## Article I. INTRODUCTION

The Medicare Advantage plan has entered a contract with the Centers for Medicare & Medicaid Services ("CMS") to provide a Dual Eligible Special Needs Plan ("D-SNP"). The MA plan and the Department enter this contract to outline each party's obligations to provide or arrange benefits for Dual Eligible members enrolled in the MA plan's D-SNP.

The legal entity offering the D-SNP receives direct capitation from the Department to provide coverage of Medicaid benefits referenced in the Contract for BadgerCare Plus and/or Medicaid SSI HMO Services ("DHS-HMO contract"). The DHS-HMO contract is the capitated contract between the MA plan and the Department to provide Medicaid benefits.

Each contracted MA plan shall assure the Department that its parent organization does have the legal and actual authority to direct, manage and control the operations of both the corporation operating its D-SNP and its companion Medicaid Managed Care Plan to the extent necessary to ensure integration of Medicare and Medicaid services for individuals enrolled for both programs.

## Article II. DEFINITIONS

**Affiliate**: With respect to any person or entity, any other person or entity which directly or indirectly controls, is controlled by or is under common control with such person or entity.

**Cost Sharing**: The dual eligible member's financial obligations that the Department would be responsible for (as defined in the State Plan) in satisfaction of the deductibles, coinsurance, and co-payments for Medicare Part A and/or Part B services in accordance with 42 CFR § 422.304(b)(2) and 42 CFR § 422.2.

**Dual Eligible**: An individual who has established eligibility for Medicare as their primary coverage and Medicaid as their secondary coverage.

**Dual Eligible Member**: A Dual Eligible who is eligible to participate in, and voluntarily enrolled in, the MA plan's D-SNP.

**Dual Eligible Special Needs Plan (D-SNP)**: A specialized Medicare Advantage plan for special needs individuals who are entitled to medical assistance under a State plan under title XIX of the Social Security Act that coordinates the delivery of Medicare and Medicaid services for individuals who are eligible for such services.

**Full Benefit Dual Eligible**: An individual who is eligible for a full benefit Medicaid plan and Medicare. Full benefit Medicaid programs in Wisconsin include, BadgerCare Plus, SSI Medicaid, SSI-related Medicaid, Medicaid Purchase Plan (MAPP), Wisconsin Well Woman Medicaid, Institutional Medicaid, Family Care, Family Care Partnership, Include, Respect, I Self-Direct (IRIS), and Children's Long-Term Support Waiver Program (CLTS).

**MA:** Medicare Advantage

**Medicare Advantage Plan (MA plan)** means health benefits coverage offered under a policy or contract by an MA organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA plan.

**MA organization:** a public or private entity organized and licensed by a State as a risk-bearing entity (except for provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

**Qualified Medicare Beneficiary (QMB)**: An individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose countable resources do not exceed applicable limits. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, and coinsurance.

**Qualified Medicare Beneficiary Plus (QMB+)**: An individual who is entitled to Medicare Part A, has income that does not exceed 100% of the FPL, whose countable resources do not exceed applicable limits, and who is also eligible for a full benefit Medicaid program.

**Qualified Disabled and Working Individual (QDWI)**: An individual who has lost Medicare Part A benefits due to a return to work but is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. QDWIs are eligible only for Medicaid payment of the Part A premium.

**Specified Low-Income Medicare Beneficiary (SLMB**): An individual entitled to Medicare Part A, has income that exceeds 100% FPL but less than 120% FPL, and whose countable resources do not exceed applicable limits. This individual is eligible for Medicaid payment of Medicare Part B premium.

**Specified Low-Income Medicare Beneficiary Plus (SLMB+)**: An individual entitled to Medicare Part A, has income that exceeds 100% FPL but less than 120% FPL, whose countable resources do not exceed applicable limits, and who is also eligible for a full benefit Medicaid program. This individual is eligible for Medicaid payment of Medicare Part B premium. (Clarifying note: This is the definition of "SLMB+" used by CMS. Historically, Wisconsin has used this term to refer to the group known at the federal level as "Qualifying Individual (QI.)

**Qualifying Individual (QI)**: An individual entitled to Medicare Part A, has income that exceeds 120% FPL but less than 135% FPL, and whose countable resources do not exceed applicable limits. This individual is eligible for Medicaid payment of Medicare Part B premium. (Clarifying note: Historically, Wisconsin has used "SLMB+" to refer to this group and has not utilized the term "Qualifying Individual (QI)".)

**State Plan**: The State of Wisconsin's plan for the Medical Assistance Program as submitted by the Department and approved by the Secretary of the U.S. Department of Health and Human Services under Title XIX of the Social Security Act, as modified, or amended.

**Subcontract**: An agreement between the MA plan and a third party under which the third party agrees to accept payment for providing health care services for the MA plan's members.

**Subcontractor**: A third party with which the MA plan has a written agreement to fulfill the requirements of this Contract. Some examples of subcontractors include administrative service providers, clinical and medical service providers, data processing providers, and allied health providers.

## Article III. MA PLAN OBLIGATIONS

*Section 3.01 Service Area.*

(a) The MA plan will offer services to Dual Eligible members as identified in **Appendix A** who:

1. Reside in a **Wisconsin** county where the D-SNP is offered, and

2. Are otherwise eligible to receive D-SNP benefits.

(b) The MA plan must provide written notice to the Department's contact (as identified in contract Section 7.08) of the addition or deletion of any **Wisconsin** service area change no later than September of the preceding year.

*Section 3.02 Enrollment*

(a) Unless a Dual Eligible individual is otherwise excluded under federal Medicare Advantage plan rules, all Dual Eligible individuals who select the D-SNP will be accepted without regard to physical or mental condition, health status or need for or receipt of health care services, claims experience, medical history, genetic information, disability, marital status, age, sex, national origin, race, color, or religion, and will not use any policy or practice that has the effect of such discrimination.

(b) The MA plan shall check an applicant's Medicaid eligibility status prior to enrollment. As outlined in Section 4.01, the Department will provide the MA plan with real-time access to the state's eligibility system (ForwardHealth) only to verify an applicant's Dual Eligible status or current Medicaid status. The MA plan may not utilize information available in the ForwardHealth Portal to market to potential members and entice enrollment in the D-SNP.

(c) The MA plan may choose to use a Subcontractor to conduct eligibility verification outlined in this Section. All subcontracts are subject to Department review and approval. The MA plan must ensure only authorized users have access to ForwardHealth data and functions provided and that all users understand and comply with HIPAA and other state and federal confidentiality laws.

*Section 3.03 Benefits.*

(a) The MA plan's D-SNP will provide services to all Dual Eligible members who qualify under its eligibility requirements without regard to any factor that is related to health status, including but not limited to medical condition, including mental as well as physical illness, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, and disability.

(b) The MA plan shall provide Wisconsin State Plan services when medically necessary and appropriate, including all covered services as defined in DHS-HMO Contract. The covered services will be provided by the MA plan or through a Medicaid contract with another organization owned by the same parent.

(c) The MA plan is not responsible for providing services that are not covered by the DHS-HMO Contract. These services are not included in the capitated rate paid by the Department. The MA

plan may provide additional supplemental benefits including those defined in Appendix B of this contract.

(d) The MA plan is responsible for the coordination of both Medicare and Medicaid benefits, regardless of whether an individual is enrolled with the D-SNP's SSI Medicaid plan for Medicaid benefits. The MA plan will identify in the Summary of Benefits, any benefits Dual Eligible members may be eligible for under the State Plan that are not covered services under the Dual Eligible member's D-SNP and coordinate access to such benefits as outlined in Section 3.03(f). The MA plan shall provide a copy of the D-SNP Summary of Benefits to the Department for review by its assigned contract analyst in the Bureau of Quality and Oversight.

(e) The MA plan shall provide the Department with a list of all Supplemental Benefits offered to D-SNP members, including any Special Supplemental Benefits for the Chronically Ill the plan offers.

(f) The MA plan and the Department will use reasonable best efforts to coordinate care of Dual Eligible members. The MA Plan shall assign appropriate staff who are responsible for ensuring integrated Medicare-Medicaid benefits are coordinated. Coordination of Medicare and/or Medicaid benefits is not the D-SNP member's responsibility. The MA plan shall assist in the coordination and access of needed Medicaid benefits through case managers, care coordinators, or other staff consistent with the Model of Care.

(g) The MA plan will provide the following:

1. Information on State Plan Medicaid Benefits for which Dual Eligible members are eligible under the State Plan but are not provided by the MA plan, as defined in 4.02 of this contract
2. Information on how to access Medicaid benefits, and assistance with coordination required for Dual Eligible members to do so,
3. Assistance with questions regarding coverage or payment issues between Medicaid and Medicare, and
4. Information for MA plan network providers on Medicaid services not provided by Medicare that are available to Dual Eligible members.

(h) The Department will provide the MA plan with resources, to the extent available, that will assist the MA plan to access information regarding the State Plan, including the State Plan's Medicaid benefits, the ForwardHealth provider updates, and Medicaid provider information.

(i) The MA plan will provide the Department with the following:

1. Information relating to Care Management activities including written Policy and Procedure instructions.
2. Information relating to Member Advisory Committee including written Policy and Procedure instructions and committee minutes.

*Section 3.04 Enrollee Liability for Payment.*

(a) Neither the MA plan nor any of its subcontractors may collect any payment for cost sharing from a Dual Eligible member other than what is allowed by federal or state law.

(b) The following applies only to those categories of Dual Eligible members as required by federal or state law:

1. The MA plan will not impose or permit its subcontractors to collect cost sharing on Dual Eligible members that exceeds the cost sharing permitted with respect to the Dual Eligible member under Medicaid if the Dual Eligible member were not enrolled in a D-SNP.
2. The MA plan must notify its subcontractors (via a provider manual, provider bulletin, or other contractual document) that they may not seek payments for cost sharing from Dual Eligible members for health care services rendered.
3. The MA plan must notify its subcontractors to seek payment from the Department for cost sharing for Dual Eligible members according to the State Plan or accept payment from the MA plan as a payment in full. The MA plan must provide the Department contact identified in Section 7.08 with a copy of such written notice.

*Section 3.05 Third Party Liability & Coordination of Benefits.*

(a) The Department is responsible for adjudicating the cost share under the State Plan.

(b) The MA plan will adjudicate and pay claims in accordance with Medicare rules and regulations and provide Evidence of Payment information to providers, which identifies coordination amounts for their claim submission to the State Plan.

(c) Pursuant to the State Plan, the Department will remain financially responsible for cost-sharing for Full Benefit Dual Eligibles and QMB who are members of the D-SNP. The Department may have financial responsibility for Medicare Part A and/or Part B premiums for other categories of Dual Eligibles (as defined in Article II) in the MA plan's D-SNP as described in the State Plan.

*Section 3.06 Marketing & Communication to Members*

(a) The MA plan must abide by all marketing and communication requirements contained within 42 C.F.R. § 422.2262.

(b) The MA plan is prohibited from using the BadgerCare Plus logo or name or the SSI Managed Care name in member marketing or outreach materials.

(c) MA plans may have agreements with third-party agents in connection with plan marketing & member communication activities consistent with Medicare regulations. If the MA plan enters into such agreements, the MA plan will:

1. Provide training for agents related to marketing regulations consistent with training provided to plan staff and
2. Submit all training policy and procedures to the Department for review.

(d) The D-SNP, through its employees, subcontractors, or agents, will not use or attempt to use its position as an employee, subcontractor, or agent of the D-SNP to influence member enrollment options directly or indirectly for the benefit of the D-SNP, its parent company, corporate affiliates, subsidiaries, or any other entity affiliated with the D-SNP.

## Article IV. DEPARTMENT OBLIGATIONS

*Section 4.01 Eligibility Verification.*

As outlined in section 3.02, the Department agrees to provide the MA plan or its subcontractors with real-time access to the state's eligibility system (ForwardHealth) only to verify an applicant's Dual Eligible status or an enrollee's current Medicaid status. Information obtained by the MA plan from the Department's eligibility verification system shall not be used by the MA plan for marketing purposes.

*Section 4.02 Sharing of Information.*

(a) The MA plan must obtain certain information from the Department to comply with CMS requirements for Dual Special Needs Plans. In particular:
   1. The Department will provide the MA plan with access to an electronic data file of participating Medicaid providers, and
   2. The Department will provide the MA plan with access to the State Plan and ForwardHealth provider updates to define the services and products for which Dual Eligible individuals qualify for.

(b) The Department will provide the MA plan with an electronic data file containing Medicaid participating providers on a weekly basis. Once the Department provides an electronic data file list of participating Medicaid providers, the MA plan will identify those health care providers that are participating in both the State Plan and the MA plan's network for Dual Eligible members who are enrolled in a Dual Special Needs Plan in the Dual Special Needs Plan's provider directory.

(c) The MA plan shall provide Medicare member enrollment and encounter data upon request from the Department.

## Article V. TERM, TERMINATION

*Section 5.01 Term.*

The initial term of this contract will begin upon approval from CMS.

*Section 5.02 Termination.*

(a) This contract may be terminated by mutual agreement of the parties. Such agreement must be in writing. The effective date of termination is dependent on any pertinent CMS requirements, including CMS requirements related to notification of Dual Eligible members.

(b) The MA plan may terminate this contract by notifying the Department that it is notified by CMS that the MA plan will not be permitted to continue offering the D-SNP plan(s) identified on Appendix A. The termination will be effective on the date specified in the MA plan's notice of termination.

(c) Either party may terminate this contract at any time due to modifications mandated by changes in federal or state laws, rules or regulations that materially affect either party's rights or responsibilities under this contract.

(d) Either party may terminate this contract at any time if it determines that the other party has substantially failed to perform any of its functions or duties under this contract.

(e) Either party may terminate this contract if federal or state funding of contractual services rendered by the D-SNP become or will become permanently unavailable.

(f) In case of termination pursuant to this section 5.02, the Department and the MA plan will develop a termination plan to ensure all ongoing service, reporting, data, and fiscal items are addressed in accordance with all applicable law, regulations, and CMS guidance.

## Article VI. DISPUTE RESOLUTION

*Section 6.01 General Agreement of the Parties.*

The parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the parties employ all reasonable and informal means to resolve any dispute under this contract. The parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

*Section 6.02 Duty to Negotiate in Good Faith.*

Any dispute that in the judgment of any party to this contract may materially or substantially affect the performance of this contract will be reduced to writing and delivered to the other party. The parties must then negotiate in good faith and use every reasonable effort to resolve such dispute and the parties shall not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by agreement between the parties shall be reduced to writing and delivered to all parties within ten (10) business days.

## Article VII. MISCELLANEOUS PROVISIONS

*Section 7.01 Entire Contract.*

This contract contains the entire understanding between the parties hereto with respect to the subject matter of this contract and supersedes any prior understandings, agreements or representations, written or oral, relating to the subject matter of this contract.

*Section 7.02 Signatures & Counterparts.*

This contract will be effective only when signed by both parties. This contract may be executed in separate counterparts, each of which will be an original and all of which taken together will constitute one and the same agreement, and a party hereto may execute this contract by signing any such counterpart.

*Section 7.03 Non-Debarment.*

The MA plan represents that neither it nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any state or federal health care program.

*Section 7.04 Severability.*

Whenever possible, each provision of this contract will be interpreted in such a manner as to be effective and valid under applicable law. If any provision of this contract is held to be invalid, illegal or unenforceable under any applicable law or rule, the validity, legality and enforceability of the other provisions of this contract will not be affected or impaired thereby.

*Section 7.05 Successors & Assigns.*

This contract will be binding upon and inure to the benefit of the parties and their respective heirs, personal representatives and, to the extent permitted by Section 7.06, successors, and assigns.

*Section 7.06 Assignment.*

This Contract and the rights and obligations of the parties under this Contract will be assignable, in whole or in part, by the Contractor (i) upon prior notice to the Department, if the proposed assignment is to a Contractor Affiliate, or (ii) with the prior written consent of the Department's point of contact identified in Section 7.08 if the proposed assignment is not to a Contractor Affiliate.

*Section 7.07 Modification, Amendment, or Waiver.*

No provision of this contract may be modified, amended, or waived except by a written signed by parties to this contract. No course of dealing between the parties will modify, amend, or waive any provision of this contractor any rights or obligations of any party under or by reason of this contract. This provision is not applicable to changes to Appendix A as described in Section 3.01.

*Section 7.08 Notices.*

All notices, consents, requests, instructions, approvals, or other communications provided for herein will be in writing and delivered by electronic mail addressed to the receiving party at the address set forth herein. All such communications will be effective when received.

**The DEPARTMENT: dhsdmshmo@wi.gov**

**D-SNP E-Mail address:**

A party may change the contact information set forth above by giving written notice to the other party.

*Section 7.09 Headings.*

The headings contained in this contract are for reference purposes only and will not in any way affect the meaning or interpretation of this contract.

*Section 7.10 Compliance with Federal and State Law.*

The parties agree to comply with all relevant federal and state laws, including but not limited to the following: the Health Insurance Portability and Accountability Act, as amended, and its implementing regulations and other applicable state or federal confidentiality laws; the Medicare Improvements for Patients and Providers Act of 2008 and its implementing regulations issued by CMS; 42 CFR Part 422; Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.); Sections 503 and 504 of the Rehabilitation Act of 1973, as amended (29 USC §§ 793 and 794); Title IX of the Education Amendments of 1972, as amended (20 USC § 1681 et seq.); Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended (41 USC § 9849); the Americans with Disabilities Act (42 USC § 12101 et seq); and the Age Discrimination Act of 1975, as amended (42 USC § 6101 et seq.).

*Section 7.11 Governing Law & Venue.*

This contract is governed by the laws of the State of **Wisconsin** and interpreted in accordance with **Wisconsin** law, except to the extent preempted by federal law. Provided the parties first comply with the procedures set forth in Article VI, "Dispute Resolution," proper venue for claims arising from this contract will be in a court of competent jurisdiction in **Wisconsin.**

*Section 7.12 No Third-party Beneficiaries.*

Nothing in this contract, express or implied, is intended to confer upon any other person any rights, remedies, obligations, or liabilities of any nature whatsoever.

*Section 7.13 Publicity.*

Except as otherwise required by this contract or by law, no party will issue or cause to be issued any press release or make or cause to be made any other public statement for purposes of marketing or advertising as to this contract or the relationship of the parties, without providing notice to the other party of the contents and manner of presentation and publication thereof. Either party shall have the ability to specifically request that prior consent shall be provided to release information publicly and the parties shall negotiate in good faith regarding whether such request can be accommodated.

*Section 7.14 No Waiver.*

No delay on the part of either party in exercising any right under this contract will operate as a waiver of such right. No waiver, express or implied, by either party of any right or any breach by the other party will constitute a waiver of any other right or breach by the other party.

*Section 7.15 Confidential Information.*

The Department agrees that information that the MA plan submits under this contract will be treated as non-public information to the extent permitted by law.

## Article VIII. Default Enrollment

*Section 8.01 Eligible Population*

On behalf of currently enrolled SSI HMO categorically eligible members who receive full medical assistance benefits, and who become newly Medicare eligible either by age or disability, and that such

Medicare eligibility results in Full Benefit Dual Eligible status for such members, the MA plan shall perform the default enrollment process as provided by 42 CFR§§ 422.66 and 422.68.

*Section 8.02 Department Approval*

In conformance with 42 CFR §§ 422.66(c)(2)(i)(B) and 42 CFR 422.107, the Department approves the MA plan's implementation of the default enrollment process subject to CMS' prior approval as per the requirements of 42 CFR §§ 422.66(c)(2)(i)(E), (F), and (G) inclusive; 422.66(c)(2)(ii); and other CMS-published regulatory guidance as applicable.

*Section 8.03 CMS Approval*

The MA plan shall coordinate with the Department regarding those activities necessary to obtain such CMS approval. The MA plan shall forward to the Department a copy of CMS' default enrollment process approval notification or correspondence to the MA plan within 10 calendar days of receipt.

The MA plan shall be responsible for coordinating those necessary activities to renew any existing default enrollment process approval(s) with CMS, as per the requirements of 42 CFR § 422.66(c)(2)(ii), so that any such subsequent CMS approval(s)/renewal(s) of an existing approved default enrollment process shall be effective no later than 120 calendar days prior to the expiration of the existing CMS approval requested to be renewed. The MA plan shall coordinate with the Department regarding those activities necessary to obtain such CMS renewal approval(s) of an existing default enrollment process. The MA plan shall forward to the Department copies of its default enrollment process renewal notification and materials to CMS, and CMS' renewal approval(s) notification or correspondence to the D-SNP within 10 calendar days to **dhsdmshmo@wi.gov**

*Section 8.04 Department Obligation*

Through implementation of the default enrollment process, the Department shall provide the MA plan with information necessary to prospectively identify those Medicaid categorically eligible members who are or will be in their Medicare Initial Coverage Election Period.

*Section 8.05 Reporting Requirements*

The MA plan shall report the following data quarterly to the Department of its default enrollment process activities and results:

(a) Number of individuals (potential dually eligible members) identified by the MA plan as eligible for default enrollment based on age or disability.
(b) Number of beneficiaries (potential dually eligible members), separated by eligibility based on age or disability, that were noticed by the MA plan at least 60 calendar days prior to the effective date of default enrollment.
(c) Number of beneficiaries (potential dually eligible members) who opt out of (decline) default enrollment prior to the effective date. Differentiate between those who opt out by telephone or in writing, as well as eligibility based on age or disability.
(d) At the end of the first month of enrollment, specify the number of rapid disenrollments (the number of dually eligible members who disenroll within their first month of default enrollment). Continue to track for rapid disenrollments within the first three months of a dually eligible member's default enrollment effective date.
(e) Information regarding any complaints received internally, including grievances relating to default enrollment.

The MA plan shall submit reports to **dhsdmshmo@wi.gov**.

*Section 8.06 Star Rating*

The MA plan shall have a minimum overall quality rating from the most recently issued ratings, under the rating system described in §§ 422.160 through 422.166, of at least 3 stars or is a low enrollment contract or new MA plan as defined in § 422.252 in order to perform default enrollment.

*Section 8.07 Continuity of Care and Network Overlap*

The D-SNP shall develop a network of providers which includes a substantial, no less than 80%, overlap of providers in its network that are also contracted with its companion SSI Medicaid HMO health plan. On its website, the MA plan shall maintain a link to its applicable companion SSI Medicaid HMO health plan's provider search capabilities to assist an enrolled Dual Eligible member in determining a provider's participation in the MA plan's provider network. The MA plan shall report to the Department on an annual basis regarding the overlap across provider networks by primary care, and specialty provider group types.

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**APPENDIX A**

MA PLAN
APPLICABLE SERVICE AREAS AND
DUAL ELIGIBLE CATEGORIES

| MA PLAN NAME<br><br>H# | SERVICE AREA | CATEGORIES OF DUAL ELIGIBLES ENROLLED (Full Benefit Dual Eligible, QMB, QMB+, SLMB, SLMB+, QI, QDWI) |
|---|---|---|
| | | |

## APPENDIX B

The following Medicaid services are not covered by the MA plan. These services are not included in the capitated rate paid to the MA plan by the Department. The MA plan is not required to provide these services, but is responsible for ensuring coordination of these services to members who want to access the following services on a fee-for-service basis.

Please refer to the HMO Contract and to the service-specific publications and the ForwardHealth Online Handbook (https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Provider/ProviderLogin.aspx) for detailed information on covered and non-covered services.

- Non-emergency Medical Transportation
- Dental, except in Milwaukee, Waukesha, Racine, Kenosha, Ozaukee, and Washington counties.
- Prenatal Care Coordination
- Targeted Case Management
- School-Based Services
- Child Care Coordination.
- Certain Tuberculosis-related services, including directly observed therapy (DOT), patient education and anticipatory guidance, symptom and treatment monitoring.
- Crisis Intervention Benefit.
- Community Support Program services.
- Comprehensive Community Services
- Community Recovery Services
- Chiropractic services
- Lead investigations, as defined in Wis. Stat. §254.11(8s), of persons having lead poisoning or lead exposure, as defined in Wis. Stat. §254.11(9).
- Medication therapy management.
- Prescription, over-the-counter drugs, and diabetic and other drug related supplies
- Provider administered drugs
- Behavioral Treatment Services (Autism Services)
- Residential Substance Use Disorder Treatment

- Hub and Spoke Integrated Recovery Support Services Health Home for SUD Treatment Pilot Program