

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

1. TRANSMITTAL NUMBER:
09-007

2. STATE
Wisconsin

FOR: HEALTH CARE FINANCING ADMINISTRATION

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
04/01/2009

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:
1916A of the SSA

7. FEDERAL BUDGET IMPACT:

a. FFY 2009 \$270K

b. FFY 2010 \$540K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.18-F, page 5.

Attachment 4.18-F, page 1 (CA)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Same

10. SUBJECT OF AMENDMENT:

Cost sharing for Medicaid recipients

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 Helgeson

14. TITLE:

State Medicaid Director

15. DATE SUBMITTED:

June 29, 2009

16. RETURN TO:

Jason Helgeson

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:

June 29, 2009

18. DATE APPROVED:

DEC 15 2009

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

04-01-2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Verlon Johnson

22. TITLE:

Associate Regional Administrator

23. REMARKS: