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State/Territory Name: Wisconsin

State Plan Amendment (SPA) #: 13-016

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

July 31, 2017

Michael Heifetz, Medicaid Director
Division of Medicaid Services
Department of Health Services
1 West Wilson Street, Room 350
Madison, WI 53702

ATTN: Al Matano, SPA Coordinator

RE: Transmittal Number (TN) 13-016

Dear Mr. Heifetz:

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA).

Termination of Benchmark Plan

Effective Date: January 1, 2014

Approval date: July 31, 2017

If you have any questions, please have a member of your staff contact Mai Le-Yuen (312) 353-2853 or by email at mai.le-yuen@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 13-016

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01/01/2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1937 of the SSA

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 ..... —$6,500K
b. FFY 2015 ..... —$4,875K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
None. .....
None. .....

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-C pages 7 to 9.
Attachment 3.1-C appendix pages 1 to 3.

10. SUBJECT OF AMENDMENT:
Termination of benchmark plan

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Brett Davis

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
September 27, 2013

16. RETURN TO:
Brett Davis
State Medicaid Director
Division of Health Care Access and Accountability
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 27, 2013

18. DATE APPROVED:
July 31, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Ruth A. Hughes

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)