AGREEMENT
BETWEEN THE WISCONSIN DEPARTMENT OF HEALTH SERVICES
AND
MEDICARE ADVANTAGE HEALTH PLAN

THIS AGREEMENT is made and entered into by the Wisconsin Department of Health Services (the "Department"), an administrative agency within the executive department of the State of Wisconsin, and _____ ("Medicare Advantage Health Plan" or "MA Health Plan"), a corporation organized under the laws of the State of Wisconsin.

Article I. BACKGROUND

The MA Health Plan has entered into a contract with the Centers for Medicare & Medicaid Services ("CMS") to provide an MA-PD Plan ("MA Agreement"). Under the Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA") and the Bipartisan Budget Act of 2018 and resulting regulations, CMS requires the MA Health Plan to enter into an agreement with the state of **Wisconsin** to provide or arrange for benefits to be provided, for which a dually eligible individual is entitled to receive. As a result, the MA Health Plan and the Department wish to enter into this agreement which shall outline each party's obligations to provide or arrange for benefits for Dual Eligible Members.

The legal entity offering the dual special needs plan (D-SNP) as part of its MA Agreement is under the ownership and control of the same parent organization, as a Wisconsin Medicaid Managed Care Plan serving dual eligible individuals operating in the same region as the D-SNP covered under this Contract. The Wisconsin Medicaid Managed Care Plan is responsible for covering the Medicaid benefits described in Appendix B.

In consideration of the premises and the mutual promises and undertakings herein contained, the parties agree to the following terms and conditions.

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 Health Plan's MA-PD Plan.

Dual Special Needs Plan: An MA-PD Plan that has received CMS approval to offer an MA-PD Plan that specifically target certain categories of Dual Eligible individuals.

Full Benefit Dual Eligible: An individual who is eligible for a full benefit Medicaid plan and 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 Agreement: The Medicare Advantage Agreement between the MA Health Plan and CMS to provide Medicare Part C and other health plan services to the MA Health Plan's members.

MA-PD Plan: The CMS approved Medicare Advantage plan sponsored, issued, or administered by the MA Health Plan as defined at 42 C.F.R. § 423.4 and includes, but is not limited to, institutional and Dual-Eligible Special Needs Plans as defined in the Medicare Advantage Rules.

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: 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 Health Plan and a third party under which the third party agrees to accept payment for providing health care services for the MA Health Plan's members.

Subcontractor: A third party with which the MA Health 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 HEALTH PLAN'S OBLIGATIONS

Section 3.01 Service Area.

The MA Health Plan will offer MA-PD Plans to Dual Eligibles as identified on **Appendix A** who: (1) reside in a **Wisconsin** county where the MA Health Plan offers the MA-PD Plan, and (2) are otherwise eligible to receive the MA-PD Plan. The MA Health Plan will also identify the service area of the MA-PD Plans according to either counties on **Appendix A**. Finally, the MA Health Plan shall identify for the Department on **Appendix A**, which categories of Dual Eligible individuals are eligible to enroll in the Dual Special Needs Plan. For each subsequent year, the MA Health Plan must provide written notice to the Department's contact identified in 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 is otherwise excluded under federal Medicare Advantage plan rules, the MA Health Plan will accept all Dual Eligible individuals who select the MA Health Plan's MA-PD Plan 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 Health Plan shall check prior to SNP enrollment an applicant's Medicaid eligibility status. As outlined in Section 4.01, the Department will provide MA Health Plan with real-time access to the state's eligibility system (ForwardHealth) only to verify a SNP applicant's Dual Eligible status or a SNP enrollee's current Medicaid status. The MA Health Plan may not utilize information available in the ForwardHealth Portal to market to potential SNP members and entice enrollment in the SNP.

(c) The MA Health 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 Health 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 Health Plan will provide the MA-PD Plan to all Dual Eligible Members who are qualified to receive such services under the eligibility requirements of the MA-PD Plan.

(b) The MA Health Plan shall provide the following Wisconsin State Plan services when medically necessary and appropriate: all covered services as defined in Article IV (B) (1) of the BadgerCare Plus and Medicaid SSI Contract by the MA Health Plan or through a Medicaid contract with another organization owned by the same parent.

(c) Services that are not covered by this Contract include: all non-covered services as defined in Article IV (A) (1) of the 2020-2021 BadgerCare Plus and Medicaid SSI Contract. These services are not included in the capitated rate paid to the MA Health Plan by the Department. The MA Health Plan is not required to provide these services, but is responsible for ensuring coordination of these services, per the federal regulations described at 42 CFR §422.107(c)(1).

(d) The MA Health Plan will identify for Dual Eligible Members in the MA Health Plan's Summary of Benefits those benefits the member may be eligible for under the State Plan that are not covered services under the Member's MA Health Plan and coordinate access to such benefits as outlined in Section 3.03(e). The benefits under the State Plan are identified in **Appendix B**. The MA Health Plan will provide a copy of the Summary of Benefits to the Department prior to CMS approval so that the Department may review the Medicaid benefit information in the Summary of Benefits. The Department will review the Summary of Benefits within five business days.

(e) The MA Health Plan and the Department will use reasonable best efforts to coordinate care of Dual Eligible Members. The MA Health Plan shall assist in the coordination and access of needed Medicaid benefits for Dual Eligible Members through the MA Health Plan's case managers, care coordinators, or other staff. Consistent with the MA Health Plan's Model of Care, coordination of care for Dual Eligible Members by the MA Health Plan will include the following:

- Identifying for Dual Eligible Members of the Special Needs Plan in the MA Health Plan's Summary of Benefits those Medicaid benefits the member may be eligible for under the State Plan that are not covered services under the Member's Dual Special Needs Plan to the extent that the Department has provided State Plan benefit information outlined in Section 4.02 of this Agreement.
- Providing Dual Eligible Members with information (including contact information) to access Medicaid benefits upon the Dual Eligible Member's request or as identified by the case coordinator or other MA Health Plan staff.
- Coordinating access to Medicaid covered services upon the Dual Eligible Member's request or as identified by the MA Health's Plan's care coordinator. Such coordination may include identification and referrals to needed services, assistance in care planning, and assistance in obtaining appointments for needed services.
- Providing assistance to dual eligible members with questions about coverage or payment issues that may arise between Medicaid and Medicare upon the Dual Eligible Member's request or as identified by the MA Health's Plan's care coordinator.
- Identifying Medicaid participating providers for the Dual Eligible Members to the extent the Department has provided such information as outlined in Section 4.02 of this Agreement.
- Making information available to MA Health Plan's network providers regarding Medicaid so that they may assist Dual Eligible Members to receive needed services not covered by Medicare. Providing information to MA Health Plan's network providers about coordination of Medicaid and Medicare benefits for Dual Eligible Members.

(f) The Department will provide contact and resource information, to the extent available, for the State Plan to the MA Dual SNP that allows the MA Dual SNP to access information regarding the State Plan, including the State Plan's Medicaid benefits, the ForwardHealth provider updates, and Medicaid providers.

Section 3.04 Enrollee Liability for Payment.

(a) Neither the MA Health 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:

- The MA Dual SNP 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 MA-PD Plan.
- The MA Health 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 to Dual Eligible Members.
- The MA Health 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 Health Plan as a payment in full. The MA Health 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 Health 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 MA Health Plan's SNP(s). 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 Health Plan's SNP as described in the State Plan.

Section 3.06 Marketing & Communication to Members

MA Plans are required to implement and enforce all of the requirements regarding member outreach and marketing processes, including Title 42 Code of Federal Regulations Part 438.10 and 42 CFR 438.104, as contained in the *Communication Outreach and Marketing Guide*, which is fully incorporated herein by reference.

Article IV. DEPARTMENT OBLIGATIONS

Section 4.01 Eligibility Verification.

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

Section 4.02 Sharing of Information.

(a) The MA Health Plan has to obtain certain pieces of information from the Department to comply with CMS requirements for Dual Special Needs Plans. In particular (i) the Department will provide the MA Health Plan with access to an electronic data file of participating Medicaid providers, and (ii) the Department will provide the MA Health 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 Health Plan with an electronic data file containing Medicaid participating providers on a monthly basis. Once the Department provides an electronic data file list of participating Medicaid providers, the MA Health Plan will identify those health care providers that are participating in both the State Plan and the MA Health 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 DHS.

Article V. TERM, TERMINATION

Section 5.01 Term.

The initial term of this Agreement will begin upon approval from Centers for Medicaid and Medicare Services.

Section 5.02 Termination.

(a) This Agreement 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 Health Plan may terminate this Agreement by notifying the Department that it is notified by CMS that all of the MA Health Plan will not be permitted to continue offering the MA-PD plans identified on Appendix A. The termination will be effective on the date specified in the MA Health 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 Contractor become or will become permanently unavailable.

(f) In case of termination pursuant to this section 5.02, the Department and the MA Health 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 Agreement. 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 Agreement may materially or substantially affect the performance of this Agreement 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 Agreement.

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

Section 7.02 Signatures & Counterparts.

This Agreement will be effective only when signed by both parties. This Agreement 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 Agreement by signing any such counterpart.

Section 7.03 *Non-Debarment.*

The MA Health 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 Agreement will be interpreted in such a manner as to be effective and valid under applicable law. If any provision of this Agreement 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 Agreement will not be affected or impaired thereby.

Section 7.05 *Successors & Assigns.*

This Agreement 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 Agreement and the rights and obligations of the parties under this Agreement will be assignable, in whole or in part, by the MA Health Plan (i) with prior notice if to an MA Health Plan Affiliate or (ii) otherwise with the prior written consent of the Department's point of contact identified in Section 7.08.

Section 7.07 *Modification, Amendment, or Waiver.*

No provision of this Agreement may be modified, amended, or waived except by a written signed by parties to this Agreement. No course of dealing between the parties will modify, amend, or waive any provision of this Agreement or any rights or obligations of any party under or by reason of this Agreement. 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

MA HEALTH PLAN:
NAME:
ADDRESS:
CITY, STATE, ZIP:
FAX:

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 Agreement are for reference purposes only and will not in any way affect the meaning or interpretation of this Agreement.

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 Agreement 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 Agreement will be in a court of competent jurisdiction in **Wisconsin.**

Section 7.12 No Third-party Beneficiaries.

Nothing in this Agreement, 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 Agreement 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 Agreement 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 Agreement 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 Health Plan submits under this Agreement 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, MA Health 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 Health 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 Health Plan shall coordinate with the Department regarding those activities necessary to obtain such CMS approval. The MA Health Plan shall forward to the Department a copy of CMS' default enrollment process approval notification or correspondence to the MAO within 10 calendar days of receipt.

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

1. Number of individuals (potential dually eligible members) identified by the MA Health Plan as eligible for default enrollment based on age or disability.
2. Number of beneficiaries (potential dually eligible members), separated by eligibility based on age or disability, that were noticed by the MA Health Plan at least 60 calendar days prior to the effective date of default enrollment.
3. 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.
4. 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.
5. Information regarding any complaints received internally, including grievances relating to default enrollment.

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

Section 8.06 Star Rating

The MA Health 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 MA Health Plan 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 Health 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 Health Plan's provider network. The MA Health 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-PD PLANS
APPLICABLE SERVICE AREAS AND
DUAL ELIGIBLE CATEGORIES

MA-PD PLAN NAME	SERVICE AREA	CATEGORIES OF DUAL ELIGIBLES ENROLLED (Full Benefit Dual Eligible, QMB, QMB+, SLMB, SLMB+, QI, QDWI)

APPENDIX B
BadgerCare Plus and Wisconsin Medicaid Covered Benefits

Medicaid covered benefits may be provided by the D-SNP, a different HMO that has a contract with Wisconsin Medicaid, or through fee-for-service. The covered services information is provided as general information. These services could change. 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. Any changes to covered services will be communicated to D-SNP plans in provider updates.

- Case management services
- Chiropractic services
- Dental services
- Family planning services and supplies
- HealthCheck (Early and Periodic Screening, Diagnosis and Treatment) for people under 21
- Some home and community-based services
- Home health services or nursing services if a home health agency is unavailable
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
    - Under 21 years of age
    - Under 22 years of age and was getting services when you turned 21 years of age
    - 65 years of age or older
- Intermediate care facility services, other than services at an institution for mental disease
- Laboratory and X-ray services
- Medical supplies and equipment
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
- Nurse midwife services
- Nursing services, including services performed by a nurse practitioner
- Optometric/optical services, including eye glasses
- Outpatient hospital services
- Personal care services
- Physical and occupational therapy

- Physician services
- Podiatry services
- Prenatal care coordination for women with high-risk pregnancies
- Prescription drugs and over-the-counter drugs
- Respiratory care services for ventilator-dependent individuals
- Rural health clinic services
- Skilled nursing home services other than in an institution for mental disease
- Smoking cessation treatment
- Speech, hearing, and language disorder services
- Substance abuse (alcohol and other drug abuse) services
- Transportation to obtain medical care
- Tuberculosis (TB) services