# 2026 DHS-MCO Contract:
# Substantive Changes Effective January 1, 2026

## Article I–Definitions

- Updating definitions of: Benefit (Family Care and Partnership Benefit Package), RAD Method, and Vulnerable/High Risk Member.
- Adding definitions for: Clinical Practice Guidelines, Contracted Rate, Decision-Making Guidelines, Prior Authorization, Prior Authorization Review Criteria, Remote Waiver Services, Standardized tool.

## Article II–MCO Governance and Consumer and Member Involvement

- Requiring the MCO to post the contact information for their tribal liaison on the MCO's website (II.C).

## Article III–Eligibility

- Clarifying MCO role in assisting with Medicaid renewals and adding a requirement for MCOs to report member changes in address to DHS on a weekly basis (III.C.3)
- Requiring MCO to notify residential providers that a member is in jeopardy or will lose Medicaid eligibility or will be disenrolled from the MCO at least 15 days before the disenrollment date (III.D.2.c.ii).

## Article IV–Enrollment and Disenrollment

- Outlining processes for disenrollment of members from the MCO due to non-payment of patient liability (IV.B.1).

## Article V–Care Management

- Adding requirements needed for MCOs to collect the data needed for DHS to comply with the HCBS Quality Measures required by CMS. Changes include:
    - Requiring the MCO to document "no need" if a category of assessment does not apply or is not needed by the member (V.C.1.c).
    - Requiring the MCO to use a standardized tool to assess the member's understanding of self-directed supports, alcohol and drug use, cognition and memory impairment, understanding of their rights and advance care planning, tobacco and nicotine dependence, and social isolation and loneliness (V.C.1.C.iv, vi-vii, xiv, and xvii-xviii).
    - Requiring the MCO to document on the member-centered plan the duration and frequency of paid services and supports and services provided by natural supports, including if there is no need for supports for an assessed topic (V.C.3.c.iii.a)).
    - Requiring the MCO to document on the member-centered plan the contact information for the member's IDT, primary care provider, and service providers (V.C.3.c.iii.d and n and V.C.3.e.iv).
    - Requiring the MCO to record the member's linguistic and cultural preferences during the initial contact and assessment, respectively (V.D.1.b.vii and V.D.1.c.v).
- Adding requirements needed to comply with the 2024 CMS Interoperability and Prior Authorization final rule. Changes include:

    - Requiring MCOs to use the RAD method to authorize services in the Family Care benefit package. Partnership MCOs may opt to use prior authorization instead of the RAD method for State Plan long-term care services (V.K.1.g and h).
    - Clarifying that Partnership MCOs may require prior authorization for any acute and primary service in the benefit package (V.K.1.h).
    - Adding language formalizing current process of waiving RAD documentation requirements for certain services (V.K.1.g).
    - Adding language formalizing process to be followed when a provider requests a service for a member (V.K.4).
    - For Partnership only, requiring the MCO to make a prior authorization decision within 7 calendar days of the request for the service (V.K.5.a).
    - Requiring the MCO to provide notice of the service authorization decision to the requesting provider. For Partnership only, this notice must include a specific reason for a denial or limited authorization (V.K.6.b).
    - For Partnership only, requiring the MCO to maintain a record of all standard and expedited prior authorization decisions, and the time elapsed between the request and the decision (V.K.7.c).
    - For Partnership only, requiring the MCO to post a list of all items and services that require prior authorization on its public website (V.K.8.a).
- Adding additional expectations for MCOs when members are discharging from the hospital. Changes include:
    - Requiring IDT staff to provide backup contact information when they are out of the office (V.B.5).
    - Requiring the MCO to authorize and arrange for services for members to discharge from the hospital the day the member is considered medically stable by the hospital or physician (V.D.1, and V.K.1).
    - Requiring the MCO to have written and department approved policies and procedures for hospital discharges. Procedures must include an assigned team to act as hospital liaison or discharge coordinators, sharing discharge information with hospitals, identifying transitional placement options for members or appropriate placements, daily contact with the hospital discharge planner and monitoring WISHIN, EPIC, or other hospital electronic health record system for member discharge status (V.E.6).
- Requiring the MCO to provide the residential provider with a copy of the portion of the member-centered plan containing the HCBS settings rule modification any time a modification is added or changed (V.C.3.c.iii.i)).
- Requiring the MCO to report in AIRs when a member is identified by the ADRC as pending enrollment into the MCO from Sand Ridge Secure Treatment Facility or Wisconsin Resource Center (V.J.7.iii).
- Adding new notification types in AIRS, including: MCO requested disenrollment, complex/challenging member situation, and provider related issue (V.J.7.c.iii- v).

## Article VII–Services

- Removing the Transportation-Other in lieu of service for members at the non-nursing home level of care. Transportation-Other is a self-directed service and members at the non-nursing home level of care cannot self-direct (VII.A.8.d.ii).
- Requiring the MCO to submit a mental health and substance use disorder parity analysis of its benefit plan that is compliant with 42 CFR 438 subpart K (VII.C.2.d.vi).
- Requiring the MCO to complete the Notice of Transfer of Protective Placement form and submit the form to the county APS when a member will be moved to a new protective placement (VII.M.3).
- Clarifying for MCOs that participation in Chapter 50 relocation team meetings is not only for closures, but also relocations of members due to a facility changing the means of reimbursement accepted (VII.O).

## Article VIII–Provider Network

- Requiring the MCO to immediately terminate a provider when DHS notifies the MCO that the provider fails to meet WI Medicaid enrollment requirements (VIII.D.5.c).
- Adding requirement for MCO provider agreements to specify a deadline for providers to submit claims that is no less than 120 days and no greater than 12 months from the date of service (VIII.D.29).
- Requiring provider agreements to include a process for the provider to return any overpayment discovered by the provider, MCO, or DHS (VIII.D.30).
- Requiring the MCO to only use providers that are enrolled in WI Medicaid through the Department's centralized provider enrollment system and have a valid Medicaid Provider ID. Removing language allowing MCOs to use non enrolled providers under certain circumstances (VIII.A.5, VIII.G.1, VIII.K.2, VIII.O.1.b).
- Require fixed site facility providers to have a unique Medicaid Provider ID for each physical location (VIII.G.1.b).
- Adding a process for self-directed support workers to enroll in Wisconsin Medicaid (VIII.G.1.c).
- Adding an exemption for the requirement to enroll in WI Medicaid for Community Transportation providers that meet the definition of mass transit system under Wis. Stat. § 85.20(1) (VIII.G.1.d).
- Requiring the MCO act as a third party delegate to assist providers with enrolling in Wisconsin Medicaid (VIII.G.6).
- Adding a process for the MCO to expedite provider enrollment when the MCO determines that services must begin immediately (VIII.G.8).
- Clarifying that the MCO must include contracted rates in provider agreements with residential providers and that a change in a member's acuity tier is not considered a change in the contracted rate (VIII.L.6).
- Clarifying that the MCO must use the nursing home rates posted on ForwardHealth as their payment rates (VIII.L.7.b).
- Adding procedure codes and revenue codes that the MCO must consider for inclusion in DCW payments (VIII.L.9.a).
- Adding a process for the MCO to distribute DCW payments when a provider has undergone a change of ownership (VIII.L.9.b.iv).

- Clarifying that the MCO may only use the definition of active supervision to set a minimum daily rate for residential services (VIII.L.6.d.i).
- Updating language to move responsibility for caregiver background checks from the MCO to the Department (VIII.N.5).

**Article IX–Marketing and Member Materials**

- Requiring MCO provider directory to be searchable (IX.D.1).
- Expanding languages to translate marketing/outreach materials to reach members and potential members to the most common languages spoken throughout the state (IX.E.4).

**Article XI–Grievances and Appeals**

- Requiring MCOs to allow appeals for non-nursing home level of care determination and issue a Notice of level of care form when a non-NH LOC is determined/maintained (XI.B.1.a and XI.E).
- For Partnership members enrolled in dual-eligible SNPs, requiring MCOs to allow 65 days from the date on the adverse benefit determination notice to file an appeal. The current timeframe is 60 days (XI.F.5.b).

**Article XII–Quality Management**

- Requiring the QM workplan to include the objectives of the WI Medicaid Managed Care Quality Strategy and requiring the MCO to document monitoring objectives from the WI Medicaid Managed Care Quality Strategy (XII.B.1 and C.1).
- Updating PIP process including:
    - Requiring submission of proposed study questions, aims and goals to MetaStar in addition to the Department
    - Requiring plans to include an improvement strategy that is evidence-based, culturally or linguistically appropriate and in accordance with CMS PIP validation protocol
    - Requiring MCOs to submit reports to MetaStar (XII.C.7).
- Requiring the MCO to develop and carry out a remediation plan for each area of the annual Quality Compliance Review that are not met and develop or update their quality improvement strategy for each area of the Care Management Review that the MCO scores below DHS's required score (XII.D.2.e and f).

**Article XIII–MCO Administration**

- Adding conflict of interest protections for when a MCO subcontracts for culturally appropriate care management services with a provider that also directly provides other waiver services (XIII.C.7).
- Moving responsibility for checks for excluded individuals and entities from the MCO to DHS as part of the new provider enrollment process (XIII.H).
- Requiring MCOs to attempt to recover all overpayments and have a documented process for requiring the provider to return overpayments within 60 days (XIII.K.5.b).
- Requiring the MCO to collect and report data on member use of the Patient Access API (XIII.Q.1.a).

**Article XIV–Reports and Data**

- Adding a biweekly overpayment report so that MCOs report all overpayments within 30 calendar days. Removing overpayment reporting language from quarterly report (XIV.C).
- Requiring the MCO to submit a quarterly report of all members who remained in the hospital after they were medically cleared for discharge (XVI.C.7).

**Article XVI–Contractual Relationship**

- Adding sanctions for non-compliance with administrative expense allocation and reporting requirements (XVI.E.2)

**Article XVII–Fiscal Components/Provisions**

- Adding requirements regarding MCO administrative expense allocations when the MCO or its parent company operate multiple lines of business in our outside of Wisconsin (XVII.I.1).
- Adding requirement for the MCO to complete the Administrative Expense Allocation report and outlining report requirements (XVII.I.2).

**Article XVIII–Payment to the Managed Care Organization**

- Removing CIE pay-for-performance initiative and Assistive Living Community initiative reporting. These initiatives ended in CY 2025 (XVIII.E.1 and 3).
- Adding new Certified Direct Care Professionals P4P (XVIII.E.1).
- Updating Community Connections P4P (XVIII.E.2). Changes include:
    - Simplifying cohort definitions to be based on living situation only.
    - Updating the definition of Community Connections Outcome to emphasize that they are specific and measurable indicators.
    - Updating withhold and incentive criteria and documentation requirements.
- Adding language about how administrative expense allocations will be considered for removal from costs used to develop the administrative portion of capitation rates (XVIII.O).