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: 09-016

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
08/01/09

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 ($845.4)K
b. FFY 2010 ($5298.1)K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, pages i to iv .....
Attachment 4.19- D, pages 1 to 70
.....

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Jason Helgerson

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

15. DATE SUBMITTED:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 5-18-10

PLAN APPROVED – ONE COPY ATTACHED

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

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMSS

23. REMARKS: