

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

1. TRANSMITTAL NUMBER:
13-004

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
02/01/2013

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:
47 CFR 447.250

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 \$0K
b. FFY 2014 \$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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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-B, Pages 1 to 12.

Attachment 4.19-B, pages 1 to 11.

10. SUBJECT OF AMENDMENT:

Outpatient hospital rates and methodologies.

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

Michelle Gauger

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Brett Davis

14. TITLE:

State Medicaid Director

15. DATE SUBMITTED:

March 26, 2013

16. RETURN TO:

Brett Davis
State Medicaid Director
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

March 26, 2013

18. DATE APPROVED:

September 17, 2013

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

February 1, 2013

20. SIGNATURE OF REGIONAL OFFICIAL:

Verlon Johnson

21. TYPED NAME:

Verlon Johnson

22. TITLE:

Associate Regional Administrator

23. REMARKS: