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: 09-001

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
03/01/2009

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

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 ..... $0K
b. FFY 2010 ..... $54K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, pages 33 and 62. .....

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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

Kuda Willing

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Jason Helgerson

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
March 31, 2009

16. RETURN TO:
Jason Helgerson
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:

18. DATE APPROVED:
9-24-09

PLAN APPROVED – ONE COPY ATTACHED

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

20. SIGNATURE OF REGIONAL OFFICIAL:
Bill Karl for CM.

21. TYPED NAME:
William Laskowski

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)