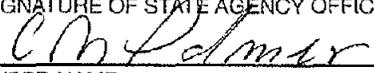
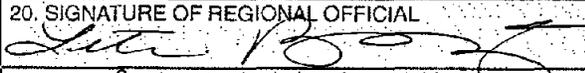


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|---|--|--|-------------------------|
| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES | | 1. TRANSMITTAL NUMBER <u>0 9 — 0 2 4</u> | 2. STATE <u>IOWA</u> |
| | | 3. PROGRAM IDENTIFICATION: TITLE 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 12/1/09 <u>12/3/09</u> | |
| 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>(\$423,333)</u> | |
| | | b. FFY '11 \$ <u>0</u> | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT <u>Attachment 4.19-B, Page 14, 14a, 14b, 17 Supplement 2 to Attachment 3.1-A, Pages 37-45</u> | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <u>Attachment 4.19-B, Page 14, 17 Supplement 2 to Attachment 3.1-A, Pages 37-45</u> | |
| 10. SUBJECT OF AMENDMENT <u>Reduction in payments to providers, per across-the-board budget cuts made by the Governor.</u> | | | |
| 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 M. PALMER DIRECTOR DEPARTMENT OF HUMAN SERVICES 1305 EAST WALNUT 5TH FLOOR DES MOINES IA 50319-0114 | |
| 13. TYPED NAME <u>CHARLES M. PALMER</u> | | | |
| 14. TITLE <u>DIRECTOR</u> | | | |
| 15. DATE SUBMITTED <u>Orig. submitted on 12/31/09</u> | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED <u>December 31, 2009</u> | | 18. DATE APPROVED <u>June 24, 2011</u> | |
| PLAN APPROVED - ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL <u>December 3, 2009</u> | | 20. SIGNATURE OF REGIONAL OFFICIAL  | |
| 21. TYPED NAME <u>Leticia Barraza</u> | | 22. TITLE <u>Acting Associate Regional Administrator for Medicaid and Children's Health Operations</u> | |
| 23. REMARKS <u>pen and ink changes per e-mail from State on 6.3.11</u> | | | |