2026 Quality Plan: Family Care (FC), Family Care Partnership (FCP), PACE (P)

Approved by: Quality Steering Committee: 02/12/2026, CCI Board of Directors: 02/18/2026, WI Department of Health Services: 03/19/2026

⌗ Denotes alignment with the Wisconsin Medicaid Managed Care Quality Strategy

Quality Monitoring		
Description	**Scope**	**Goal(s)**
Assessment, Care Planning, Service Delivery	FC, FCP, P	a. A composite score of ≥90% for all indicators reviewed. b. Increase the percentage of member-centered service plans that are comprehensive by properly addressing members' needs and personal goals at or above the 2026 statewide performance target of 85% (FC and FCP combined)⌗ c. Increase percent of Care Management Review (CMR) standards met for all indicators at or above the 2026 statewide performance target of 88% (FC and FCP).⌗
Monitoring for Provider Choice	FC, FCP, P	≥ 90% compliance of ensuring members are afforded choice among covered services and providers.
Long Term Care Functional Screens	FC, FCP, P	Monitor and maintain the completeness, accuracy, and timeliness of annual and change of condition functional screens ≥90%.
Monitoring of Home and Community Based Settings (HCBS) Rule	FC, FCP, P	a. Monitoring 100% of members living in settings that meet the HCBS rule; and b. HCBS targeted audit scores of ≥90% for all indicators reviewed.
Care Management for Vulnerable High Risk Members (VHRM)	FC, FCP, P	a. 100% accuracy in the identification of members who meet the DHS definition of "Vulnerable High Risk" b. For members assessed as VHRM, ≥ 90% compliance with care management expectations. (See full Quality Plan for detail of expectations)
Member Satisfaction	FC, FCP, P	a. Achieve 5-star member satisfaction ratings on the DHS MCO Scorecard b. Increase members who report that they know who to talk to if they want to change services at or above the 2026 statewide performance target of 92% (FC) and 87% (FCP)⌗; c. Increase rate of positive levels of member satisfaction with the number of opportunities to participate in social activities at or above the 2026 statewide performance target of 4.0 out of 5.0 (FC) and 4.0 out of 5.0 (FCP)⌗; d. Increase members who report they do things they like in their communities as much as they want at or above the 2026 statewide performance target of 65% (FC) and 60% (FCP)⌗;

		e. Increase members who report staff treat them with respect at or above the 2026 statewide performance target of 92% (FC) and 87% (FCP)⌗; f. Increase members who respond positively to the question of how well their supports and services meet their needs at or above the 2026 statewide performance target of 86% (FC) and 82% (FCP)⌗.
Caregiver Satisfaction	P	Improve the percentage of respondents describing communication with the care team as good, very good or excellent from 72.5% to 80%.
Provider Satisfaction	FC, FCP, P	Maintain an average score of 85% for the response of "always or most of the time" for the question "Our agency has a good relationship overall with Community Care."
Member Incidents	FC, FCP, P	a. ≥90% timely reporting of incidents. b. ≥90% timely reporting of notifications. c. ≥90 timely incident investigations. d. ≥90% timely investigation notifications.
Appeals and Grievances	FC, FCP, P	a. 100% of appeals will be processed timely. b. 100% of members/legal decision makers will be contacted for resolution. c. ≥ 25% resolution rate will occur with appeals. d. 100% of grievances will be processed timely. e. ≥ 50% resolution rate will occur with grievances.
Provider Access	FC, FCP, P	≥90% compliance with provider network drive time and distance standards and provider to member ratio requirements for each county service area (2026 target 95%). ⌗
Verification Services Were Provided	FC, FCP, P	Increase care coordination by increasing timely follow-up/monitoring to verify authorized services and supports were received by members at or above the 2026 statewide performance target of 65%.⌗
Provider Quality	FC, FCP, P	a. Caregiver background checks: Provider compliance ≥88%. b. Education or skills training for individuals who provide specific services: Offer two provider training topics. c. Reporting of member incidents to Community Care: ≥90% timely reporting of incidents. d. Compliance with DQA standards, where applicable: 100% of Division of Quality Assurance (DQA) Statement of Deficiency (SOD)related to Community Care

		providers will be reviewed and follow-up action determined and sent to Program Leaders. e. Appropriateness of staff providing medical services: 100% of new rending providers (non-hospital entities) are credentialed through Andros.
Utilization Management	FC, FCP, P	a. Monitor and detect underutilization, overutilization, and mis-utilization of services. b. Safeguard against unnecessary or inappropriate use of Medicare and Medicaid services available under these plans and guard against excess payments. c. Assess the quality of care and services, including preventative health services, furnished to members to assure that members receive and have access to services that promote health and safety. d. Medical record content for hospitals and mental hospitals is consistent with the utilization control requirements of 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211; e. Provide key information to IDTS to ensure the members' individual outcomes are supported in an efficient and cost-effective manner.
Participation in the Quality Management Program	FC, FCP, P	Participation in the Quality Management Program by members (tri-annually), community representatives of the target populations, (tri-annually), staff (tri-annually) and providers including long-term care and health care providers with appropriate professional expertise to participate, attendants and informal caregivers (quarterly).
Restrictive Measures	FC, FCP, P	a. 100% compliance of approved restrictive measures b. b) Reduction/elimination of restrictive measures: <0.20% of active members with restrictive measures approvals.#
Institutions for Mental Disease (IMD) Admission Monitoring	FC, FCP, P	Maintain the number of members who are admitted to IMDs multiple times in the calendar year at 18%.#(Medicaid Quality Strategy goal reference: Reduce the number of FC members who are admitted to IMDs multiple times in a calendar year by 7% over the next three years. (2023 FC baseline: 25.5%. 2026 Target: 21%)
Competitive Integrated Employment (CIE)	FC, FCP	Increase the percentage of members aged 18-64 who are working in Competitive Integrated Employment (CIE) settings by 3% between the fourth quarter 2025 and the fourth quarter 2026.#
Healthcare Effectiveness Data and Information Set (HEDIS)	FCP	Improve HEDIS rates to five-star ratings.

Prevention and Wellness	FC, FCP, P	Refer to Community Care's Prevention and Wellness Program/Plan for additional Quality Program initiatives.
Wisconsin DHS Quality Indicator		
Description	**Scope**	Goal(s)
Care Management Staff Turnover	FC, FCP, P	Maintain/Increase "Care Team Characteristic" Star Rating on the DHS ADRC MCO Scorecard.
Wisconsin DHS Pay for Performance Initiatives		
Description	**Scope**	**Goal(s)**
Certified Direct Care Professionals (CDCP)	FC, FCP	a. 100% compliance with DHS Pay for Performance (P4P) expectations related to submission deadlines. b. Withhold 1: Increase the rate of the SDS member population that are Certified Direct Care Professional (CDCP) employers by five percentage points between 12/31/2025 and 12/31/2026. c. Withhold 2: Increase the rate of CDCP employers with a Handshake account by ten percentage points between 12/31/2025 and 12/31/2026. d. Incentive 1: Increase the rate of CDCP employers with a Handshake account by 25 percentage points between 12/31/2025 and 12/31/2026.
Community Connections	FC, FCP	a. 100% compliance with DHS P4P expectations related to submission deadlines and successful earning of withhold amounts; b. Withhold 1: Complete a new Interest Inventory with 90% of FC members and 90% of FCP members from Cohort 1; c. Withhold 2: Develop at least one Community Connections outcome and complete at least one approved activity with 90% of FC members and 90% of FCP members from Cohort 1 that expressed defined levels of interest; d. Incentive 1: Complete an Interest Inventory, develop at least on Community Connections outcome and completed at least one approved activity with 30% of Family members and 30% of FCP members from Cohort 2 that expressed defined levels of interest. (Note: Must include at least five members from each residential type); and e. During the 2026 calendar year, and with all participating MCOs in the GSR, at least one MCO will complete and timely submit single documentation of two Building

		Inclusive Communities Assessments or Building Inclusive Communities Tasks in each GSR.
Formal Projects		
Description	**Scope**	**Goal(s)**
Caregiving for Caregivers Wisconsin DHS Non-Clinical Performance Improvement Project	FC	Can a continued educational campaign targeting paid SDS caregivers and unpaid preferred caregivers in FC, identified as mild to moderate or moderate to high risk of burnout, reduce their risk of burnout from 11.8% to 6% between 1/1/26 and 12/31/26?
Taking Control of Your A1c: "Less Than 8, is Great!" CMS Chronic Care Improvement Project & Wisconsin DHS Clinical Performance Improvement Project	FC, FCP, P	Can implementing diabetic management goals and interventions increase the percentage of members actively enrolled in FC (Kenosha and Waukesha), FCP and PACE, aged 18-75 year, who have a diagnosis of Type 1 or 2 Diabetes, with a controlled A1c percentage of less than 8, from 41% to 46% between 1/1/26 and 12/31/26?
Informal Projects		
Description	**Scope**	**Goal(s)**
Increasing consistency of functional screen and MCO documentation	FC, FCP, P	Increase consistency of functional screen and Community Care documentation to >90%.
Wisconsin Medicaid Managed Care Quality Strategy 2025-2027		
Description	**Scope**	**Goal(s)**
Monitoring Objectives	FC, FCP, P	Monitoring 100% of the applicable objectives within the Wisconsin Medicaid Managed Care Quality Strategy. See full Quality Plan and Wisconsin Medicaid Managed Care Quality Strategy for more details: https://www.dhs.wisconsin.gov/medicaid/medicaid-managed-care-quality-strategy-20252027.pdf