

Resolved appeals related to lack of timely plan response to an appeal or grievance

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

Community Care, Inc. (CCI)

0

Inclusa, Inc.

0

Lakeland Care, Inc.

0

My Choice Wisconsin, Inc. (MCW)

		0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Community Care, Inc. (CCI)** 0 **Inclusa, Inc.** 0 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Community Care, Inc. (CCI)** 13 **Inclusa, Inc.** 1 **Lakeland Care, Inc.** 1 **My Choice Wisconsin, Inc. (MCW)** 3

Appeals by Service

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

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

D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that 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".	**Community Care, Inc. (CCI)** 0 **Inclusa, Inc.** 0 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 0
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Community Care, Inc. (CCI)** N/A **Inclusa, Inc.** N/A **Lakeland Care, Inc.** N/A **My Choice Wisconsin, Inc. (MCW)** N/A
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Community Care, Inc. (CCI)** 4 **Inclusa, Inc.** 5 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 7
D1IV.7g	**Resolved appeals related to long-term services and**	**Community Care, Inc. (CCI)**

	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".	7 **Inclusa, Inc.** 11 **Lakeland Care, Inc.** 2 **My Choice Wisconsin, Inc. (MCW)** 9
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Community Care, Inc. (CCI)** N/A **Inclusa, Inc.** N/A **Lakeland Care, Inc.** N/A **My Choice Wisconsin, Inc. (MCW)** N/A
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**Community Care, Inc. (CCI)** N/A **Inclusa, Inc.** N/A **Lakeland Care, Inc.** N/A **My Choice Wisconsin, Inc. (MCW)** N/A
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that	**Community Care, Inc. (CCI)** 0

were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i paid primarily by Medicaid, enter "N/A".

Inclusa, Inc.

2

Lakeland Care, Inc.

1

My Choice Wisconsin, Inc. (MCW)

4

State Fair Hearings

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

D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Community Care, Inc. (CCI)** 8 **Inclusa, Inc.** 1 **Lakeland Care, Inc.** 2 **My Choice Wisconsin, Inc. (MCW)** 23
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).	**Community Care, Inc. (CCI)** N/A **Inclusa, Inc.** N/A **Lakeland Care, Inc.** N/A **My Choice Wisconsin, Inc. (MCW)** N/A
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Community Care, Inc. (CCI)** N/A **Inclusa, Inc.** N/A **Lakeland Care, Inc.** N/A **My Choice Wisconsin, Inc. (MCW)** N/A

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Community Care, Inc. (CCI)** 51 **Inclusa, Inc.** 37 **Lakeland Care, Inc.** 17 **My Choice Wisconsin, Inc. (MCW)** 32
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Community Care, Inc. (CCI)** 0 **Inclusa, Inc.** 1 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 0
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Community Care, Inc. (CCI)** 51 **Inclusa, Inc.** 38 **Lakeland Care, Inc.** 17 **My Choice Wisconsin, Inc. (MCW)** 32

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 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	**Community Care, Inc. (CCI)** 0 **Inclusa, Inc.** 0 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 0

	grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Community Care, Inc. (CCI)** 51 **Inclusa, Inc.** 37 **Lakeland Care, Inc.** 17 **My Choice Wisconsin, Inc. (MCW)** 32

Grievances by Service

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

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

D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc. (CCI)** 0 **Inclusa, Inc.** 0 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 1
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc. (CCI)** N/A **Inclusa, Inc.** N/A **Lakeland Care, Inc.** N/A **My Choice Wisconsin, Inc. (MCW)** N/A
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc. (CCI)** 0 **Inclusa, Inc.** 7 **Lakeland Care, Inc.** 1 **My Choice Wisconsin, Inc. (MCW)** 4
D1IV.15g	**Resolved grievances related to long-term services and**	**Community Care, Inc. (CCI)**

	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".	46 **Inclusa, Inc.** 25 **Lakeland Care, Inc.** 16 **My Choice Wisconsin, Inc. (MCW)** 27
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc. (CCI)** N/A **Inclusa, Inc.** N/A **Lakeland Care, Inc.** N/A **My Choice Wisconsin, Inc. (MCW)** N/A
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc. (CCI)** 0 **Inclusa, Inc.** 0 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 0
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that	**Community Care, Inc. (CCI)** 5

were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i paid primarily by Medicaid, enter "N/A".	**Inclusa, Inc.** 5 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 0	

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Community Care, Inc. (CCI)** 35 **Inclusa, Inc.** 15 **Lakeland Care, Inc.** 2 **My Choice Wisconsin, Inc. (MCW)** 16
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Community Care, Inc. (CCI)** 10 **Inclusa, Inc.** 5 **Lakeland Care, Inc.** 11 **My Choice Wisconsin, Inc. (MCW)** 7

D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Community Care, Inc. (CCI)** 2 **Inclusa, Inc.** 5 **Lakeland Care, Inc.** 1 **My Choice Wisconsin, Inc. (MCW)** 1
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Community Care, Inc. (CCI)** 11 **Inclusa, Inc.** 5 **Lakeland Care, Inc.** 3 **My Choice Wisconsin, Inc. (MCW)** 5
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Community Care, Inc. (CCI)** 15 **Inclusa, Inc.** 0 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 3

D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Community Care, Inc. (CCI)** 0 **Inclusa, Inc.** 7 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 0
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Community Care, Inc. (CCI)** 0 **Inclusa, Inc.** 0 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Community Care, Inc. (CCI)** 0 **Inclusa, Inc.** 0 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)**

0

D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved 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).	**Community Care, Inc. (CCI)** 0 **Inclusa, Inc.** 0 **Lakeland Care, Inc.** 0 **My Choice Wisconsin, Inc. (MCW)** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Community Care, Inc. (CCI)** 1 **Inclusa, Inc.** 5 **Lakeland Care, Inc.** 3 **My Choice Wisconsin, Inc. (MCW)** 1
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Community Care, Inc. (CCI)** 0 **Inclusa, Inc.** 0 **Lakeland Care, Inc.** 0

My Choice Wisconsin, Inc. (MCW)

0

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Quality & performance measure total count: 1

Complete

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

1 / 1

D2.VII.2 Measure Domain

Long-term services and supports

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

N/A

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

Cross-program rate: Family Care, Family Care Partnership

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

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

Measure results

Community Care, Inc. (CCI)

6.94%

Inclusa, Inc.

11.20%

Lakeland Care, Inc.

17.16%

My Choice Wisconsin, Inc. (MCW)

15.17%

Topic VIII. Sanctions

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

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

Sanction total count: 2

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 2

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Inclusa, Inc.

D3.VIII.4 Reason for intervention

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

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/24/2023

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 2

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Community Care, Inc. (CCI)

D3.VIII.4 Reason for intervention

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

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/14/2023

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Community Care, Inc. (CCI)** 1 **Inclusa, Inc.** 5 **Lakeland Care, Inc.** 3 **My Choice Wisconsin, Inc. (MCW)** 1
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Community Care, Inc. (CCI)** 25 **Inclusa, Inc.** 46 **Lakeland Care, Inc.** 3 **My Choice Wisconsin, Inc. (MCW)** 5
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Community Care, Inc. (CCI)** 1.79:1,000 **Inclusa, Inc.** 2.68:1,000 **Lakeland Care, Inc.** 0.41:1,000 **My Choice Wisconsin, Inc. (MCW)** 0.33:1,000

D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Community Care, Inc. (CCI)** 22 **Inclusa, Inc.** 15 **Lakeland Care, Inc.** 20 **My Choice Wisconsin, Inc. (MCW)** 5
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Community Care, Inc. (CCI)** 1.58:1,000 **Inclusa, Inc.** 0.87:1,000 **Lakeland Care, Inc.** 2.73:1,000 **My Choice Wisconsin, Inc. (MCW)** 0.33:1,000
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Community Care, Inc. (CCI)** Makes some referrals to the SMA and others directly to the MFCU **Inclusa, Inc.** Makes some referrals to the SMA and others directly to the MFCU **Lakeland Care, Inc.** Makes some referrals to the SMA and others directly to the MFCU **My Choice Wisconsin, Inc. (MCW)**

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

D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**Community Care, Inc. (CCI)** 2 **Inclusa, Inc.** 2 **Lakeland Care, Inc.** 22 **My Choice Wisconsin, Inc. (MCW)** 0
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	**Community Care, Inc. (CCI)** 0.14:1,000 **Inclusa, Inc.** 0.12:1,000 **Lakeland Care, Inc.** 3:1,000 **My Choice Wisconsin, Inc. (MCW)** 0:1,000
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2).	**Community Care, Inc. (CCI)** """1/1/23-12/31/23 $644,207,369 Recovered Ratio = 0.0003""" **Inclusa, Inc.** """1/1/22-12/31/22 $1,662,345 Recovered Ratio = 0.0022""" **Lakeland Care, Inc.** """1/1/23-12/31/23 $4,017,087 Recovered Ratio = 0.0120"""

		My Choice Wisconsin, Inc. (MCW) """1/1/23-12/31/23 $2,269,708 Recovered Ratio = 0.0033"""
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Community Care, Inc. (CCI)** Daily **Inclusa, Inc.** Daily **Lakeland Care, Inc.** Daily **My Choice Wisconsin, Inc. (MCW)** Daily

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

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

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

Due date	Last edited	Edited by	Status
05/29/2024	06/24/2024	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.	DHSDMSLTC@dhs.wisconsin.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Kimberly Schindler
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	Kimberly.Schindler@dhs.wisconsin.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/24/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/01/2023
A6	**Program name** Auto-populated from report dashboard.	Family Care Partnership

Add plans (A.7)

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

	Indicator	Response
	Plan name	Community Care, Inc (CCI) Independent Health Plan (iCare) My Choice Wisconsin (MCW)

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

	Indicator	Response
	BSS entity name	Multi-location ADRC

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.	1,467,789
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,095,234

Topic III. Encounter Data Report

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter 'No PI activities were performed during the reporting period' as your response. 'N/A' is not an acceptable response.	Capitation payments against date of death reviews are completed. EVV soft launch to allow home visit supportive home care and personal care worker time validation. Will not conduct actual audits until hard launch and vendor compliance requirements are in place. Other data analytics and reviews will be implemented after the DHS MLTSS system rewrite that is in process goes live. Once implemented there will be the ability to scrub the data for targeted anomalies.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State requires the return of overpayments
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Art III.D.30, Art III.K.1.g, Art.XIV.C.4, Article XIV.C.5.g
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	Include in Program Integrity Quarterly Reporting overpayments recovered and retained by MCO versus those returned to the SMA because the plan is not permitted to retain them and identify those due to potential fraud.
BX.5	**State overpayment reporting monitoring**	The SMA tracks satisfaction and timeliness of compliance with the reporting requirement.

	Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	This is an automated function in the Forward Health System and used to produce the monthly capitation. The plan reports enrollment changes such as deaths, incarcerations, and disenrollments to the local income maintenance agency. The data is updated in the system which then updates the SMA MMIS programed to produce Capitation payments and capitation adjustments. Updates to the enrollee's functional screen and annual financial eligibility reviews or as required updates are used to maintain accurate enrollment records in the SMA MMIS.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or	No

	PCCM entity through routine checks of Federal databases.	
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	Yes
BX.9b	**Website posting of 5 percent or more ownership control: Link** What is the link to the website? Refer to 42 CFR 602(g)(3).	https://www.dhs.wisconsin.gov/familycare/mcocontacts.pdf
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter 'No such audits were conducted during the reporting year' as your response. 'N/A' is not an acceptable response.	https://oci.wi.gov/Pages/Companies/FinExams.aspx

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Family Care Contract between Wisconsin Department of Health Division of Medicaid Services and <>;. Amended January 1, 2023
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	1/1/2023
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.dhs.wisconsin.gov/familycare/mcos/fc-fcp-2022-generic-final.pdf
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Dental Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per	3,644

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

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Art. XIV.B
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality	Art. XIV.B.5 and XVI.G

	standards. Use contract section references, not page numbers.	
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	Incentives are not awarded to managed care plans for encouter data quality.
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting 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.	The MCO is required to report immediately to its DHS Member Care Quality Specialist any of the following: Upon learning a member's whereabouts are not known for 24 hours or more, under any of the following circumstances: The member is under guardianship/protective placement; The member has been identified as a vulnerable/high risk member as defined under Article I.144; The MCO has reason to believe that the member's health or safety is at risk; The member is a potential threat to the community or self; The member has a significant medical condition that would deteriorate without medications/care; The member lives in a residential facility; or The area is experiencing potentially life-threatening weather conditions. Upon learning a member has died under any of the following circumstances: Death involving unexplained, unusual, or suspicious circumstances; Death involving apparent abuse or neglect; Apparent homicide; Apparent suicide; Apparent poisoning; Contract for <> Program between the Wisconsin Department of Health Services, Division of Medicaid Services and <> Article V, Care Management Page 93 Apparent accident, whether the resulting injury is or is not the primary cause of death; or When a physician refuses to sign the death certificate. Upon learning a member has suffered or caused an injury or accident related to any of the following circumstances: When unexplained, unusual, or suspicious circumstances exist; When physical abuse, sexual abuse, or neglect exist; When the member has been poisoned; or When law enforcement, Adult Protective Services (APS), or a court of law have investigated and/or are involved; Upon learning a member has been admitted to a state IMD or Intensive Treatment Program (ITP). A list of both county and privately operated IMDs in Wisconsin can be found in section 27.11 of the Medicaid Eligibility Handbook. Upon learning that an Emergency Restrictive Measure, as defined in Wis. Stat. § 46.90(1)(i), was used on a member regardless of injury.

C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	Unless the member requests expedited resolution, for Family Care and Partnership the MCO must mail or hand-deliver a written decision on the appeal no later than thirty (30) calendar days after the date of receipt of the appeal.
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	The MCO must make reasonable efforts to give the member prompt oral notice of approval or denial of the request for expedited resolution and a written notice within two (2) calendar days.
C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	The MCO grievance and appeal committee for Family Care and Partnership Medicaid-only must mail or hand-deliver a written decision on a grievance to the member and the member's legal decision maker, if applicable, as expeditiously as the member's situation and health condition require, but no later than ninety (90) calendar days after the date of receipt of the grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter 'No challenges were encountered' as your response. 'N/A' is not an acceptable response.	Two of the main challenges are limited numbers of providers in rural regions/counties, and the caregiver workforce shortage.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	MCPs provided explanations on similar services that can be provided to meet member needs. For the caregiver workforce shortage, there have been rate increases provided through state and federal assistance with ARPA. The state is also implementing the Wiscaregiver career program which prepares job seekers to enter the caregiving workforce. The program teaches essential skills that direct care workers can use from one employer to another without the need for re-training. This will help employers officially recognize workers' skills and will help professionalize their career. The goal is to certify at least 10,000 new workers in the profession of direct care.

Access Measures

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

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

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

Access measure total count: 47

Complete

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

1 / 47

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

2 / 47

C2.V.2 Measure standard

1:350

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-adult day care	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

3 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

4 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

5 / 47

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

6 / 47

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

7 / 47

C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

8 / 47

C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Supported employment – small group employment support	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

9 / 47

C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

10 / 47

C2.V.2 Measure standard

1:350

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Community support program	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

11 / 47

C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

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

Counseling and therapeutic resources	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

12 / 47

C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Self-directed personal care	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

16 / 47

C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

17 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Supported employment – individual employment support	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

22 / 47

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

23 / 47

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Transportation (excluding ambulance)	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Transportation (specialized transportation) – community transportation	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

25 / 47

C2.V.2 Measure standard

1:1200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Home-delivered meals	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:900

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

27 / 47

C2.V.2 Measure standard

1:900

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

28 / 47

C2.V.2 Measure standard

1:75

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:75

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Adult residential care – 3-4 bed adult family homes	All counties	MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

30 / 47

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:350

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Nursing home stays (nursing home,	All counties	MLTSS

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

No more than 60 business days from time of service approval

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

No more than 60 business days from time of service approval

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

No more than 60 business days from time of service approval

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

No more than 60 business days from time of service approval

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

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C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.dhs.wisconsin.gov/adrc/index.htm
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	The ADRC must provide information and assistance to members of the target populations and their families, friends, caregivers, advocates and others who ask for assistance on their behalf. Information and assistance must be provided in a manner convenient to the customer including, but not limited to, being provided in-person in the customer's home or at the ADRC office as an appointment or walk-in, over the telephone, virtually, via email, or through written correspondence.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	ADRCs identify the unmet needs of their customer populations, including unserved or underserved subgroups within the customer populations, and the types of services, facilities, or funding sources that are in short supply.
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	The State ADRC regional quality specialists evaluate the quality, effectiveness, and efficiency of ADRC performance through a series of quality monitoring activities including; annual ADRC site visits, minimum of monthly contact with ADRC Directors, quarterly review of required reports and customer data regarding ADRC service delivery, ensure new staff complete and pass options counseling training and required post-test, verify each options counselor has their work observed for quality at least once annually by a peer or supervisor, ensure completion of annual quality improvement project for each ADRC, complete subrecipient risk assessments, review ADRC board meeting minutes, and individually investigating and responding to ADRC complaints. The ADRC regional quality team identifies trends, issues, concerns, and best practices through these activities and

		addresses quality concerns through the provision of technical assistance, training, policy development, and corrective action as needed.

Topic X: Program Integrity

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

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Community Care, Inc (CCI)** 752 **Independent Health Plan (iCare)** 1,545 **My Choice Wisconsin (MCW)** 1,347
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Community Care, Inc (CCI)** 0.05% **Independent Health Plan (iCare)** 0.11% **My Choice Wisconsin (MCW)** 0.09%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Community Care, Inc (CCI)** 0.07% **Independent Health Plan (iCare)** 0.14% **My Choice Wisconsin (MCW)** 0.12%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Community Care, Inc (CCI)** 100% **Independent Health Plan (iCare)** 92.4% **My Choice Wisconsin (MCW)** 99.1%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Community Care, Inc (CCI)** Program-specific regional **Independent Health Plan (iCare)** Program-specific regional **My Choice Wisconsin (MCW)** Program-specific regional
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Community Care, Inc (CCI)** N/A **Independent Health Plan (iCare)** N/A **My Choice Wisconsin (MCW)** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Community Care, Inc (CCI)** Yes **Independent Health Plan (iCare)**

		Yes **My Choice Wisconsin (MCW)** Yes
N/A	Enter the start date.	**Community Care, Inc (CCI)** 01/01/2022 **Independent Health Plan (iCare)** 01/01/2022 **My Choice Wisconsin (MCW)** 01/01/2022
N/A	Enter the end date.	**Community Care, Inc (CCI)** 12/31/2022 **Independent Health Plan (iCare)** 12/31/2022 **My Choice Wisconsin (MCW)** 12/31/2022

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Community Care, Inc (CCI)** Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter. **Independent Health Plan (iCare)** Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter. **My Choice Wisconsin (MCW)** Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**Community Care, Inc (CCI)** 100% **Independent Health Plan (iCare)** 93.8% **My Choice Wisconsin (MCW)** 43.2%
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	**Community Care, Inc (CCI)** 96.9% **Independent Health Plan (iCare)** 86.3% **My Choice Wisconsin (MCW)**

	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.	77.5%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Community Care, Inc (CCI)** 9 **Independent Health Plan (iCare)** 19 **My Choice Wisconsin (MCW)** 19
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.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Community Care, Inc (CCI)** 9 **Independent Health Plan (iCare)** 19 **My Choice Wisconsin (MCW)** 19
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal**	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)**

	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 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.	0 **My Choice Wisconsin (MCW)** 0
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Community Care, Inc (CCI)** 9 **Independent Health Plan (iCare)** 19 **My Choice Wisconsin (MCW)** 19
D1IV.5b	**Expedited appeals for which timely resolution was**	**Community Care, Inc (CCI)**

	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.	0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Community Care, Inc (CCI)** 4 **Independent Health Plan (iCare)** 8 **My Choice Wisconsin (MCW)** 10
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Community Care, Inc (CCI)** 5 **Independent Health Plan (iCare)** 7 **My Choice Wisconsin (MCW)** 2
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0

D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Community Care, Inc (CCI)** 1 **Independent Health Plan (iCare)** 4 **My Choice Wisconsin (MCW)** 2
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 5 **My Choice Wisconsin (MCW)** 0
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)**

	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".	0 **My Choice Wisconsin (MCW)** 0
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Community Care, Inc (CCI)** 4 **Independent Health Plan (iCare)** 4 **My Choice Wisconsin (MCW)** 7
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Community Care, Inc (CCI)** 4 **Independent Health Plan (iCare)** 5 **My Choice Wisconsin (MCW)** 8
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)**

	were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	0 **My Choice Wisconsin (MCW)** 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".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 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".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 2

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Community Care, Inc (CCI)** 2 **Independent Health Plan (iCare)** 1 **My Choice Wisconsin (MCW)** 2
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Community Care, Inc (CCI)** 2 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 1
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 1 **My Choice Wisconsin (MCW)** 1

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).	**Community Care, Inc (CCI)** N/A **Independent Health Plan (iCare)** N/A **My Choice Wisconsin (MCW)** N/A
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Community Care, Inc (CCI)** N/A **Independent Health Plan (iCare)** N/A **My Choice Wisconsin (MCW)** N/A

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Community Care, Inc (CCI)** 7 **Independent Health Plan (iCare)** 177 **My Choice Wisconsin (MCW)** 8
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Community Care, Inc (CCI)** 7 **Independent Health Plan (iCare)** 177 **My Choice Wisconsin (MCW)** 8
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	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0

	the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	**My Choice Wisconsin (MCW)** 0
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.	**Community Care, Inc (CCI)** 7 **Independent Health Plan (iCare)** 177

See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**My Choice Wisconsin (MCW)** 8

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc (CCI)** 2 **Independent Health Plan (iCare)** 2 **My Choice Wisconsin (MCW)** 0
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc (CCI)** 2 **Independent Health Plan (iCare)** 157 **My Choice Wisconsin (MCW)** 5
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 2 **My Choice Wisconsin (MCW)** 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	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)**

	mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	0 **My Choice Wisconsin (MCW)** 0
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 3
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc (CCI)** 2 **Independent Health Plan (iCare)** 177 **My Choice Wisconsin (MCW)** 0
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 4

	not cover this type of service, enter "N/A".	**My Choice Wisconsin (MCW)** 0
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i paid primarily by Medicaid, enter "N/A".	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 12 **My Choice Wisconsin (MCW)** 0

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 12 **My Choice Wisconsin (MCW)** 3
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 67 **My Choice Wisconsin (MCW)** 3
D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.	**Community Care, Inc (CCI)** 2 **Independent Health Plan (iCare)** 63 **My Choice Wisconsin (MCW)** 1

	Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 24 **My Choice Wisconsin (MCW)** 1
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0

D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** 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).	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 0 **My Choice Wisconsin (MCW)** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal**	**Community Care, Inc (CCI)** 0

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

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Quality & performance measure total count: 1

Complete

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

D2.VII.2 Measure Domain

Long-term services and supports

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

N/A

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

Cross-program rate: Family Care and Family Care Partnership

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

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

Measure results

Community Care, Inc (CCI)

6.94%

Independent Health Plan (iCare)

27.27%

My Choice Wisconsin (MCW)

15.17%

Topic VIII. Sanctions

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

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

Sanction total count: 1

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 1

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Community Care, Inc (CCI)

D3.VIII.4 Reason for intervention

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

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/14/2023

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Community Care, Inc (CCI)** 1 **Independent Health Plan (iCare)** 3.4 **My Choice Wisconsin (MCW)** 0.69
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 17 **My Choice Wisconsin (MCW)** 5
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Community Care, Inc (CCI)** 0:1,000 **Independent Health Plan (iCare)** 11:1,000 **My Choice Wisconsin (MCW)** 3.71:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 10 **My Choice Wisconsin (MCW)** 5

D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Community Care, Inc (CCI)** 0:1,000 **Independent Health Plan (iCare)** 6.47:1,000 **My Choice Wisconsin (MCW)** 3.71:1,000
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Community Care, Inc (CCI)** Makes some referrals to the SMA and others directly to the MFCU **Independent Health Plan (iCare)** Makes some referrals to the SMA and others directly to the MFCU **My Choice Wisconsin (MCW)** Makes some referrals to the SMA and others directly to the MFCU
D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**Community Care, Inc (CCI)** 0 **Independent Health Plan (iCare)** 6 **My Choice Wisconsin (MCW)** 0
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1).	**Community Care, Inc (CCI)** 0:1,000 **Independent Health Plan (iCare)** 3.88:1,000 **My Choice Wisconsin (MCW)** 0:1,000

	Express this as a ratio per 1,000 beneficiaries.	
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2).	**Community Care, Inc (CCI)** """1/1/23-12/31/23 $109,595 Recovered Ratio = 0.0017""" **Independent Health Plan (iCare)** """1/1/23-12/31/23 $72,903 Recovered Ratio = 0.0006""" **My Choice Wisconsin (MCW)** """1/1/23-12/31/23 $0 Recovered Ratio = 0.0"""
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Community Care, Inc (CCI)** Daily **Independent Health Plan (iCare)** Daily **My Choice Wisconsin (MCW)** Daily

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

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

Governor's Task Force on the Healthcare Workforce 2024 Advisory Action Plan

Task Force Overview

Executive Order

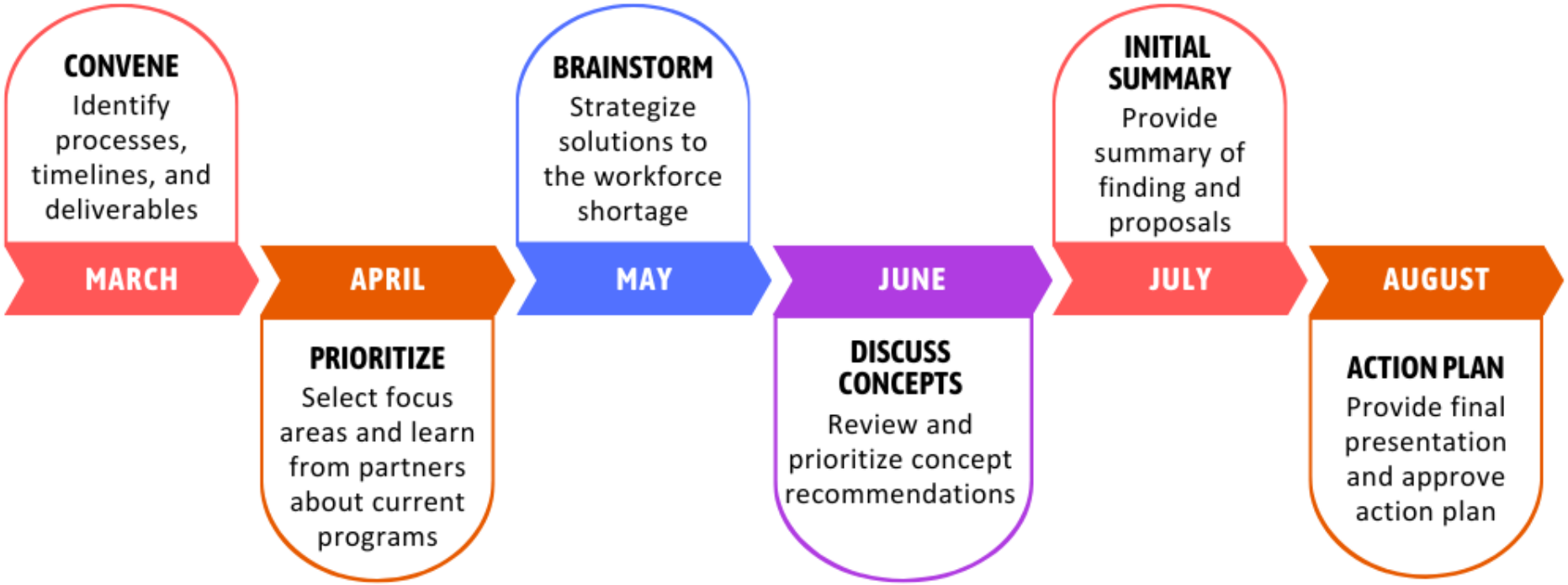
- The task force shall gather and analyze information and produce an advisory action plan for the Governor.
- The task force shall provide its action plan for 2025-27 biennial budget consideration no later than September 1, 2024, and shall disband after the plan is submitted.

Membership

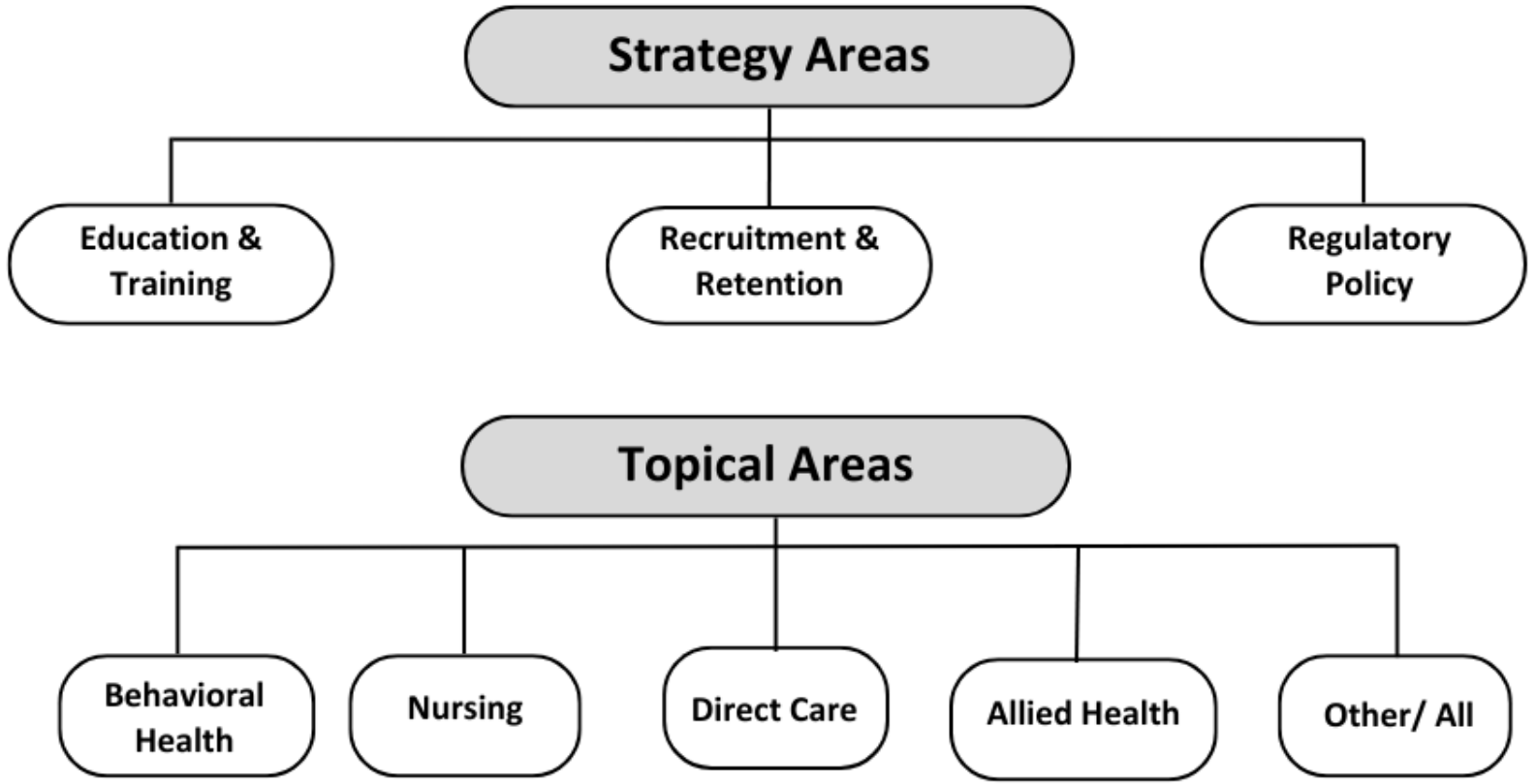
25 members

- Leadership:
  - Lieutenant Governor Sara Rodriguez
  - Secretary Kirsten Johnson, Department of Health Services
  - Secretary Amy Pechacek, Department of Workforce Development
- Health systems
- Educators
- Providers
- Community partners

Timeline


CONVENE
Identify processes, timelines, and deliverables
MARCH
APRIL
PRIORITIZE
Select focus areas and learn from partners about current programs
BRAINSTORM
Strategize solutions to the workforce shortage
MAY
JUNE
DISCUSS CONCEPTS
Review and prioritize concept recommendations
INITIAL SUMMARY
Provide summary of finding and proposals
JULY
AUGUST
ACTION PLAN
Provide final presentation and approve action plan

Priorities Identified



Task Force Action Plan

Current Status of Wisconsin's Healthcare Workforce

The report details shared challenges, such as:

- Demographics (for rural and aging populations).
- High cost of living and education (including childcare and housing).
- Education and training pipelines (lack of resources for schools).
- Burnout and safety concerns among health professionals.

Current Status of Wisconsin's Healthcare Workforce

The report also analyzes challenges for prioritized areas:

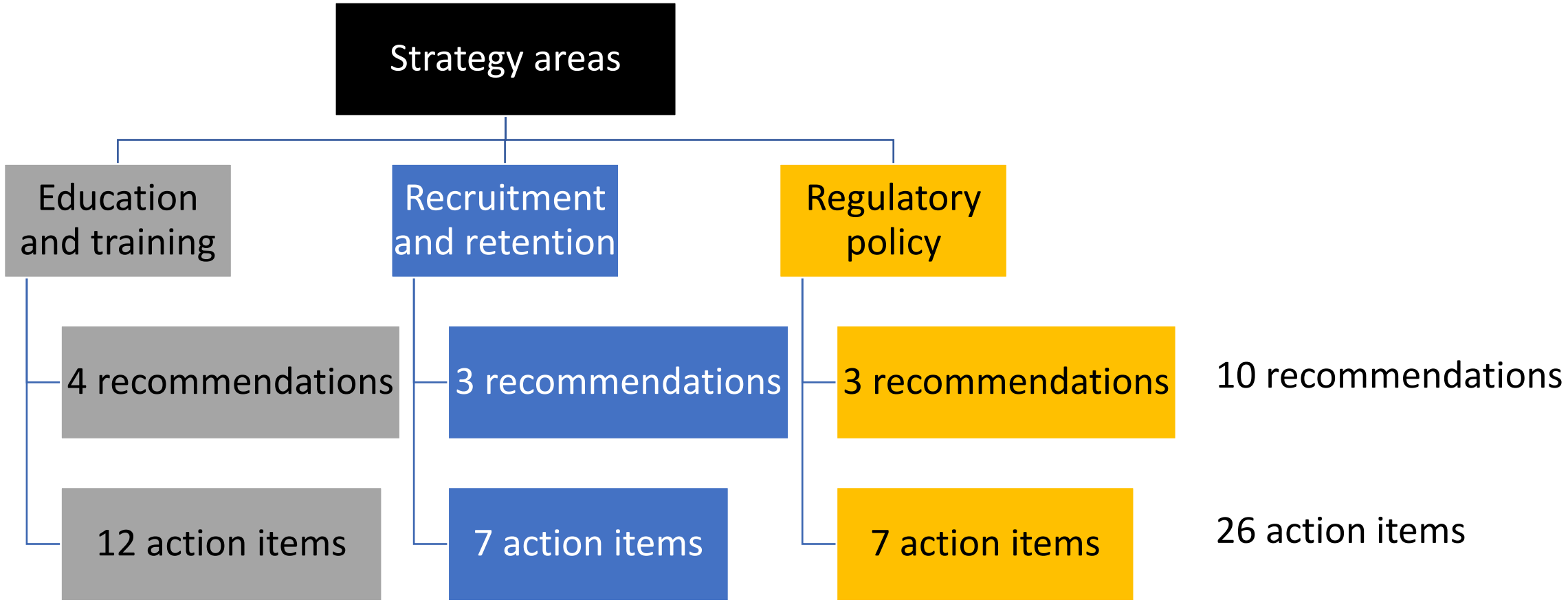
- Financial, educational, and workplace challenges for behavioral health, nursing, direct care, allied health, and other professions.
- Federally designated shortage areas for behavioral health, oral health, and primary care.

State Investments in the Healthcare Workforce

The report describes:

- Current state programs that support the healthcare workforce.
- Prior state budget allocations (proposed and enacted).
- Federally-funded investments, such as through the American Rescue Plan Act.

Final Recommendations



Recommendations: Education and Training

1) Support health professions faculty.

- Expand incentive programs for health profession educators.
- Increase compensation for health professions faculty.

Recommendations: Education and Training

2) Strengthen clinical training and experience.

- Sustain Qualified Treatment Trainee Grants.
- Support clinical partnerships and preceptors.
- Expand experiential learning (simulation).

Recommendations: Education and Training

3) Reduce barriers to training.

- Fund wraparound services programs for students.
- Train caregivers through WisCaregiver Careers.
- Reduce GED/HSED costs for students.
- Increase and modify the Allied Health Professionals and Advanced Practice Clinician Grant programs.

Recommendations: Education and Training

4) Expand apprenticeships and other learning opportunities.

- Provide additional state funding for apprenticeship programs.
- Fund Worker Advancement Initiative grants.
- Increase student access to health science and dual enrollment.

Recommendations: Recruitment and Retention

5) Increase payer support for recruitment and retention.

- Adopt Medicaid expansion.
- Increase Medicaid rates for home and community-based services.
- Increase Medicaid rates for behavioral health services.

Recommendations: Recruitment and Retention

6) Foster recruitment and retention in areas of need.

State incentives for health professionals that serve in state-defined shortage areas.

Recommendations: Recruitment and Retention

7) Support regional innovation.

- Employer-based solutions through Provider Innovation Grants
- Regional collaboration through Workforce Innovation Grants.
- Support direct care professionals through Covering Wisconsin.

Recommendations: Regulatory Policy

8) Support expanded pathways to licensure.

- Medicaid reimbursements for community-focused providers (community health workers, doulas, peer specialists, etc.).
- Pathways for qualified internationally educated professionals.
- Ratify and enter into multi-state licensing compacts.
- Revise faculty educational requirements.

Recommendations: Regulatory Policy

9) Strengthen state capacity to support licensure.

Maintain licensing improvements and enhance licensing supports.

Recommendations: Regulatory Policy

10) Strengthen workforce monitoring and support.

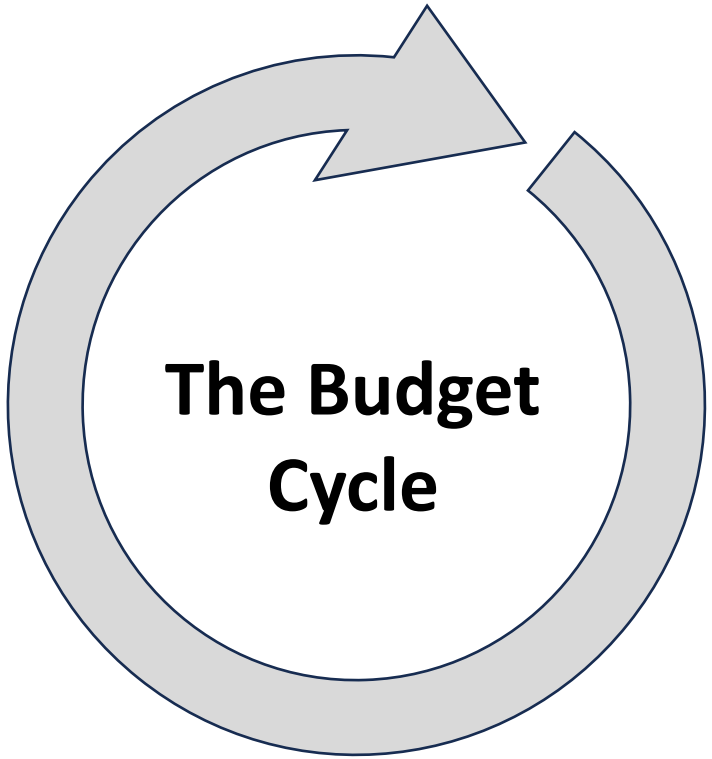
- Increase workforce wellness programming to support retention.
- Gather and analyze data on the healthcare workforce.

Next Steps

Next Steps

- Read and share report and summary
- Governor's Office reviews recommendations
- Governor submits budget proposal, incorporating recommendations
- Legislature debates and modifies proposal

State Budget Process



1. Preparation and Submittal of Agency Budget Requests

April to September 2024

+ Task Force Report

2. Preparation & Submittal of Governor's Budget

October 2024 to January 2025

3. Consideration of Executive Budget Bill by Joint Finance Committee

February through May/June 2025

+ Discuss merits of recommendations

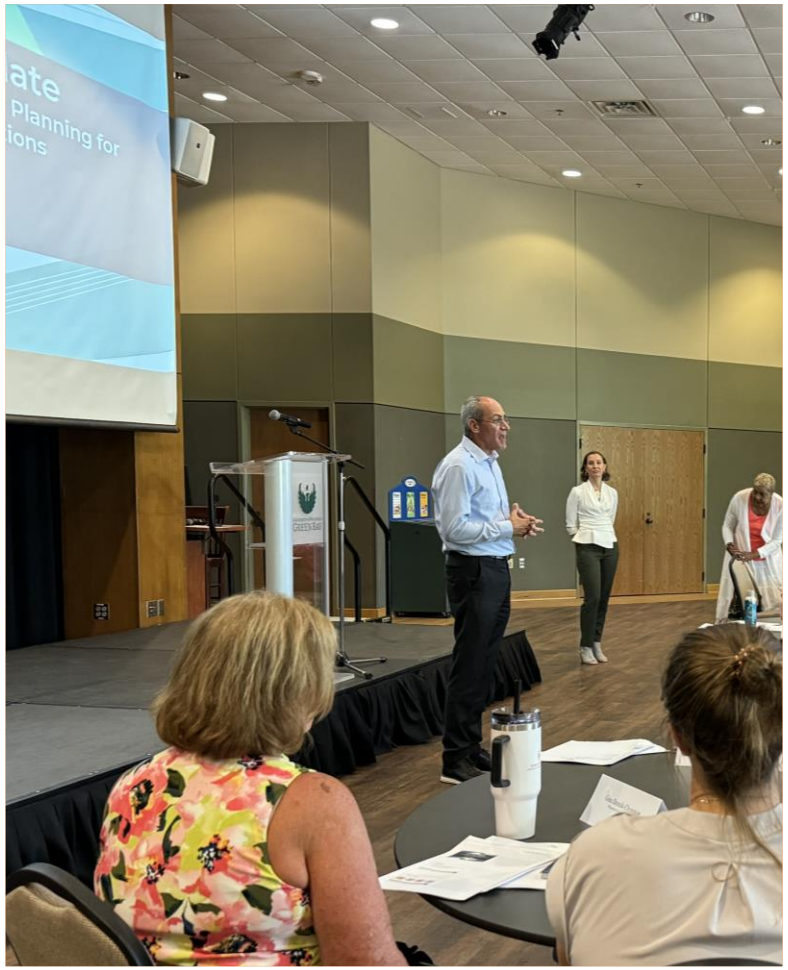
4. Legislative Enactment of Budget Bill

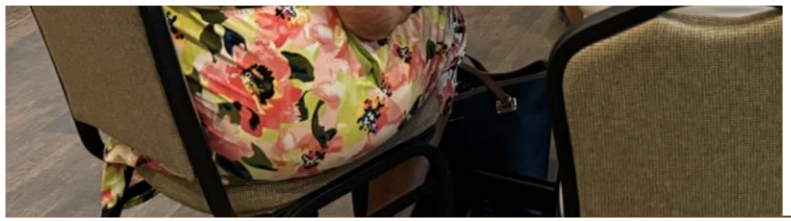
Summer 2025

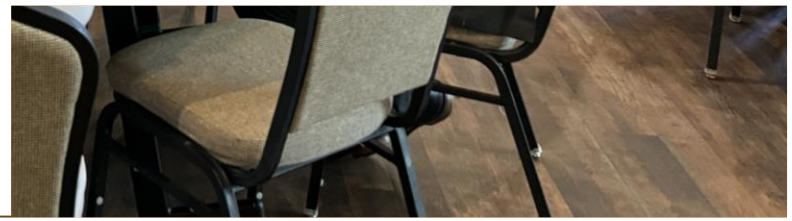
5. Governor's Vetoes on Budget Bill

Summer 2025

Thank you!







WISCONSIN DEPARTMENT of HEALTH SERVICES

Supporting Wisconsin to Expand Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)

Project funded by Arnold Ventures

Long-Term Care Advisory Council

September 10, 2024

ATI Advisory

SPEIRE HEALTHCARE STRATEGIES

Agenda

- Welcome & Introductions
- Project Overview and Background on Dual Eligible Special Needs Plans (D-SNPs)
- Discussion
- Opportunities for Continued Engagement

About the Team

Wisconsin is receiving support from ATI Advisory and Speire Healthcare Strategies through funding from Arnold Ventures, a foundation with a focus on improving care for populations with complex needs.

ATI Advisory (ATI) is a research and policy advisory services firm supporting clients across sectors to solve healthcare policy and programmatic challenges.

Speire Healthcare Strategies (Speire) is a boutique healthcare consulting firm providing advisory services at the intersection of policy and strategy.

Project Scope

The purpose of this engagement is to support Wisconsin DHS to develop a strategic plan to advance expansion of a Fully Integrated Dual Eligible (FIDE) SNP program statewide to serve more dual eligible individuals.

- Landscape analyses on dual eligible enrollment
- Conduct outreach and engagement with key partners on integrated care options
- Desktop review of relevant state statute and procurement requirements
- Facilitate decision-making to identify policy options to expand FIDE SNPs, both geographically and by population
- Administer survey to partners on improving integrated care for dual eligible individuals
- Develop a strategic plan outlining options for FIDE SNP expansion in partnership with DHS

Key Deliverable

Strategic plan outlining the best options for Wisconsin DHS to expand FIDE SNPs.

D-SNPs are Medicare Advantage plans tailored to the needs of dual eligible individuals

- A D-SNP is a type of Medicare Advantage product that:
  - Only enrolls individuals who are dually eligible for Medicare and Medicaid
  - Must have a contract between the plan and state, the State Medicaid Agency Contract (SMAC)
  - Must have a Model of Care tailored to the needs of dual eligible individuals
  - Must coordinate or integrate Medicaid services and Medicaid appeals and grievances
  - Can serve both full benefit dual eligible individuals (people who are eligible for all Medicare and Medicaid benefits) and partial benefit dual eligible individuals (people who receive some Medicaid cost-sharing and support)

FIDE SNPs, such as Family Care Partnership plans, offer the most integrated coverage option for full benefit dual eligible individuals as compared to other D-SNPs

The Dual Eligible Population of Wisconsin

There are a total of 184,290 dual eligible individuals in Wisconsin
- 169,523 are full benefit dual eligible individuals

There are 84,673 dual eligible individuals enrolled in D-SNPs

There are 2,332 dual eligible individuals enrolled in FIDE SNPs

There 82,341 dual eligible individuals enrolled in other D-SNPs

Source: ATI Advisory analysis of Medicare Master Beneficiary Summary File (2019 - 2024), CMS Plan Benefit Package (2019 - 2024), MMCO Integration Status File (2019 - 2024)

State oversight of D-SNPs: States can design D-SNP programs to improve care for dual eligible individuals

While states do not have oversight authority for non-D-SNP Medicare Advantage plans and for beneficiaries enrolled in Traditional Medicare,* states can design D-SNP programs to achieve state-specific goals. Examples of how states can influence how D-SNPs operate are included below.

*Oversight authority refers to state oversight outside of the scope of State Department of Insurance and other regulatory oversight obligations at the state level.

Goals for Partner Engagement

1. Identify the key barriers and challenges to plans offering FIDE SNPs in the state of Wisconsin

2. Understand the overall experience of dual eligible individuals currently enrolled in Partnership and non-Partnership plans

3. Understand general perception of current integrated coverage options and a proposed effort to expand FIDE SNPs, both geographically and/or by population

Discussion Questions

- What do you view as the most common needs of people who are dual eligible?
- What is the overall experience for members, families, providers, and other interested parties with Wisconsin's coverage options for dual eligible individuals?
- For organizations and providers serving dual eligible individuals, what are the most frequent gaps in long-term care or services that providers struggle to address on behalf of these individuals?
- How should the state think about expanding FIDE SNP options including by geography or by population?

Opportunities for Continued Engagement

- DHS remains committed to hearing from its partners and may be **available for one-on-one discussions** as time allows to receive additional feedback.
  - Please contact DHSDMSHMO@dhs.wisconsin.gov if interested in scheduling a 1:1 meeting.
- Other opportunities to remain engaged include:
  - DHS plans to administer a broad partner engagement survey in the next month or so on topics similar to those discussed today. DHS welcomes attendees of the Long-Term Care Advisory Council to participate in the survey.
- Please send any other thoughts or feedback to DHSDMSHMO@dhs.wisconsin.gov.

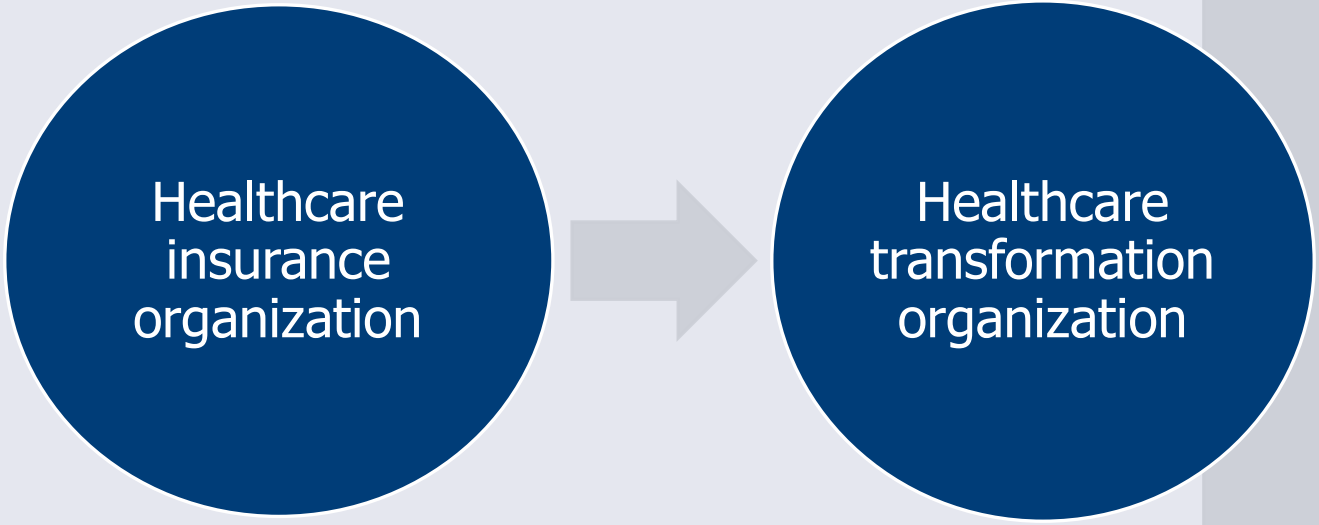
Managed Care Quality Strategy

Long-Term Care Advisory Council
September 10, 2024

Quality Strategy Requirements

- Federally required in accordance with CMS 32 CFR 438.340
- Each state contracting with managed care organizations must develop a quality strategy for continuous improvement
- In Wisconsin, the Quality Strategy will govern:
  - BadgerCare Plus and Medicaid SSI HMOs
  - Family Care and Family Care Partnership (MCOs)
  - Care4Kids Prepaid Inpatient Health Plan (PIHP)

Division of Medicaid Services Vision



- Exceptional member experience
- Improved outcomes through accountability
- Innovation and problem solving
- Support an inclusive culture

We Can Do Better

Affects nearly 1M vulnerable people

Disproportionate rates of maternal and infant mortality

Wisconsin’s performance is below national average

What is the Role of the Quality Strategy?

MC Quality Framework

Identify goals, objectives, and measures to support continuous improvement

Implementation with MC Partners

Ongoing effectiveness evaluation and partner reporting over next three years to monitor achievements

Quality improvements, accountability measures, celebrate success

Wisconsin Quality Strategy Goals

1–Improve Member Health and Social Connectedness

Measured by aggregate performance on specified priority measures.

2– Reduce Health Disparities and Support Underserved Populations

Provide person-centered services and supports.

3–Support Overall Quality Improvement

Compliance with federal requirements, contracts, and Wisconsin benchmarks.

Long-Term Care Examples

Goal 1: Improve Member Health and Social Connectedness

Example long-term care objective: "Increase overall health, safety, and social connectedness of members receiving long-term supports and services by MY 2027."

Example objective metrics:

- Each Family Care and Partnership MCO will increase the percentage of members aged 18-66 who are working in Competitive Integrated Employment settings by 3% annually over their previous year baselines.
- Achieve 10,000 individuals statewide who have completed Certified Direct Care Professional (CDCP) program by 2027. Achieve 1,500 MCO providers or agencies statewide participating in the CDCP program by 2027.

Example LTC Performance Baseline and Targets

Goal 1: Improve member health and social connectedness as measured by aggregate performance on specified priority measures.		
Objective 4: Increase overall health, safety, and social connectedness of members receiving long-term supports and services by MY 2027.		
Quality Measure	Statewide performance baseline (year)	Statewide performance target (year)
(State Developed Measure, LTSS Measure) Each Family Care and Partnership MCO will increase the percentage of members aged 18-66 who are working in Competitive Integrated Employment settings by 3% annually over their previous year performance.	Baseline = Q4 2024 results.	(2025) – 3%-point increase (2026) – 3%-point increase (2027) – 3%-point increase Targets indicate % point increases over previous MY performance by MCO

Goal 2: Reduce Health Disparities and Support Underserved Populations

Example LTC objective: Family Care and Partnership MCOs will increase the percentage of member-centered service plans that are comprehensive by properly addressing members' assessed needs and personal goals by MY 2027.

Example LTC metrics:

- Increase the percentage of Family Care and Family Care Partnership members who respond positively to the question of how well their supports and services meet their needs.

- Increase the percentage of member-centered service plans that are comprehensive by properly addressing members' assessed needs and personal goals.

Example LTC Performance Baseline and Targets

Goal 2: Reduce health disparities and support underserved populations providing person-centered services and supports.		
Objective 1: Family Care and Partnership MCOs will increase the percentage of member-centered service plans that are comprehensive by properly addressing members' assessed needs and personal goals by MY 2027.		
Quality Measure	Statewide performance baseline (year)	Statewide performance target (year)
(State Developed Measure, LTSS Measure) Increase the percentage of member-centered service plans that are comprehensive by properly addressing members' assessed needs and personal goals.	(2023) Combined FC and FCP = 75.5% based on CMS 372 Report.	(2025) – 80% (2026) – 85% (2027) – 90% (Target measures are combined FC and FCP)

Goal 3: Support Overall Quality Improvement

- Example LTC objective: By 2027, MCOs will have an overall quality compliance review (QCR) score of 90% or higher.

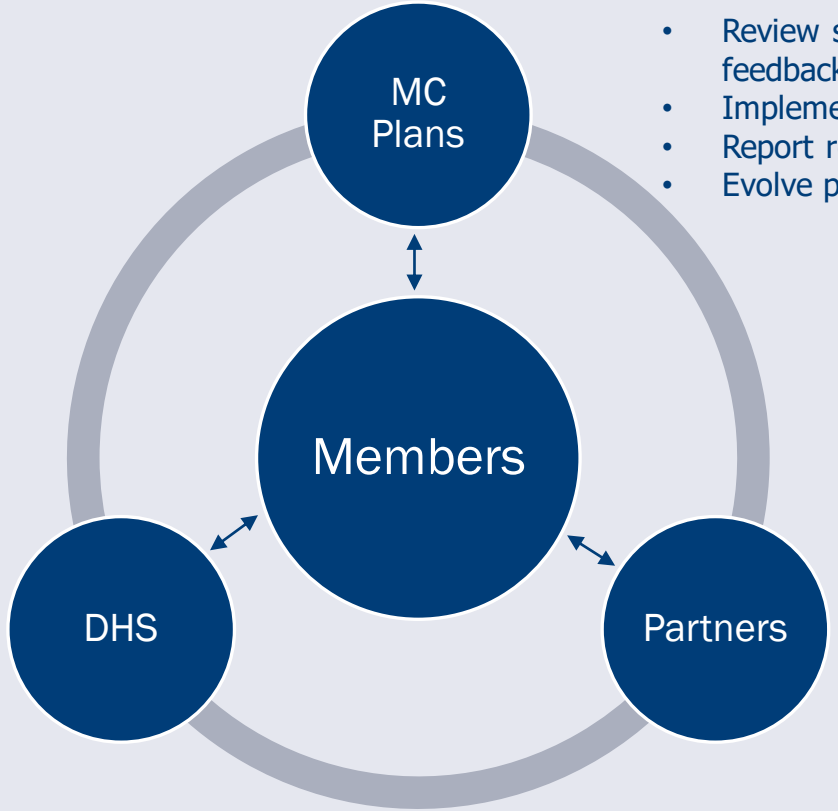
- Example LTC objective metric:
  - QCR assesses the strengths and weaknesses of the MCO related to quality, timeliness, and access to services, including health care and LTSS.

Example LTC Performance Baseline and Targets

Goal 3: Support Overall Quality Improvement		
Objective 5: By 2027, MCOs will have an overall quality compliance review (QCR) score of 90% or higher.		
Quality Measure	Statewide performance baseline (year)	Statewide performance target (year)
(State Developed Measure, LTSS Measure) QCR assesses the strengths and weaknesses of the MCO related to quality, timeliness, and access to services, including health care and LTSS.	(2023) Baseline will be established following the FY2023-2024 review cycle.	(2025) – 80% (2026) – 85% (2027) – 90%

Collaborative Approach and Roles

- Review strategy and provide feedback
- Implement into daily practices
- Report results
- Evolve practices as needed



- Draft initial Quality Strategy
- Actively listen to partner feedback
- Set metrics and monitor results
- Evolve practices as needed

- Review strategy and provide feedback
- Review results and suggest improvements

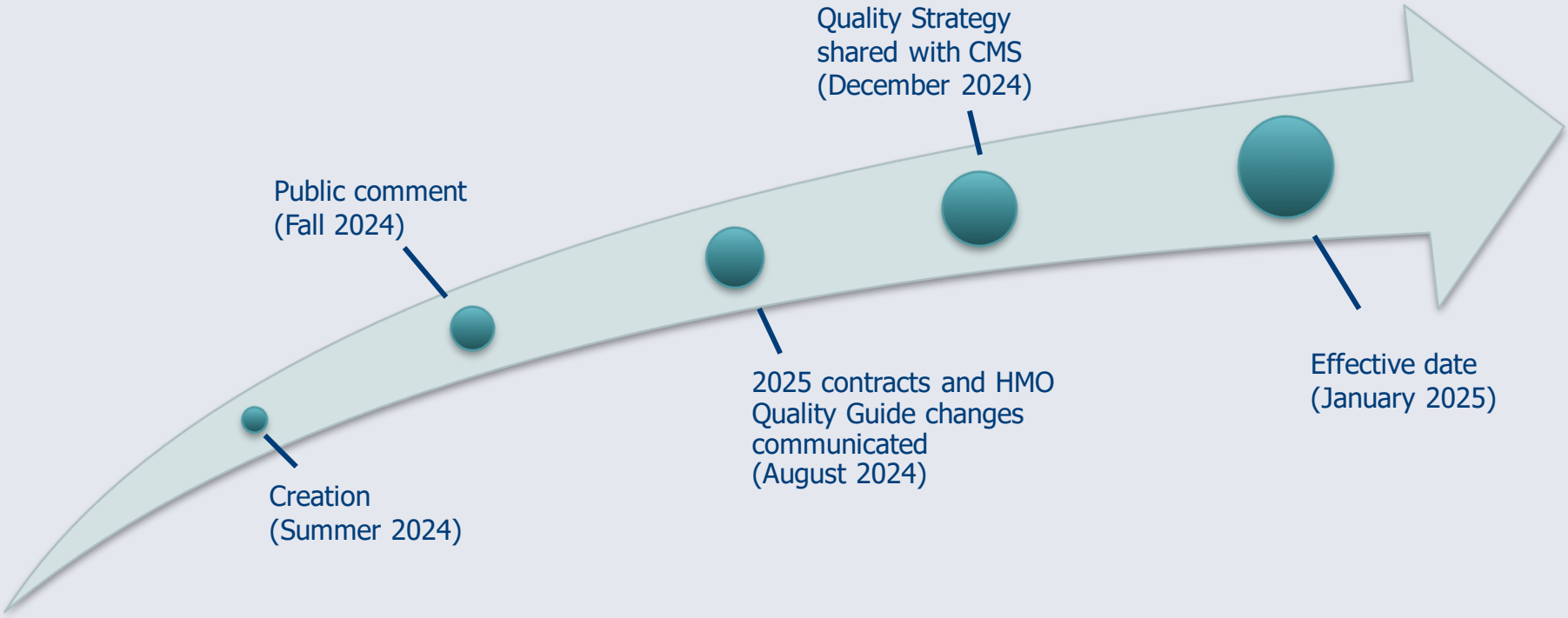
Public Comment Period

Public comment period: September 23-October 25, 2024

- Dedicated DHS webpage will feature Quality Strategy and public comment period information:
  https://www.dhs.wisconsin.gov/medicaid/quality-strategy.htm

- Public comments can be submitted via email or postal mail
  - Email: DHSDMSQualityStrategy@dhs.wisconsin.gov
  - Postal mail:
    Wisconsin Department of Health Services
    Division of Medicaid Services
    Bureau of Programs and Policy
    Attn: Managed Care Quality Strategy
    PO Box 309
    Madison, WI 53701-0309

Timeline


Creation
(Summer 2024)
Public comment
(Fall 2024)
2025 contracts and HMO
Quality Guide changes
communicated
(August 2024)
Quality Strategy
shared with CMS
(December 2024)
Effective date
(January 2025)