DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 10 — 006

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: July 1, 2010

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

7. FEDERAL BUDGET IMPACT
a. FFY '10 $ $167,624 (3mth)
b. FFY '11 $ 611,514

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, Page 11

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B, Page 11

10. SUBJECT OF AMENDMENT
This request continues the reduction in the dispensing fee.

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: Charles J. Krogmeier

14. TITLE: Director

15. DATE SUBMITTED: 7-1-10

16. RETURN TO
Charles J. Krogmeier
Director
Department of Human Services
1305 East Walnut, 5th Floor
Des Moines, IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 1, 2010

18. DATE APPROVED: August 25, 2010

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2010

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME: James G. Scott

22. TITLE: Associate Regional Administrator for Medicaid and Children's Health Operations

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back