

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:
09-015

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
07/01/09

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 1902(a)(13)A of SSA and 42 Subpart C and
42 CFR 447.250(a) & (b) & 447.253(b) to (g)

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 \$29.5K
b. FFY 2010 \$0K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19-D, pages i to iv
Attachment 4.19- D, pages 1 to
70.....

Same.....
Attachment 4.19- D, pages 1 to 68

10. SUBJECT OF AMENDMENT:

Payment of Nursing Facilities and ICF-MRs.

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:

Lawrence A. Palchut

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Jason Helgeson

14. TITLE:
Administrator, Division of Health Care Access and
Accountability

15. DATE SUBMITTED:
September 30, 2009

16. RETURN TO:
Jason Helgeson
Administrator
Division of Health Care Access and Accountability
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

17. DATE RECEIVED:

FOR REGIONAL OFFICE USE ONLY

18. DATE APPROVED:
5-18-10

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 1 2009

PLAN APPROVED - ONE COPY ATTACHED

20. SIGNATURE OF REGIONAL OFFICIAL:
Bill Brown

21. TYPED NAME:
William Lasowski

22. TITLE:
Deputy Director, CMCS

23. REMARKS: