TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL 1. HANSMITTAL NUMBER: 2. SHAH POR: HEALTH CARE FINANCING ADMINISTRATION 3. PROGRAM DENTIFICATION: TITLE XIN OF THE SOCIAL SECURITY ACT (MEDICAID) TO. REGIONAL ADMINISTRATOR 4. PROPOSED DEFECTIVE DATE OLARS ETNANCING ADMINISTRATION 4. PROPOSED DEFECTIVE DATE OLARD TITLE XIN OF THE SOCIAL SECURITY ACT (MEDICAID) TO. REGIONAL ADMINISTRATOR 4. PROPOSED DEFECTIVE DATE OLARS ETNANCING ADMINISTRATION 4. PROPOSED DEFECTIVE DATE OLARD TITLE XIN OF THE SOCIAL SECURITY ACT (MEDICAID) INEW STATE PLAN CAMENDMENT TO BE CONSIDERED AS NEW PLAN SAMENDMENT COMPLETE BLOCKS & FIRMU IO PTHIS NA AMEEDMENT (Separae Transmittal for each anonhomai) 7. FEDERAL SECURITY ACT 8. FFY 2013 Social Security Act 7. FEDERAL SECURITION CTATION 7. FEDERAL SECURITY SOK Section 1915(a)(42) of the Social Security Act 7. FEDERAL SECURITY SOK S. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 7. FEDERAL SECURITY SOK Text page 792a 50K SOK SOK 10. SUBJECT OF AMENDMENT: COMMENT GOVERNOR'S OFFICE ENCLOSED OTHER, AS SPECIFIED: CONNENTS OFFICE ENCLOSED 10. RETURE RECEIVED WEITIN 35 DAYS OF SIBMUTTAL SIGNATURE OF STATE ADMINISTRATION OF SORTICE 11. GOVERNOR'S OFFICE ENCLOSED 10. RETURE REC	DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION		FORM APPROVED OMB NO. 0938-0193	
STATE PLAN MATERIAL 13-007 Wisconsin POR: HEALTH CARE FINANCING ADMINISTRATION 3. PROGRAM DENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAD) TO: REGIONAL ADMINISTRATOR 4. PROPOSED EFFECTIVE DATE HEALTH CARE FINANCING ADMINISTRATION 4. PROPOSED EFFECTIVE DATE DEPARTMENT OF HEALTH AND HUMAN SERVICES 04/01/2013 S. TYPE OF PLAN MATERIAL (Check One): COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT Gragarate Transmitted Or each amendment) 6. FEDERAL BLOGET IMPACT: \$OK 6. FEDERAL CODECT THE SUPERSEDUCATION CITATON: 7. FEDERAL BLOGET IMPACT: \$OK 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT: 10. SUBJECT OF AMENDMENT: Recovery Audit Contractors Same OTHER, AS SPECIFIED: II. GOVERNOR'S OFFICE ENCLOSED OTHER, AS SPECIFIED: OCMMENTS OF GOVERNOR'S OFFICE ENCLOSED OTHER, AS SPECIFIED: II. GOVERNOR'S OFFICE ENCLOSED II. RECUVED WITHIN 45 DAYS OF SUBMITTAL III. COMMENTS OF GOVERNOR'S OFFICE ENCLOSED DURING IS COMMENT II. SUBJECT OF AMENDMENT: FOR THE DAVIS State Medicaid Director DUVISION OF HEALTH CA		1. TRANSMITTAL NUMBER:		
FOR: HEALTH CARE FINANCING ADMINISTRATION 3. PROGRAM IDENTIFICATION: ITLE XIX OF THE SOCIAL SECURITY ACT (MEDICALD) TO: REGIONAL ADMINISTRATOR 4. PROPOSED EFFECTIVE DATE HEALTH CARE FINANCING ADMINISTRATION 4. PROPOSED EFFECTIVE DATE DEPARTMENT OF HEALTH AND HUMAN SERVICES 4. PROPOSED EFFECTIVE DATE Image: State PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmitted for each amendment) 7. FEDERAL BUDGET IMPACT: 6. FEDERAL STATUTURROULATION CITATION: 7. FEDERAL BUDGET IMPACT: \$0K 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE SUFERSEDED PLAN SECTION OR ATTACHMENT: 9. APAGE NUMBER OF THE SUFERSEDED PLAN SECTION OR ATTACHMENT: 10. SUBJECT OF AMENDMENT: Recovery Audit Contractors 9. APAGE NUMBER OF THE SUFERSEDED PLAN SECTION OR ATTACHMENT (# Applicable): 11. GOVERNOR'S REVIEW (Check One): 0 OTHER, AS SPECIFIED: \$0K 11. GOVERNOR'S OFFICE REPORTED NO COMMENT 0 OTHER, AS SPECIFIED: \$0K 12. SUGNATURE OF STATE AGENCY OTICIAL: 16. RETURN TO: 16. RETURN TO: 13. TYPED NAME: 16. RETURN TO: 16. RETURN TO: 14. THTLE: 17. WWISON SL. 16. RETURN TO: 15. OPEFLY RECEIVED 16. RETURN TO		13-007	Wisconsin	
HEALTH CARE FINANCING ADMINISTRATION 04/01/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES 3. 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 Transmittel for each amendment) 7. FEDERAL BLOGET IMPACT: Section 1915(a)(42) of the Social Security Act 9. FFY 2013 \$0K b. FAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: \$0K Io. SUBJECT OF AMENDMENT: PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): \$3me Io. SUBJECT OF AMENDMENT: Io. SUBJECT OF AMENDMENT: \$3me \$3me Io. SUBJECT OF AMENDMENT: III. GOVERNOR'S OFFICE REPORTED NO COMMENT □ OTHER, AS SPECIFIED: \$3me Io. SUBJECT OF AMENDMENT: III. GOVERNOR'S OFFICE REPORTED NO COMMENT □ OTHER, AS SPECIFIED: \$3me III. GOVERNOR'S OFFICE REPORTED NO COMMENT □ OTHER, AS SPECIFIED: 10. SUBMITTAL □ OTHER, AS SPECIFIED: \$3me III. GOVERNOR'S OFFICE REPORTED NO COMMENT □ OTHER, AS SPECIFIED: 10. STHE DE SPECIFIED: <td< td=""><td></td><td></td><td></td></td<>				
HEALTH CARE FINANCING ADMINISTRATION 04/01/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES 3. 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 Transmittel for each amendment) 7. FEDERAL BLOGET IMPACT: Section 1915(a)(42) of the Social Security Act 9. FFY 2013 \$0K b. FAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: \$0K Io. SUBJECT OF AMENDMENT: PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): \$3me Io. SUBJECT OF AMENDMENT: Io. SUBJECT OF AMENDMENT: \$3me \$3me Io. SUBJECT OF AMENDMENT: III. GOVERNOR'S OFFICE REPORTED NO COMMENT □ OTHER, AS SPECIFIED: \$3me Io. SUBJECT OF AMENDMENT: III. GOVERNOR'S OFFICE REPORTED NO COMMENT □ OTHER, AS SPECIFIED: \$3me III. GOVERNOR'S OFFICE REPORTED NO COMMENT □ OTHER, AS SPECIFIED: 10. SUBMITTAL □ OTHER, AS SPECIFIED: \$3me III. GOVERNOR'S OFFICE REPORTED NO COMMENT □ OTHER, AS SPECIFIED: 10. STHE DE SPECIFIED: <td< td=""><td>TO: REGIONAL ADMINISTRATOR</td><td>4. PROPOSED EFFECTIVE DATE</td><td></td></td<>	TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE		
5. TYPE OF PLAN MATERIAL (Check One): □ NEW STATE PLAN □ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT COMPLETE BLOCKS 6 THRU 10 F THIS IS AN AMENDMENT (Separate Transmitted for each amendment) 6. FEDERAL STATUTE/REGULATION CITATION: 7. FEDERAL BUGGET IMPACT: Section 1915(a)(42) of the Social Security Act a. FFY 2013 \$0K b. FFZ 2014 s. OK b. FFY 2014 \$0K rext page 792a OR ATTACHMENT (If Applicable): \$ame 10. SUBJECT OF AMENDMENT: Recovery Audit Contractors OTHER, AS SPECIFIED: \$ame 10. SUBJECT OF AMENDMENT: Image 792a Image 7000 COMMENT: \$ame 10. SUBJECT OF AMENDMENT: Image 7000 COMMENT Image 7000 COMMENT \$ame Image 7000 Common Store of Covernors of FICE ENCLOSED Image 7000 COMMENT Same Image 7000 Covernors of FICE ENCLOSED Image 7000 COMMENT Same Image 7000 Covernors of FICE ENCLOSED Image 7000 COVERNOR'S STEVE (Check One): Image 7000 COVERNOR'S STEVE (Check One): Image 7000 COVERNOR'S STEVE (Check One): Image 7000 Covernors of FICE REPORTED NO COMMENT Image 7000 COVERNOR'S OFFICE ENCLOSED Image 7000 COVERNOR'S OFFICE ENCLOSED Image 7000 COVERNOR'S OFFICE ENCLOSED Image 70000 COVERNOR'S OFFICE ENCLOSED				
□ 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. EEDERAL STATUTERRGULATION CITATION: 7. FEDERAL SUBMENT Soft Section 1915(a)(42) of the Social Security Act a. FFY 2013 \$0K 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. RAE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT: 9. RAE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT: Text page 79za Same OR ATTACHMENT (If Applicable): 10. SUBJECT OF AMENDMENT: Same II. GOVERNOR'S REVIEW (Check One): OTHER, AS SPECIFIED: ☐ GOVERNOR'S REVIEW (Check One): ☐ OTHER, AS SPECIFIED: ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED: ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED: ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED: ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED: ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED: ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED: ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED: ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED:	DEPARTMENT OF HEALTH AND HUMAN SERVICES			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) 6. FEDERAL STATUTEREGULATION CITATION: Section 1915(a)(42) of the Social Security Act Section 1915(a)(42) of the Social Security Act 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 7. PEDERAL BUDGET IMPACT: Text page 79za. Same 10. SUBJECT OF AMENDMENT: Recovery Audit Contractors II. GOVERNOR'S OFFICE REPORTED NO COMMENT C GOVERNOR'S OFFICE REPORTED NO COMMENT C OTHER, AS SPECIFIED: C GOVERNOR'S OFFICE REPORTED NO COMMENT C OTHER, AS SPECIFIED: C GOVERNOR'S OFFICE REPORTED NO COMMENT C OTHER, AS SPECIFIED: C GOVERNOR'S OFFICE REPORTED NO COMMENT C OTHER, AS SPECIFIED: C GOVERNOR'S OFFICE REPORTED NO COMMENT D OTHER, AS SPECIFIED: C GOVERNOR'S OFFICE NECLOSED D OTHER, AS SPECIFIED: C MALLIEL C Art Set Medicaid Director D ALLIEL For the Julie M THER: For the Julie I C SUBMITTED: For the Julie J TYPED NAME: For the Julie Brett Davis State Medicaid Dire	5. TYPE OF PLAN MATERIAL (Check One):			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) 6. FEDERAL STATUTE/REGULATION CITATION: Section 1915(a)(42) of the Social Security Act Section 1915(a)(42) of the Social Security Act 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 7. FEDERAL BUDGET IMPACT: Text page 79za. Text page 79za. II. GOVERNOR'S REVIEW (Check One): COMMENTS OF GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE REPORTED NO SUBMITTAL II. GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED No. OTHER, AS SPECIFIED: 12. SIGNATURE OF STATE AGENCY OFFICIAL: Moltantian Moltantian Brett Davis 13. TYPED NAME: Brett Davis State Medicaid Director Division of Health Care Access and Accountability 14. TITLE: State Medicaid Director Date SUBMITTED:				
6. FEDERAL STATUTE/REGULATION CITATION: 7. FEDERAL DUGET IMPACT: Section 1915(a)(42) of the Social Security Act 7. FEDERAL DUGET IMPACT: a. FFY 2013 a. FFY 2013 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT: Text page 79za. 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT: 10. SUBJECT OF AMENDMENT: 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (Jf Applicable): Same 9. AGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (Jf Applicable): 10. SUBJECT OF AMENDMENT: Same II. GOVERNOR'S REVIEW (Check One): OTHER, AS SPECIFIED: OWNERT'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Brett Davis 12. SIGNATURE OF STATE AGENCY OFFICIAL: Brett Davis 13. TYPED NAME: Data Submittal 14. TITLE: Date SUBMITTED: 15. DATE SUBMITTED: Date SUBMITTED: June 27, 2013 FOR REGIONAL OFFICE USE ONLY 17. DATE RECEIVED: IR. NATE APPROVED: June 27, 2013 FOR REGIONAL OFFICE USE ONLY 19. DEFECTIVE DATE OF APPROVED MATERIAL: 20. SIGNATURE OF REPLONAL OFFICIAL: Appli 1.				
Section 1915(a)(42) of the Social Security Act a. FFY 2013 \$0K 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Sok Text page 79za			ich amendment)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: b. FFY 2014 \$0K 7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: OR ATTACHMENT (If Applicable): 7. Text page 79za. Same 10. SUBJECT OF AMENDMENT: Same Recovery Audit Contractors Same 11. GOVERNOR'S REVIEW (Check One): OTHER, AS SPECIFIED: COMMENTS OF GOVERNOR'S OFFICE ENCLOSED OTHER, AS SPECIFIED: MOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: MOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: MOVERNOR'S OFFICE PROPORTED NO COMMENT OTHER, AS SPECIFIED: MOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: MOVERNOR'S OFFICE REPORTED NO COMMENT DIVISION OF REPORTED NO COMMENT MOVERNOR'S OFFICE REPORTED NO COMMENT BOTHER, AS SPECIFIED: 12. SIGNATURE OF STATE AGENCY OFFICIAL: BIG RETURN TO: Brett Davis BIG REGIONAL OFFICE USE ONLY 13. TYPED NAME: BOTHER REGIONAL OFFICE USE ONLY 14. TITLE: FO			۹0×	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT: Text page 79za. OR ATTACHMENT (If Applicable): Same Same 10. SUBJECT OF AMENDMENT: Same Recovery Audit Contractors II. GOVERNOR'S REVIEW (Check One): II. GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: COMMENTS OF GOVERNOR'S OFFICE ENCLOSED OTHER, AS SPECIFIED: IN OR REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL If RETURN TO: Brett Davis State Medicaid Director I3. TYPED NAME: Division of Head ID core Access and Accountability I4. TITLE: P.O. Box 309 I5. DATE SUBMITTED: Madison, WI 53701-0309 June 27, 2013 FOR REGIONAL OFFICE USE ONLY I7. DATE RECEIVED II. B. DATE APPROVED June 27, 2013 PLAN APPROVED - ONE COPY AT IACHED I9. EFFECTIVE DATE OF APPROVED MATERIAL: 20. SIGNATURE DE REGIONAL OFFICIAL: April 1. 2013. PLAN APPROVED - ONE COPY AT IACHED I9. EFFECTIVE DATE OF APPROVED MATERIAL: 20. SIGNATURE DE REGIONAL OFFICIAL: April 1. 2013. 22. TITLE Verton Johnson Associate Regional Administrator	Section 1915(a)(42) of the Social Security Act		-	
Text page 79za. OR ATTACHMENT (If Applicable): Text page 79za. Same 10. SUBJECT OF AMENDMENT: Same Recovery Audit Contractors II. GOVERNOR'S REVIEW (Check One): Image: Commentation of GovErnoR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: COMMENTS OF GOVERNOR'S OFFICE ENCLOSED OTHER, AS SPECIFIED: Image: Commentation of GovErnoR'S OFFICE ENCLOSED OTHER, AS SPECIFIED: Image: Commentation of GovErnoR'S OFFICE ENCLOSED If other, as specified: Image: Commentation of GovErnoR'S OFFICE ENCLOSED If other, as specified: Image: Commentation of GovErnoR'S OFFICE ENCLOSED If other, as specified: Image: Commentation of GovErnoR'S ofFICE ENCLOSED If other, as specified: Image: Commentation of GovErnoR'S ofFICE ENCLOSED If other, as specified: Image: Commentation of GovErnoR'S ofFICE ENCLOSED If other, as specified: Image: Commentation of GovErnoR'S ofFICE ENCLOSED If other of there of there of the formore office: Is the decicaid Director Division of Health Care Access and Accountability Is. Date: Submitted: PO. Box 309 Madison, WI 53701-0309 Madison, WI 53701-0309 June 27, 2013 Its Approved - one Copy attrached Is. Date Rece	& PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9 PAGE NUMBER OF THE SUPE	RSEDED PLAN SECTION	
Text page 79za. Same 10. SUBJECT OF AMENDMENT: Recovery Audit Contractors 11. GOVERNOR'S REVIEW (Check One): GOWENTOR'S REVIEW (Check One): GOMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Multic Laugue 12. SIGNATURE OF STATE AGENCY OFFICIAL: Michaeling 13. TYPED NAME: Brett Davis 13. TYPED NAME: Brett Davis 14. TITLE: State Medicaid Director 15. DATE SUBMITTED: June 27, 2013 FOR REGIONAL OFFICE USE ONLY 17. DATE RECEIVED: June 27, 2013 FOR REGIONAL OFFICE USE ONLY 17. DATE RECEIVED: June 27, 2013 FLAN APPROVED September 13, 2013 PLAN APPROVED September 13, 2013 PLAN APPROVED	8, TAGE NUMBER OF THE FLAN SECTION OR ATTACHMENT.			
10. SUBJECT OF AMENDMENT: Recovery Audit Contractors 11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Mutual: HALL: H. MALL: H. M. MIL:	Text name 79za			
Recovery Audit Contractors 11. GOVERNOR'S REVIEW (Check One): OTHER, AS SPECIFIED: GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: COMMENTS OF GOVERNOR'S OFFICE ENCLOSED OTHER, AS SPECIFIED: NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL If RETURN TO: I.2. SIGNATURE OF STATE AGENCY OFFICIAL: If RETURN TO: Brett Davis State Medicaid Director I3. TYPED NAME: Division of Health Care Access and Accountability I4. TITLE: State Medicaid Director State Medicaid Director P.O. Box 309 I5. DATE SUBMITTED: Madison, WI 53701-0309 June 27, 2013 FOR REGIONAL OFFICE USE ONLY I7. DATE RECEIVED: I8. DATE APPROVED June 27, 2013 PLAN APPROVED ONE COPY ATTACHED I9. EFFECTIVE DATE OF APPROVED MATERIAL: 20. SIGNATURE/OF REGIONAL OFFICIAL: April 1, 2013 22. TITLE: 21. TYPED NAME: 22. TITLE: Verion Johnson 22. TITLE:	Text page 702a.			
Recovery Audit Contractors 11. GOVERNOR'S REVIEW (Check One): OTHER, AS SPECIFIED: GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: COMMENTS OF GOVERNOR'S OFFICE ENCLOSED OTHER, AS SPECIFIED: NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL If an arrow of the arrow of				
Recovery Audit Contractors 11. GOVERNOR'S REVIEW (Check One): OTHER, AS SPECIFIED: GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: COMMENTS OF GOVERNOR'S OFFICE ENCLOSED OTHER, AS SPECIFIED: NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL If an arrow of the arrow of				
Recovery Audit Contractors 11. GOVERNOR'S REVIEW (Check One): OTHER, AS SPECIFIED: GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: COMMENTS OF GOVERNOR'S OFFICE ENCLOSED OTHER, AS SPECIFIED: NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL If an arrow of the arrow of				
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Mutually Cauges I.6. RETURN TO: Brett Davis I.7. TYPED NAME: Brett Davis I.4. TITLE: State Medicaid Director DATE SUBMITTED: June 27, 2013 FOR REGIONAL OFFICE USE ONLY I.8. DATE RECEIVED June 27, 2013 I.8. DATE RECEIVED June 27, 2013 FOR REGIONAL OFFICE USE ONLY I.8. DATE APPROVED ONE COPY ATTACHED I.9. EFFECTIVE DATE OF APPROVED MATERIAL: 20. SIGNATURE OF REGIONAL OFFICIAL: April 1, 2013 I.7. TYPED NAME: Verion Johnson 	10. SUBJECT OF AMENDMENT:			
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Mutually Cauges I.6. RETURN TO: Brett Davis I.7. TYPED NAME: Brett Davis I.4. TITLE: State Medicaid Director DATE SUBMITTED: June 27, 2013 FOR REGIONAL OFFICE USE ONLY I.8. DATE RECEIVED June 27, 2013 I.8. DATE RECEIVED June 27, 2013 FOR REGIONAL OFFICE USE ONLY I.8. DATE APPROVED ONE COPY ATTACHED I.9. EFFECTIVE DATE OF APPROVED MATERIAL: 20. SIGNATURE OF REGIONAL OFFICIAL: April 1, 2013 I.7. TYPED NAME: Verion Johnson 				
GOVERNOR'S OFFICE REPORTED NO COMMENT GOMMENTS OF GOVERNOR'S OFFICE ENCLOSED ON REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Huttuille augus 12. SIGNATURE OF STATE AGENCY OFFICIAL: Huttuille for for 13. TYPED NAME: Brett Davis 13. TYPED NAME: June 27, 2013 FOR REGIONAL OFFICE USE ONLY 17. DATE RECEIVED: June 27, 2013 FOR REGIONAL OFFICE USE ONLY 17. DATE RECEIVED: June 27, 2013 FOR REGIONAL OFFICE USE ONLY 19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2013 31. TYPED NAME: Verion Johnson Additional provide the provide material: Account the provide material: Ac	Recovery Audit Contractors			
M M M Brett Davis 13. TYPED NAME: Brett Davis State Medicaid Director 14. TITLE: Division of Health Care Access and Accountability 14. TITLE: P.O. Box 309 State Medicaid Director N. Wilson St. 15. DATE SUBMITTED: June 27, 2013 FOR REGIONAL OFFICE USE ONLY 17. DATE RECEIVED: I8. DATE APPROVED: June 27, 2013 September 13, 2013 PLAN APPROVED – ONE COPY ATTACHED Signature of the proved material: April 1, 2013 21. TYPED NAME: Verion Johnson 22. TITLE:	GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		ECIFIED:	
13. TYPED NAME: State Medicaid Director Brett Davis Division of Health Care Access and Accountability 14. TITLE: Division of Health Care Access and Accountability 15. DATE SUBMITTED: Nadison, WI 53701-0309 17. DATE RECEIVED: June 27, 2013 FOR REGIONAL OFFICE USE ONLY 17. DATE RECEIVED: June 27, 2013 PLAN APPROVED – ONE COPY ATTACHED 19. EFFECTIVE DATE OF APPROVED MATERIAL: 20. SIGNATURE OF REGIONAL OFFICIAL: April 1, 2013 22. TITLE: Verion Johnson 22. TITLE:	12. SIGNATURE OF, STATE AGENCY OFFICIAL:	16. RETURN TO:		
13. TYPED NAME: State Medicaid Director Brett Davis Division of Health Care Access and Accountability 14. TITLE: 1 W. Wilson St. State Medicaid Director P.O. Box 309 15. DATE SUBMITTED: Madison, WI 53701-0309 June 27, 2013 FOR REGIONAL OFFICE USE ONLY 17. DATE RECEIVED: I8. DATE APPROVED: June 27, 2013 September 13, 2013 PLAN APPROVED - ONE COPY ATTACHED Signature of Regional Official: April 1, 2013. 20. SIGNATURE OF REGIONAL OFFICIAL: April 1, 2013. 22. TITLE: Verion Johnson Associate Regional Administrator	11 10 lin Kill in the bor 60			
14. TITLE: 1 W. Wilson St. State Medicaid Director P.O. Box 309 15. DATE SUBMITTED: Madison, WI 53701-0309 June 27, 2013 FOR REGIONAL OFFICE USE ONLY 17. DATE RECEIVED: 18. DATE APPROVED: June 27, 2013 September 13, 2013 PLAN APPROVED – ONE COPY ATTACHED September 13, 2013 19. EFFECTIVE DATE OF APPROVED MATERIAL: 20. SIGNATURE OF REGIONAL OFFICIAL: April 1, 2013 22. TITLE: Verlon Johnson 22. TITLE:				
State Medicaid Director P.O. Box 309 15. DATE SUBMITTED: Madison, WI 53701-0309 June 27, 2013 FOR REGIONAL OFFICE USE ONLY 17. DATE RECEIVED: 18. DATE APPROVED: June 27, 2013 September 13, 2013 PLAN APPROVED – ONE COPY ATTACHED September 13, 2013 19. EFFECTIVE DATE OF APPROVED MATERIAL: 20. SIGNATURE OF REGIONAL OFFICIAL: April 1, 2013 21. TYPED NAME: 21. TYPED NAME: 22. TITLE: Verion Johnson 22. TITLE:	Brett Davis	Division of Health Care Acces	s and Accountability	
15. DATE SUBMITTED: June 27, 2013 Madison, WI 53701-0309 FOR REGIONAL OFFICE USE ONLY 17. DATE RECEIVED: June 27, 2013 18. DATE APPROVED: September 13, 2013 PLAN APPROVED – ONE COPY ATTACHED 19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2013 20. SIGNATURE OF REGIONAL OFFICIAL: April 1, 2013 21. TYPED NAME: Verion Johnson 22. TITLE: Associate Regional Administrator	14. TITLE:			
June 27, 2013 FOR REGIONAL OFFICE USE ONLY 17. DATE RECEIVED: 18. DATE APPROVED: June 27, 2013 September 13, 2013 PLAN APPROVED - ONE COPY ATTACHED 19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2013 20. SIGNATURE OF REGIONAL OFFICIAL: April 1, 2013 22. TITLE: Verion Johnson Associate Regional Administrator	State Medicaid Director			
FOR REGIONAL OFFICE USE ONLY 17. DATE RECEIVED: 18. DATE APPROVED: June 27, 2013 September 13, 2013 PLAN APPROVED – ONE COPY ATTACHED PLAN APPROVED MATERIAL: 19. EFFECTIVE DATE OF APPROVED MATERIAL: 20. SIGNATURE OF REGIONAL OFFICIAL: April 1, 2013 22. TITLE: Verion Johnson Associate Regional Administrator		Madison, WI 53701-0309		
17. DATE RECEIVED: 18. DATE APPROVED: June 27, 2013 September 13, 2013 PLAN APPROVED – ONE COPY ATTACHED 19. EFFECTIVE DATE OF APPROVED MATERIAL: 20. SIGNATURE OF REGIONAL OFFICIAL: April 1, 2013 21. TYPED NAME: Verion Johnson 22. TITLE:				
June 27, 2013 September 13, 2013 PLAN APPROVED - ONE COPY ATTACHED 19. EFFECTIVE DATE OF APPROVED MATERIAL; April 1, 2013 21. TYPED NAME: Verion Johnson 22. TITLE: Associate Regional Administrator				
PLAN APPROVED – ONE COPY ATTACHED 19. EFFECTIVE DATE OF APPROVED MATERIAL: 20. SIGNATURE OF REGIONAL OFFICIAL: April 1, 2013 22. TITLE: Verion Johnson Associate Regional Administrator				
19. EFFECTIVE DATE OF APPROVED MATERIAL: 20. SIGNATURE OF REGIONAL OFFICIAL: April 1, 2013 21. TYPED NAME: Verion Johnson Associate Regional Administrator	June 27, 2013	and the state of the	n sin sense des net des sinnen als resultes cause o part. E 1 de mai de jui de la company de sense de la company de	
April 1, 2013 21. TYPED NAME: Verlon Johnson 22. TITLE: Associate Regional Administrator			DEFICIAL	
21. TYPED NAME: Verlon Johnson Associate Regional Administrator				
	21. TYPED NAME:			
23. REMARKS:	Verlon Johnson	Associate Regional Administrat	or	
	23. REMARKS:		n men en e	

. .

3 .

i i