2026 DHS-PACE Contract
Substantive Changes Effective January 1, 2026

Article I–Definitions

- Updating definition of: Vulnerable/High Risk Member.

Article III–Eligibility

- Clarifying PO 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.B.1).

Article V–Care Management

- Adding additional expectations for the PO 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.I.1.g.vii).
    - Requiring the PO 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.J.1).
    - Requiring the PO 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.5).
- Requiring the PO to report in AIRS when a member is identified by the ADRC as pending enrollment into the PO from Sand Ridge Secure Treatment Facility or Wisconsin Resource Center (V.I.7.a.iii).
- Adding new notification types in AIRS, including: PO requested disenrollment, complex/challenging member situation, and provider related issue (V.I.7.c.iii- v).

Article VII–Services

- Requiring the PO 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.K.3).
- Clarifying for the PO 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.M).

Article VIII–Provider Network

- Adding requirement for PO 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.21).
- Requiring provider agreements to include a process for the provider to return any overpayment discovered by the provider, PO, or DHS (VIII.D.22).

- Requiring the PO 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 the PO to use non enrolled providers under certain circumstances (VIII.A.3, VIII.G.1, VIII.K.2).
- Requiring 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 PO act as a third-party delegate to assist providers with enrolling in Wisconsin Medicaid (VIII.G.6).
- Adding a process for the PO to expedite provider enrollment when the PO determines that services must begin immediately (VIII.G.8).
- Clarifying that the PO must use the nursing home rates posted on ForwardHealth as their payment rates (VIII.L.6.b).
- Updating language to move responsibility for caregiver background checks from the PO to the Department (VIII.N.5).

Article IX–Marketing and Member Materials

- Requiring PO provider directory to be searchable and electronic and include information about whether the provider offers covered services via telehealth (IX.D.1, IX.D.5).

Article XII–Quality Management

- Requiring the PO 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 PO scores below DHS's required score (XII.D.2.e and f).

Article XIII–PO Administration

- Moving responsibility for checks for excluded individuals and entities from the PO to DHS as part of the new provider enrollment process (XIII.H).
- Requiring the PO to attempt to recover all overpayments and have a documented process for requiring the provider to return overpayments within 60 days (XIII.K.4).

Article XIV–Reports and Data

- Adding a biweekly overpayment report so that the PO reports all overpayments within 30 calendar days. Removing overpayment reporting language from quarterly report (XIV.C.3 and 7).
- Requiring the PO to submit a quarterly report of all members who remained in the hospital after they were medically cleared for discharge (XIV.C.7.h).
- Removing reference to MLR report. MLR is not appliable to PACE (XIV.3).

Article XVII–Fiscal Components or Provisions

- Removing reference to MLR. MLR does not apply to PACE (XVII.H).