

2026–2027 BadgerCare Plus and Medicaid SSI HMO Contract: Substantive Changes Effective January 1, 2026

Article I – Definitions and Acronyms

- Adding the following definitions for clarity and to align with federal regulations, including 42 CFR 438.210(d)(2) and the 2024 Interoperability Rule (Article I.A):
 - Authorized service
 - Prior authorization
 - Standard prior authorization
 - Expedited prior authorization
- Adding the following definitions for clarity (Article I.A)
 - Annual Compliance Review
 - Updating the use of “certification” to “annual compliance review” where appropriate throughout the contract
 - Contract Change Activity Tool
 - Credentialing
 - Initial Readiness Assessment
 - Updating the use of “certification” to “annual compliance review” where appropriate throughout the contract
- Modifying definition of post-stabilization services to align with 42 CFR 438.114(a) (Article IV.A)
- Removing definition of service authorization because it did not align with federal regulations (Article I.A)
- Removing definition of low birth weight because it is defined within each pertinent section of the contract (Article I.A)

Article III – Care Management

- Aligning care management screening requirements (Article III.A.2)
- Clearly excluding from requirements for special health care needs members who are enrolled in a Medicare Advantage organization (Article III.A.5)
- Removing approval requirement for Care Management Staff Training plan because such approval is not required (Article III.A.4)
- Allowing the HMO to mail or e-mail member initial screen results if a member refuses communication through other allowed methods (Article III.B.2 and Article III.C.3)
- Allowing HMO WICT Core Team to meet virtually with the member if the member prefers (Article III.C.2)
- Requiring HMOs to monitor care management activities coding classification (Article III.C.4)
- Adding exemption requirements for members who receive sickle cell gene therapy (Article III.C.13)

Article IV – Services

- Adding requirement that HMOs submit mental health parity analysis in a manner that can be posted on the Department’s website to align with 42 CFR 438.920(b) (Article IV.F.2)

- Removing requirement that HMOs complete an assessment of services when a member requests or a provider refers a member for mental health or substance abuse treatment services because this requirement is not a federal requirement nor a necessary State-created requirement (Article IV.F.3)
- Removing requirement that the HMO cover examination and treatment services with adequate provider expertise for members who are victims of child abuse, incest and/or neglect; members diagnosed with post-traumatic stress syndrome; members who are victims of domestic violence; and members are perpetrators of child abuse, incest, neglect, and/or domestic violence.
because this requirement is not a federal requirement nor a necessary State-created requirement (Article IV.F.5)
- Updating those eligible for medically tailored meals to limit to those with primary or secondary diagnosis of diabetes or cardiovascular disease (Article IV.C.2)
- Removing the 1-year limit on medically tailored meal reauthorizations and clarifying that after the initial 12-week authorization, an HMO may reauthorize medically tailored meals based on criteria established by the HMO (Article IV.C.2.)
- Removing memorandum of understanding requirement with prenatal care coordination providers to align with administrative rule update (Article IV.D.3; Article XI.C.11)
- Removing dental benefits administrator survey because it is not being administered (Article IV.E.6)
- Aligning emergency and post-stabilization services section with 42 CFR 438.114(a) (Article IV.E.8)
- Removing requirement to obtain authorization for urgent care and transportation because this authorization is not required (Article IV.E.8)
- Removing sub-acute psychiatric community-based psychiatric and recovery center services (Article IV.F.2)

Article V – Provider Network and Access Requirements

- Aligning prior authorization timeframe for standard prior authorization with 42 CFR 438.210(d) (Article V.A)
- Updating culturally competency language to align with 42 CFR 438.206(c)(2) (Article V.A.3)
- Removing reasonable distance requirement from Narcotic Treatment Services section (Article V.F.4)

Article VI – Marketing and Member Materials

- Updating prevalent non-English languages as follows: (Article IV.A.2)
 - Rate Region 1: Removing Burmese and Mandarin Chinese; adding Somali
 - Rate Region 5: Adding Ukrainian
- Clarifying that oral interpretation can be conducted over the phone, using telehealth, or in-person (Article VI.A.2)
- Adding requirement for member handbook to include enrollee rights related to in lieu of services to align with 42 CFR 438.10(g)(2)(ix) (Article VI.A.3)
- Requiring HMOs to submit event schedules at least 5 days prior to the updating of an event if the materials were previously approved by the Department (Article VI.C.1)

- Removing requirement for HMOs to receive Department-approval before sending HIPAA breach notification letters (Article VI.C.4)
- Implementing SUPPORT Act Compliance template to improve and simplify HMO compliance (Article IV.F.4)

Article VII – Member Rights and Responsibilities

- Aligning travel requirements for member advocates to align with 42 CFR 438.71(b)(2) (Article VII.B.1)
- Clarifying that the continued access requirement applies to in lieu of services that the HMO offers (Article VII.G.8)
- Adding adult immunizations under health education and disease prevention (Article VII.I.5)

Article IX – Member Grievances and Appeals

- Removing requirement that HMOs distribute Ombuds brochures because the HMOs are not responsible for these brochures and do not receive updated brochures (Article IX.J.)

Article X – Quality Assessment Performance Improvement (QAPI)

- Removing provider QAPI requirements from contract because providers are not a party to this Contract (Article X.B.8)
- Clarifying that HMOs must provide opportunities for member involvement in quality improvement initiatives and in soliciting member feedback in quality of care and services the HMO provides (Article X.F.4)
- Updating accreditation section of Contract to align with current processes (Article X.J)
- Updating performance improvement plan proposal process to align with the MCO contract and reflect the current proposal submission process (Article X.K)

Article XI – HMO Administration

- Requiring HMOs to establish and include in their provider agreements that providers have no less than 120 days to submit claims to the HMO, and that the HMO must specify in the provider agreement how the claims submission deadline is applied to claims consisting of multiple dates of service. (Article XI.C)
- Clarifying that the Department may override the 120-day deadline for provider submission of claims when there is a coordination of benefits issue or other exceptional situation (Article XI.C)
- Moving Article XI.C.11, coordination with community-based organizations, to Article IV.A (Article XI.C.11)
- Removing Healthy Wisconsin information from the contract because it does not include any HMO requirements and is informational only (Article XI.C)

Article XII – Reports and Data

- Removing birth cost reporting requirement because this report is no longer used (Article XII.F.3)
- Updating timeline for compliance plan reviews to ensure current compliance plans and compliance plan reviews are aligned with the current year's contract language (Article XII.L.3)

- Adding timeline for comprehensive reviews of compliance plans (Article XII.L.3)
- Clarifying that HMOs must only report Wisconsin Medicaid cases of suspected fraud, waste and abuse (Article XII.L.6)
- Changing requirements from 24 hours to 1 business day to allow flexibility for weekends and holidays (Article XII.L.7)
- Clarifying that the HMO must return overpayment amount to the State for any identified overpayment of network providers, even if the HMO chooses not to pursue the overpayment from the provider, to address scenarios where education is provided instead of overpayment recovery (Article XII.L.9)
- Changing overpayment report from quarterly program integrity report to the biweekly overpayment report (Article XII.L.9)
- Adding report requirement to align with CMS definition of “prompt reporting of overpayments” in 42 CFR 438.608(a)(2) (Article XII.L.9)
- Clarifying that DHS OIG can recover overpayments made to HMOs (Article XII.L.10)
- Adding lookback period of HMOs’ network providers of up to five years (Article XII.L.11)
- Clarifying that the Department will not adjust or void encounters that are two or more years old (Article XII.L.11)
- Clarifying what data mining activities for purposes of the quarterly program integrity report includes (Article XII.L.13)
- Updating subcontractor database checks and attestations to ensure alignment with 42 CFR 455.436 (Article XII.L.13)
- Clarifying that HMOs must have a unit or staff that perform all functions of a special investigation unit to allow HMOs flexibility in their organizational structure while meeting the requirements of 42 CFR 438.608(a)(1)(vii) (Article XII.L.17)
- Requiring HMOs to provide administrative expense allocation documentation and calculations (Article XII.I)
- Adding requirement that HMOs complete the Contract Change Activity Tool each year (Article XII.V)
- Adding an existing prior authorization data file requirement from the HMO Report Matrix to confirm requirements for HMOs (Article XII.W)
- Adding new reporting requirement that HMOs report to the Department and post on their website by March 31 patient access API usage data listed in 42 CFR 431.60(f) and prior authorization metrics listed in 42 CFR 438.210(f) from the previous calendar year to comply with 42 CFR 438.210(f) and 42 CFR 438.210(f) (Article XII.W)
- Adding new API reporting requirements to comply with 2024 Interoperability Rule (Article XII.W)
- Adding requirement that HMOs submit weekly report of member address changes to DHS to comply with 42 CFR 435.919(f) (Article XII.X)

Article XIII – Functions and Duties of the Department

- Removing Vaccines for Children information because this is not a requirement, and the information is available on ForwardHealth (Article XIII.D)

Article XIV – Contractual Relationship

- Moving notification requirements for provider termination requirements from Article XIV.B to Article V. and editing this language to clarify that the requirements are for provider, not subcontractor, terminations (XIV.B.5)

Article XV – Fiscal Components or Provisions

- Identifying HMOs’ responsibility in addressing inappropriate member billing by network providers to protect members and clearly define responsible parties and processes (Article XV.A.3)
- Requiring HMOs to regularly monitor claims processing and denial trends (Article XV.D.1)
- Requiring HMOs to complete outreach to providers on necessary claims submission corrections when the HMO experiences more than 50 claim denials due to operational or systematic issues with the HMO (Article XV.D.2)
- Removing obsolete coverage requirement for disabled members less than three years old (Article XV.D.3)

Article XVI – Payments to the HMO

- Updating rates for ambulance state-directed payments (Article XVI.O)
- Adding a quarterly due date for qualifying ambulance payments report (Article XVI.O.2)
- Clarifying that the Department may take action as provided under Article XIV.D for HMO noncompliance with ambulance state-directed payment requirements (Article XVI.O.3)
- Changes to hospital access state directed payments in a 2025 contract amendment including: increased access payment rates, excluding long-term care acute hospitals, childless adults are newly eligible, and a new reporting template (Article XVI.I.2.)
- New UW Medical Foundation state directed payment in a 2025 contract amendment (Art XVI.O.4)
- Adding quarterly report for 2026 UW Medical Foundation state directed payments (Art XVI.O.4.)
- Rate changes for 2026 UW Medical Foundation state directed payment (Art XVI.O.4.)
- Removing 2022 American Rescue Plan Rate increase information because this increase is already included in the capitation rate development (Art. XV.D.10)

Article XVII – HMO Specific Contract Terms

- Removing annual risk adjustment reconciliation because the benefits of this reconciliation are outweighed by the administrative burden (Article XVII.D.3)

Addendum V: Intensive Care Coordination Pilot Program

- Deleting this addendum because this program has ended

Addendum VI: Links Referenced in this Contract (new)

- Adding this addendum

Addendum VII: Marketing Communications/Outreach Checklist

- Deleting this addendum and making a stand-alone checklist document