

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 09-011	2. STATE Wisconsin
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE 07/01/2009	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

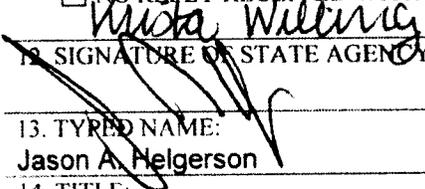
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.250	7. FEDERAL BUDGET IMPACT: a. FFY 2009 \$0K b. FFY 2010 \$0K
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Pages 1 to 14.	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, Pages i, ii, 1 to 4, 4.1 to 4.5, 5 to 11, 11.1, 12, 12.1 to 12.3, and 13 to 16.

10. SUBJECT OF AMENDMENT:
Outpatient hospital rates and methodologies - SFY 2010 update

11. GOVERNOR'S REVIEW (Check One):

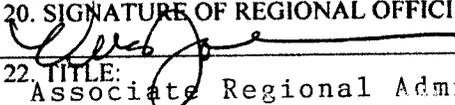
GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Jason A. Helgerson State Medicaid Director 1 W. Wilson St. P.O. Box 309 Madison, WI 53701-0309
13. TYPED NAME: Jason A. Helgerson	
14. TITLE: State Medicaid Director	
15. DATE SUBMITTED: June 29, 2009	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 29 2009	18. DATE APPROVED: MAR 17 2010
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2009	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Verlon Johnson	22. TITLE: Associate Regional Administrator

23. REMARKS: