


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

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

Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Point of Contact


 Find in the Excel Workbook
A_Program_Info

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

States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.

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

Reporting Period

 Find in the Excel Workbook
A_Program_Info

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

Add plans (A.7)

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



Find in the Excel Workbook

A_Program_Info

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

Add BSS entities (A.8)

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

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



Find in the Excel Workbook

A_Program_Info

Indicator	Response
BSS entity name	Multi-location ADRC

Topic I. Program Characteristics and Enrollment



Find in the Excel Workbook

B_State

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

Topic III. Encounter Data Report

 Find in the Excel Workbook
B_State

Number	Indicator	Response
BIII.1	<p>Data validation entity</p> <p>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</p>	Other third-party vendor

Topic X: Program Integrity



Find in the Excel Workbook

B_State

Number	Indicator	Response
BX.1	Payment risks between the state and plans Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	Capitation payments against date of death reviews are completed. EVV soft launch to allow home visit supportive home care and personal care worker time validation. Will not conduct actual audits until hard launch and vendor compliance requirements are in place. Other data analytics and reviews will be implemented after the DHS MLTSS system rewrite that is in process goes live. Once implemented there will be the ability to scrub the data for targeted 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	Art III.D.30, Art III.K.1.g, Art.XIV.C.4, Article XIV.C.5.g

plan contracts, as required by 42 CFR 438.608(d)(1)(i).

BX.4	Description of overpayment contract standard Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	Include in Program Integrity Quarterly Reporting overpayments recovered and retained by MCO versus those returned to the SMA because the plan is not permitted to retain them, and identify those due to potential fraud
BX.5	State overpayment reporting monitoring Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The SMA tracks satisfaction and timeliness of compliance with the reporting requirement
BX.6	Changes in beneficiary circumstances Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	This is an automated function in the Forward Health System and used to produce the monthly capitation. The plan reports enrollment changes such as deaths, incarcerations, and disenrollments to the local income maintenance agency. The data is updated in the system which then updates the SMA MMIS 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** No

Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.

BX.8a **Federal database checks: Excluded person or entities** No

During the state's federal database checks, did the state find any person or entity excluded? Select one.

Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.

BX.9a **Website posting of 5 percent or more ownership control** Yes

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).

BX.9b Website posting of 5 percent or more ownership control: Link <https://www.dhs.wisconsin.gov/familycare/mcocontacts.pdf>

What is the link to the website? Refer to 42 CFR 602(g)(3).

BX.10 Periodic audits <https://oci.wi.gov/Pages/Companies/FinExams.aspx>

If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).

Topic I: Program Characteristics



Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C11.1	Program contract Enter the title of the contract between the state and plans participating in the managed care program.	Family Care Contract between Wisconsin Department of Health Division of Medicaid Services and <>. Issued January 1, 2022
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2022
C11.2	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
C11.3	Program type	Prepaid Inpatient Health Plan (PIHP)

What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.

C11.4a	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
C11.4b	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
C11.5	Program enrollment Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	53,349
C11.6	Changes to enrollment or benefits Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	No major changes.

Topic III: Encounter Data Report



Find in the Excel Workbook

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

failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.

C1III.5	Incentives for encounter data quality Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	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 period.	None.

Topic IV. Appeals, State Fair Hearings & Grievances



Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1IV.1	State's definition of "critical incident," as used for reporting purposes in its MLTSS program If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	Member's whereabouts are not known for 24 hours or more, under any of the following circumstances: i. The member is under guardianship/protective placement; ii. The member has been identified as a vulnerable/high risk member as defined under Article I.139; iii. The MCO has reason to believe that the member's health or safety is at risk; iv. The member is a potential threat to the community or self; v. The member has a significant medical condition that would deteriorate without medications/care; vi. The member lives in a residential facility; or vii. The area is experiencing potentially life-threatening weather conditions. Member has died under any of the following circumstances: i. Death involving unexplained, unusual, or suspicious circumstances; ii. Death involving apparent abuse or neglect; iii. Apparent homicide; iv.

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

C1IV.2**State definition of "timely" resolution for standard appeals**

Provide the state's definition of timely resolution for standard appeals in the managed care program.
Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.

Unless the member requests expedited resolution, for Family Care and Partnership the MCO must mail or hand-deliver a written decision on the appeal no later than thirty (30) calendar days after the date of receipt of the appeal.

C1IV.3**State definition of "timely" resolution for expedited appeals**

Provide the state's definition of timely resolution for expedited appeals in the managed care program.
Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.

The MCO must make reasonable efforts to give the member prompt oral notice of approval or denial of the request for expedited resolution and a written notice within two (2) calendar days.

C1IV.4**State definition of "timely" resolution for grievances**

Provide the state's definition of timely resolution for grievances in the managed care program.
Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.

The MCO grievance and appeal committee for Family Care and Partnership Medicaid-only must mail or hand-deliver a written decision on a grievance to the member and the member's legal decision maker, if applicable, as expeditiously as the member's situation and health condition require, but no later than ninety (90) calendar days after the date of receipt of the grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy



Find in the Excel Workbook

C1_Program_Set

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

Topic V. Availability, Accessibility and Network Adequacy

Access Measures

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

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if

covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

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



Find in the Excel Workbook

C2_Program_State

Access measure total count: 98



Complete

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

1 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

LTSS assistive technology

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

2 / 98

C2.V.2 Measure standard

1:225

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

LTSS-adult day care

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

3 / 98

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

AODA services
(excluding inpatient
or physician
provided)

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

4 / 98

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

C2.V.7 Monitoring Methods

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 / 98

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

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

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

6 / 98

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

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

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

Mental health day
treatment

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

7 / 98

C2.V.2 Measure standard

1:275

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Day habilitation
services

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

8 / 98

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Supported
employment – small
group employment
support

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

9 / 98

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Prevocational
services

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

10 / 98

C2.V.2 Measure standard

1:1500

C2.V.3 Standard type

Provider to enrollee ratios

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

Community support Urban
program

MLTSS

C2.V.7 Monitoring Methods

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 / 98

C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Counseling and
therapeutic
resources

C2.V.5 Region

Urban

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

12 / 98

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Home health
services

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

13 / 98

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Supportive home care

C2.V.5 Region

Urban

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

14 / 98

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Personal care

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

15 / 98

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Self-directed
personal care

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

16 / 98

C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Respite

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



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

17 / 98

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Occupational
therapy

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



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

18 / 98

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Physical therapy

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



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

19 / 98

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Skilled nursing
services registered
nurse/licensed
practical nurse

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

20 / 98

C2.V.2 Measure standard

1:775

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Nursing (including
intermittent and
private duty)

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

21 / 98

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Supported
employment –
individual
employment support

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

22 / 98

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Transportation
(specialized
transportation) –
other transportation

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

23 / 98

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Transportation
(excluding
ambulance)

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

24 / 98

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Transportation
(specialized
transportation) –
community
transportation

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

25 / 98

C2.V.2 Measure standard

1:1200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Home-delivered
meals

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

26 / 98

C2.V.2 Measure standard

1:900

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Financial
management
services

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

27 / 98

C2.V.2 Measure standard

1:900

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Consumer-directed supports (self-directed supports) broker

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

28 / 98

C2.V.2 Measure standard

1:50

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Adult residential care – 1-2 bed adult family homes

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

29 / 98

C2.V.2 Measure standard

1:50

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Adult residential care
– 3-4 bed adult
family homes

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

30 / 98

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Adult residential care
– community-based
residential facility

C2.V.5 Region

Urban

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

31 / 98

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 Urban MLTSS
- residential care
apartment complex

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



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

32 / 98

C2.V.2 Measure standard

1:350

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Nursing home stays
(nursing home,
institute for mental
disease, and
immediate care
facility for individuals
with intellectual
disabilities)

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



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

33 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

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

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

34 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Disposable medical supplies

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

35 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Specialized medical equipment and supplies

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

36 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Adaptive aids

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

37 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Personal emergency
response systems
services

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

38 / 98

C2.V.2 Measure standard

No more than 60 - 90 business days from time of service approval.

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Environmental
accessibility
adaptations (home
modifications)

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

39 / 98

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Daily living skills
training

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

40 / 98

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

Consultative clinical
and therapeutic
services for
caregivers

C2.V.5 Region

Urban

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 / 98

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

Consumer education
and training

C2.V.5 Region

Urban

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 / 98

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

Housing counseling

C2.V.5 Region

Urban

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

43 / 98

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

Training services for
unpaid caregivers

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

44 / 98

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

Relocation services

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

45 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Vocational futures
planning and

C2.V.5 Region

Urban

C2.V.6 Population

MLTSS

support

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

46 / 98

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

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

C2.V.5 Region

Urban

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

47 / 98

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Respiratory care

C2.V.5 Region

Urban

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

48 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Case management

C2.V.5 Region

Urban

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

49 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Care management

C2.V.5 Region

Urban

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

50 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

LTSS assistive
technology

C2.V.5 Region

Rural

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

51 / 98

C2.V.2 Measure standard

1:350

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

LTSS-adult day care

C2.V.5 Region

Rural

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



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

52 / 98

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

AODA services
(excluding inpatient
or physician
provided)

C2.V.5 Region

Rural

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



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

53 / 98

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

AODA day treatment

C2.V.5 Region

Rural

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



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

54 / 98

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

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

C2.V.5 Region

Rural

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

55 / 98

C2.V.2 Measure standard

1:150

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Mental health day treatment

C2.V.5 Region

Rural

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

56 / 98

C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Day habilitation services

C2.V.5 Region

Rural

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

57 / 98

C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Supported employment – small group employment support

C2.V.5 Region

Rural

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

58 / 98

C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Prevocational services

C2.V.5 Region

Rural

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

59 / 98

C2.V.2 Measure standard

1:350

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Community support program

C2.V.5 Region

Rural

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

60 / 98

C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

C2.V.5 Region

C2.V.6 Population

Counseling and
therapeutic
resources

Rural

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

61 / 98

C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Home health
services

C2.V.5 Region

Rural

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

62 / 98

C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Supportive home
care

C2.V.5 Region

Rural

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

63 / 98

C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Personal care

C2.V.5 Region

Rural

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

64 / 98

C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Self-directed
personal care

C2.V.5 Region

Rural

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

65 / 98

C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Respite

C2.V.5 Region

Rural

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

66 / 98

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Occupational
therapy

C2.V.5 Region

Rural

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



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

67 / 98

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Physical therapy

C2.V.5 Region

Rural

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



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

68 / 98

C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Skilled nursing
services registered
nurse/licensed
practical nurse

C2.V.5 Region

Rural

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



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

69 / 98

C2.V.2 Measure standard

1:400

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Nursing (including intermittent and private duty)

C2.V.5 Region

Rural

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

70 / 98

C2.V.2 Measure standard

1:250

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Supported employment – individual employment support

C2.V.5 Region

Rural

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

71 / 98

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Transportation
(specialized
transportation) –
other transportation

C2.V.5 Region

Rural

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

72 / 98

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Transportation
(excluding
ambulance)

C2.V.5 Region

Rural

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

73 / 98

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Transportation
(specialized
transportation) –
community
transportation

C2.V.5 Region

Rural

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

74 / 98

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Home-delivered
meals

C2.V.5 Region

Rural

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

75 / 98

C2.V.2 Measure standard

1:300

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Financial
management
services

C2.V.5 Region

Rural

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

76 / 98

C2.V.2 Measure standard

1:900

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Consumer-directed
supports (self-
directed supports)
broker

C2.V.5 Region

Rural

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

77 / 98

C2.V.2 Measure standard

1:75

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Adult residential care
 – 1-2 bed adult
 family homes

C2.V.5 Region

Rural

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

78 / 98

C2.V.2 Measure standard

1:75

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Adult residential care
 – 3-4 bed adult
 family homes

C2.V.5 Region

Rural

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

79 / 98

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

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

Adult residential care Rural
– community-based
residential facility

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

80 / 98

C2.V.2 Measure standard

1:200

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Adult residential care
– residential care
apartment complex

C2.V.5 Region

Rural

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

81 / 98

C2.V.2 Measure standard

1:125

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Nursing home stays
(nursing home,

C2.V.5 Region

Rural

C2.V.6 Population

MLTSS

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

82 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

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

C2.V.5 Region

Rural

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

83 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Disposable medical supplies

C2.V.5 Region

Rural

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

84 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Specialized medical equipment and supplies

C2.V.5 Region

Rural

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

85 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Adaptive aids

C2.V.5 Region

Rural

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

86 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Personal emergency response systems services

C2.V.5 Region

Rural

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

87 / 98

C2.V.2 Measure standard

No more than 60 - 90 business days from time of service approval.

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Environmental
accessibility
adaptations (home
modifications)

C2.V.5 Region

Rural

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

88 / 98

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Daily living skills
training

C2.V.5 Region

Rural

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

89 / 98

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

Consultative clinical and therapeutic services for caregivers

C2.V.5 Region

Rural

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

90 / 98

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

Consumer education and training

C2.V.5 Region

Rural

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

91 / 98

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

Housing counseling

C2.V.5 Region

Rural

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

92 / 98

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

Training services for unpaid caregivers

C2.V.5 Region

Rural

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

93 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

C2.V.5 Region

C2.V.6 Population

Relocation services

Rural

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

94 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider

Vocational futures
planning and
support

C2.V.5 Region

Rural

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

95 / 98

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Speech and
language pathology
services (except in

C2.V.5 Region

Rural

C2.V.6 Population

MLTSS

inpatient and
hospital settings)

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually



Complete

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

96 / 98

C2.V.2 Measure standard

1:100

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Respiratory care

C2.V.5 Region

Rural

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

97 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Case management

C2.V.5 Region

Rural

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

98 / 98

C2.V.2 Measure standard

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

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Care management

C2.V.5 Region

Rural

C2.V.6 Population

MLTSS

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)



Find in the Excel Workbook

C1_Program_Set

Number	Indicator	Response
C1IX.1	BSS website List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.dhs.wisconsin.gov/adrc/index.htm
C1IX.2	BSS auxiliary aids and services How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services,	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

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.

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

 Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1X.3	Prohibited affiliation disclosure	No

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).

Topic I. Program Characteristics & Enrollment



Find in the Excel Workbook

D1_Plan_Set

Number	Indicator	Response
D1I.1	Plan enrollment What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	Community Care, Inc. (CCI) 13,658
		Inclusa, Inc. 16,934
		Lakeland Care, Inc. 7,400
		My Choice Wisconsin, Inc. (MCW) 15,357
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? <ul style="list-style-type: none">• Numerator: Plan enrollment (D1.I.1)• Denominator: Statewide Medicaid enrollment (B.I.1)	Community Care, Inc. (CCI) 0.83%
		Inclusa, Inc. 1.03%
		Lakeland Care, Inc. 0.45%
		My Choice Wisconsin, Inc. (MCW)

0.94%

D1I.3	Plan share of any Medicaid managed care	Community Care, Inc. (CCI)
		1.15%
		Inclusa, Inc.
		1.42%
	<p>What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?</p> <ul style="list-style-type: none"> • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2) 	Lakeland Care, Inc.
		0.62%
		My Choice Wisconsin, Inc. (MCW)
		1.29%

Topic II. Financial Performance



Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1II.1a	Medical Loss Ratio (MLR)	Community Care, Inc. (CCI)
		92.50%
		Inclusa, Inc.
		95.90%
	<p>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.</p>	Lakeland Care, Inc.
		97.50%
		My Choice Wisconsin, Inc. (MCW)
		94.40%
D1II.1b	Level of aggregation	Community Care, Inc. (CCI)
		Program-specific regional
	<p>What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one.</p> <p>As permitted under 42 CFR 438.8(i), states are allowed to</p>	Inclusa, Inc.

aggregate data for reporting purposes across programs and populations.

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)

01/01/2021

Inclusa, Inc.

01/01/2021

Lakeland Care, Inc.

01/01/2021

My Choice Wisconsin, Inc. (MCW)

01/01/2021

N/A

Enter the end date.

Community Care, Inc. (CCI)

12/31/2021

Inclusa, Inc.

12/31/2021

Lakeland Care, Inc.

12/31/2021

My Choice Wisconsin, Inc. (MCW)

12/31/2021

Topic III. Encounter Data



Find in the Excel Workbook

D1_Plan_Set

Number	Indicator	Response
D1III.1	Definition of timely encounter data submissions Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	Community Care, Inc. (CCI) Encounters must be submitted within 30 days after the end of the month in which the MCO adjudicated the claim prompting the encounter. 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	Community Care, Inc. (CCI) 100%
	What percent of the plan’s encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	Inclusa, Inc. 45.58%
		Lakeland Care, Inc. 19.69%
		My Choice Wisconsin, Inc. (MCW) 79.35%

D1III.3	Share of encounter data submissions that were HIPAA compliant	Community Care, Inc. (CCI) 96.15%
	What percent of the plan’s encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	Inclusa, Inc. 98.48%
		Lakeland Care, Inc. 97%
		My Choice Wisconsin, Inc. (MCW) 94.80%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview



Number	Indicator	Response
D1IV.1	<p>Appeals resolved (at the plan level)</p> <p>Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or 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.</p>	<p>Community Care, Inc. (CCI) 50</p> <p>Inclusa, Inc. 44</p> <p>Lakeland Care, Inc. 19</p> <p>My Choice Wisconsin, Inc. (MCW) 113</p>
D1IV.2	<p>Active appeals</p> <p>Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.</p>	<p>Community Care, Inc. (CCI) 5</p> <p>Inclusa, Inc. 0</p> <p>Lakeland Care, Inc. 1</p> <p>My Choice Wisconsin, Inc. (MCW) 1</p>
D1IV.3	<p>Appeals filed on behalf of LTSS users</p> <p>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).</p>	<p>Community Care, Inc. (CCI) 55</p> <p>Inclusa, Inc. 44</p> <p>Lakeland Care, Inc. 20</p>

D1IV.4	<p>Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal</p> <p>For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A".</p> <p>Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A".</p> <p>The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.</p> <p>To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.</p>	<p>Community Care, Inc. (CCI)</p> <p>0</p> <p>Inclusa, Inc.</p> <p>0</p> <p>Lakeland Care, Inc.</p> <p>0</p> <p>My Choice Wisconsin, Inc. (MCW)</p> <p>0</p>
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D1IV.5a	<p>Standard appeals for which timely resolution was provided</p>	<p>Community Care, Inc. (CCI)</p> <p>50</p>
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Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period.
See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.

Inclusa, Inc.

44

Lakeland Care, Inc.

19

My Choice Wisconsin, Inc. (MCW)

113

D1IV.5b

Expedited appeals for which timely resolution was provided

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

Community Care, Inc. (CCI)

0

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)

18

Inclusa, Inc.

34

Lakeland Care, Inc.

10

My Choice Wisconsin, Inc. (MCW)

79

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

Community Care, Inc. (CCI)

34

Inclusa, Inc.

were related to the plan's reduction, suspension, or termination of a previously authorized service.

9

Lakeland Care, Inc.

99

My Choice Wisconsin, Inc. (MCW)

28

D1IV.6c

Resolved appeals related to payment denial

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

Community Care, Inc. (CCI)

0

Inclusa, Inc.

0

Lakeland Care, Inc.

1

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)

4

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

Community Care, Inc. (CCI)

0

Inclusa, Inc.

0

§438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

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)

3

Inclusa, Inc.

1

Lakeland Care, Inc.

0

My Choice Wisconsin, Inc. (MCW)

3

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals by Service

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



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

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)

0

Inclusa, Inc.

0

Lakeland Care, Inc.

0

My Choice Wisconsin, Inc. (MCW)

D1IV.7g	Resolved appeals related to long-term services and supports (LTSS)	Community Care, Inc. (CCI)
		55
	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".	Inclusa, Inc.
		44
		Lakeland Care, Inc.
		19
		My Choice Wisconsin, Inc. (MCW)
		113
D1IV.7h	Resolved appeals related to dental services	Community Care, Inc. (CCI)
		N/A
	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".	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)	Community Care, Inc. (CCI)
		0
	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".	Inclusa, Inc.
		0
		Lakeland Care, Inc.
		0
		My Choice Wisconsin, Inc. (MCW)
		0

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

Topic IV. Appeals, State Fair Hearings & Grievances

State Fair Hearings



Number	Indicator	Response
D1IV.8a	State Fair Hearing requests	Community Care, Inc. (CCI)
	Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	25
		Inclusa, Inc.
		7
		Lakeland Care, Inc.
		3
		My Choice Wisconsin, Inc. (MCW)
		24
D1IV.8b	State Fair Hearings resulting in a favorable decision for the enrollee	Community Care, Inc. (CCI)
	Enter the total number of State Fair Hearing decisions rendered during the reporting year that	4
		Inclusa, Inc.

were partially or fully favorable to the enrollee.

1

Lakeland Care, Inc.

0

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.

3

Lakeland Care, Inc.

1

My Choice Wisconsin, Inc. (MCW)

8

D1IV.8d

State Fair Hearings retracted prior to reaching a decision

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

Community Care, Inc. (CCI)

2

Inclusa, Inc.

2

Lakeland Care, Inc.

1

My Choice Wisconsin, Inc. (MCW)

8

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

Community Care, Inc. (CCI)

N/A

Inclusa, Inc.

N/A

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).

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

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances Overview

 Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.10	Grievances resolved	Community Care, Inc. (CCI)
	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.	60
		Inclusa, Inc.
		12
		Lakeland Care, Inc.
		48
		My Choice Wisconsin, Inc. (MCW)

D1IV.11	Active grievances	Community Care, Inc. (CCI)
	Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	0
		Inclusa, Inc.
		0
		Lakeland Care, Inc.
		0
		My Choice Wisconsin, Inc. (MCW)
		0
D1IV.12	Grievances filed on behalf of LTSS users	Community Care, Inc. (CCI)
	Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users.	60
	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.	Inclusa, Inc.
		12
		Lakeland Care, Inc.
		48
		My Choice Wisconsin, Inc. (MCW)
		26
D1IV.13	Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance	Community Care, Inc. (CCI)
	For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been	0
		Inclusa, Inc.
		0
		Lakeland Care, Inc.
		0
		My Choice Wisconsin, Inc. (MCW)
		0

filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user.

If the managed care plan does not cover LTSS, the state should enter "N/A" in this field.

Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field.

To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.

D1IV.14

Number of grievances for which timely resolution was provided

Enter the number of grievances for which timely resolution was provided by plan during the reporting period.

See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.

Community Care, Inc. (CCI)

60

Inclusa, Inc.

12

Lakeland Care, Inc.

48

My Choice Wisconsin, Inc. (MCW)

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Service

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



Find in the Excel Workbook
D1_Plan_Set

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

D1IV.15c	Resolved grievances related to inpatient behavioral health services	Community Care, Inc. (CCI)
		N/A
	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".	Inclusa, Inc.
		N/A
		Lakeland Care, Inc.
		N/A
		My Choice Wisconsin, Inc. (MCW)
		N/A
<hr/>		
D1IV.15d	Resolved grievances related to outpatient behavioral health services	Community Care, Inc. (CCI)
		0
	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".	Inclusa, Inc.
		0
		Lakeland Care, Inc.
		0
		My Choice Wisconsin, Inc. (MCW)
		0
<hr/>		
D1IV.15e	Resolved grievances related to coverage of outpatient prescription drugs	Community Care, Inc. (CCI)
		N/A
	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".	Inclusa, Inc.
		N/A
		Lakeland Care, Inc.
		N/A
		My Choice Wisconsin, Inc. (MCW)
		N/A
<hr/>		
D1IV.15f	Resolved grievances related to skilled nursing facility	Community Care, Inc. (CCI)

(SNF) services

0

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".

Inclusa, Inc.

0

Lakeland Care, Inc.

0

My Choice Wisconsin, Inc. (MCW)

0

D1IV.15g**Resolved grievances related to long-term services and supports (LTSS)****Community Care, Inc. (CCI)**

60

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".

Inclusa, Inc.

12

Lakeland Care, Inc.

48

My Choice Wisconsin, Inc. (MCW)

26

D1IV.15h**Resolved grievances related to dental services****Community Care, Inc. (CCI)**

N/A

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".

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

0

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".

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 were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".

Community Care, Inc. (CCI)

0

Inclusa, Inc.

0

Lakeland Care, Inc.

0


My Choice Wisconsin, Inc. (MCW)

0

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Reason

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

 Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.16a	Resolved grievances related to plan or provider customer service	Community Care, Inc. (CCI)
		17
	Enter the total number of grievances resolved by the plan during the reporting year that	Inclusa, Inc.
		0

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.

Lakeland Care, Inc.

0

My Choice Wisconsin, Inc. (MCW)

0

D1IV.16b Resolved grievances related to plan or provider care management/case management

Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management.

Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.

Community Care, Inc. (CCI)

0

Inclusa, Inc.

10

Lakeland Care, Inc.

26

My Choice Wisconsin, Inc. (MCW)

6

D1IV.16c Resolved grievances related to access to care/services from plan or provider

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

Community Care, Inc. (CCI)

0

Inclusa, Inc.

0

Lakeland Care, Inc.

0

My Choice Wisconsin, Inc. (MCW)

0

D1IV.16d Resolved grievances related to quality of care

Enter the total number of grievances resolved by the plan during the reporting year that

Community Care, Inc. (CCI)

15

Inclusa, Inc.

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.

1
8
0

Lakeland Care, Inc.

My Choice Wisconsin, Inc. (MCW)

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)
17

Inclusa, Inc.

0

Lakeland Care, Inc.

0

My Choice Wisconsin, Inc. (MCW)

0

D1IV.16f

Resolved grievances related to payment or billing issues

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

Community Care, Inc. (CCI)
0

Inclusa, Inc.

0

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 during the reporting year that were related to suspected fraud.

Community Care, Inc. (CCI)
0

Inclusa, Inc.

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.

0

Lakeland Care, Inc.

0

My Choice Wisconsin, Inc. (MCW)

0

D1IV.16h

Resolved grievances related to abuse, neglect or exploitation

Community Care, Inc. (CCI)

0

Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation.

Inclusa, Inc.

0

Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.

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)

Community Care, Inc. (CCI)

0

Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).

Inclusa, Inc.

0

Lakeland Care, Inc.

0

My Choice Wisconsin, Inc. (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 during the

Inclusa, Inc.

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.

0

Lakeland Care, Inc.

0

My Choice Wisconsin, Inc. (MCW)

0

D1IV.16k

Resolved grievances filed for other reasons

Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.

Community Care, Inc. (CCI)

11

Inclusa, Inc.

1

Lakeland Care, Inc.


14

My Choice Wisconsin, Inc. (MCW)

20

Topic VII: Quality & Performance Measures

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

 Find in the Excel Workbook
D2_Plan_Measures

Quality & performance measure total count: 1



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

Yes

D2.VII.8 Measure Description

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

Measure results

Community Care, Inc. (CCI)

15%

Inclusa, Inc.

34%

Lakeland Care, Inc.

34%

My Choice Wisconsin, Inc. (MCW)

13%

Topic VIII. Sanctions

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

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



Sanction total count: 2

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 2

D3.VIII.2 Intervention topic	D3.VIII.3 Plan name
Performance management	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	D3.VIII.6 Sanction amount
2	\$ 0
D3.VIII.7 Date assessed	D3.VIII.8 Remediation date non-compliance was corrected
11/09/2021	No
D3.VIII.9 Corrective action plan	
No	

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 2

D3.VIII.2 Intervention topic	D3.VIII.3 Plan name
Performance management	My Choice Wisconsin, Inc. (MCW)

D3.VIII.4 Reason for intervention

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

Sanction details

D3.VIII.5 Instances of non-compliance

70

D3.VIII.7 Date assessed

08/19/2021

D3.VIII.9 Corrective action plan

No

D3.VIII.6 Sanction amount

\$ 0

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

Yes 04/01/2022

Topic X. Program Integrity



Find in the Excel Workbook

D1_Plan_Set

Number	Indicator	Response
D1X.1	Dedicated program integrity staff Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	Community Care, Inc. (CCI)
		1
		Inclusa, Inc.
		5
D1X.2	Count of opened program integrity investigations How many program integrity investigations have been opened by the plan in the past year?	Lakeland Care, Inc.
		3
		My Choice Wisconsin, Inc. (MCW)
		1.76
D1X.2	Count of opened program integrity investigations How many program integrity investigations have been opened by the plan in the past year?	Community Care, Inc. (CCI)
		7
		Inclusa, Inc.
		18
D1X.2	Count of opened program integrity investigations How many program integrity investigations have been opened by the plan in the past year?	Lakeland Care, Inc.
		25

D1X.3	Ratio of opened program integrity investigations to enrollees	Community Care, Inc. (CCI) 0:51
	What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	Inclusa, Inc. 1:06
		Lakeland Care, Inc. 3:39
		My Choice Wisconsin, Inc. (MCW) 0:59

D1X.4	Count of resolved program integrity investigations	Community Care, Inc. (CCI) 7
	How many program integrity investigations have been resolved by the plan in the past year?	Inclusa, Inc. 15
		Lakeland Care, Inc. 22
		My Choice Wisconsin, Inc. (MCW) 4

D1X.5	Ratio of resolved program integrity investigations to enrollees	Community Care, Inc. (CCI) 0:51
	What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	Inclusa, Inc. 1:0
		Lakeland Care, Inc. 3:00
		My Choice Wisconsin, Inc. (MCW)

D1X.6	<p>Referral path for program integrity referrals to the state</p> <p>What is the referral path that the plan uses to make program integrity referrals to the state? Select one.</p>	<p>Community Care, Inc. (CCI)</p> <p>Makes some referrals to the SMA and others directly to the MFCU</p> <p>Inclusa, Inc.</p> <p>Makes some referrals to the SMA and others directly to the MFCU</p> <p>Lakeland Care, Inc.</p> <p>Makes some referrals to the SMA and others directly to the MFCU</p> <p>My Choice Wisconsin, Inc. (MCW)</p> <p>Makes some referrals to the SMA and others directly to the MFCU</p>
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D1X.7	<p>Count of program integrity referrals to the state</p> <p>Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made to the SMA and the MFCU in aggregate.</p>	<p>Community Care, Inc. (CCI)</p> <p>6</p> <p>Inclusa, Inc.</p> <p>3</p> <p>Lakeland Care, Inc.</p> <p>1</p> <p>My Choice Wisconsin, Inc. (MCW)</p> <p>3</p>
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D1X.8	<p>Ratio of program integrity referral to the state</p> <p>What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.2) as the denominator.</p>	<p>Community Care, Inc. (CCI)</p> <p>0:44</p> <p>Inclusa, Inc.</p> <p>0:18</p> <p>Lakeland Care, Inc.</p> <p>0:14</p>
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D1X.9	<p>Plan overpayment reporting to the state</p> <p>Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information:</p> <ul style="list-style-type: none"> • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2). 	<p>Community Care, Inc. (CCI)</p> <p>1/1/22-12/31/22 \$377,477 Recovered Ratio = 0.0006</p> <p>Inclusa, Inc.</p> <p>1/1/22-12/31/22 \$1,490,737 Recovered Ratio = 0.0020</p> <p>Lakeland Care, Inc.</p> <p>1/1/22-12/31/22 \$670,814 Recovered Ratio = 0.0020</p> <p>My Choice Wisconsin, Inc. (MCW)</p> <p>1/1/22-12/31/22 \$1,340,186 Recovered Ratio = 0.0019</p>
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D1X.10	<p>Changes in beneficiary circumstances</p> <p>Select the frequency the plan reports changes in beneficiary circumstances to the state.</p>	<p>Community Care, Inc. (CCI)</p> <p>Daily</p> <p>Inclusa, Inc.</p> <p>Daily</p> <p>Lakeland Care, Inc.</p> <p>Daily</p> <p>My Choice Wisconsin, Inc. (MCW)</p> <p>Daily</p>
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Topic IX. Beneficiary Support System (BSS) Entities

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

on how BSS entities support program-level functions is on the Program-Level BSS page.



Find in the Excel Workbook

E_BSS_Entities

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