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State/Territory Name: WI

State Plan Amendment (SPA) #: 17-0006

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

September 10, 2018

Heather K. Smith, Medicaid Director
Division of Medicaid Services
Department of Health Services
1 West Wilson Street, Room 350
Madison, WI 53702

ATTN: Krista Willing, Assistant Administrator

RE: Transmittal Number (TN) 17-0006

Dear Ms. Smith:

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

Outpatient Hospital Rates & Methodologies – Pay-for-Performance Program

Effective Date: April 1, 2017

Approval date: September 10, 2018

If you have any questions, please have a member of your staff contact Mai Le-Yuen at (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: 17-0006

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
04/01/2017

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:
42 CFR 447 Subpart F, §§447.300, 447.302, 447.304, 447.321, and 447.325.

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 ..... $0K
b. FFY 2018 ..... $0K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Removed pages 8 and 9.
~~Attachment 4.19-B, Pages 8 and 9.~~ .....

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Pages 8, and 9 .....

10. SUBJECT OF AMENDMENT:

Outpatient hospital rates and methodologies. Update assessment pay for performance program.

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:
[redacted]

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Michael G. Heifetz

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
June 27, 2017

16. RETURN TO:
Michael G. Heifetz
State Medicaid Director
Department of Health Services
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
June 27, 2017

18. DATE APPROVED:
September 10, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 2017

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Ruth A. Hughes

22. TITLE:
Associate Regional Administrator

23. REMARKS: