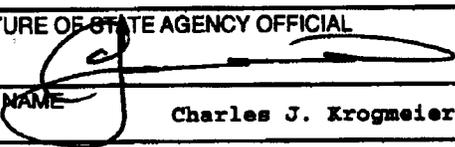


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <u>0 9 - 0 2 0</u>	2. STATE IOWA
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <p style="text-align: center;">December 1, 2009</p>	
5. TYPE OF PLAN MATERIAL (Check One)			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION		7. FEDERAL BUDGET IMPACT	
		a. FFY '10 <u>\$ (20,685,858)</u>	
		b. FFY '11 <u>\$ 0</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)	
Attachment 4.19-A, Page 12, 24, 25, 26b Attachment 4.19-C, Page 1, 2 Attachment 4.19-D, Page 2, 2a, 5a, 5b, 13 Supplement 4 to Attachment 4.19-D, Page 4, 5		Attachment 4.19-A, Page 12, 24, 25, 26b Attachment 4.19-C, Page 1, 2 Attachment 4.19-D, Page 2, 2a, 5a, 5b, 13 Supplement 4 to Attachment 4.19-D, Page 4, 5	
10. SUBJECT OF AMENDMENT			
Reductions in payment rates and changes in payment standards for inpatient hospital and NPs related to across the board budget cuts made by the Governor.			
11. GOVERNOR'S REVIEW (Check One)			
<input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL		16. RETURN TO	
		Charles J. Krogmeier Director Department of Human Services 1305 East Walnut, 5th Floor Des Moines, IA 50319-0114	
13. TYPED NAME			
Charles J. Krogmeier			
14. TITLE			
Director			
15. DATE SUBMITTED			
12/24/09			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED		18. DATE APPROVED	
December 24, 2009		AUG 19 2010	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL		20. SIGNATURE OF REGIONAL OFFICIAL	
DEC - 1 2009			
21. TYPED NAME		22. TITLE	
CINDY MANN		DIRECTOR, CMCS	
23. REMARKS			