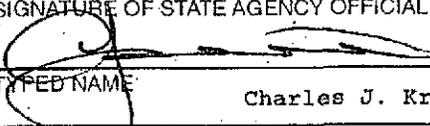
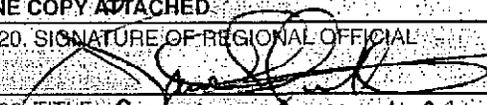


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER <u>1 0 — 0 0 6</u>	2. STATE <u>IOWA</u>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <p style="text-align: center;">July 1, 2010</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>\$167,624 (3mth)</u>	
		b. FFY '11      \$ <u>611,514</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT <p style="text-align: center;">Attachment 4.19-B, Page 11</p>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <p style="text-align: center;">Attachment 4.19-B, Page 11</p>	
10. SUBJECT OF AMENDMENT <p style="text-align: center;">This request continues the reduction in the dispensing fee.</p>			

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 <p style="text-align: center;">Charles J. Krogmeier</p>	
14. TITLE <p style="text-align: center;">Director</p>	
15. DATE SUBMITTED <p style="text-align: center;">7-1-10</p>	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED <p style="text-align: center;">July 1, 2010</p>	18. DATE APPROVED <p style="text-align: center;">August 25, 2010</p>
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL <p style="text-align: center;">July 1, 2010</p>	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME <p style="text-align: center;">James G. Scott</p>	22. TITLE <p style="text-align: center;">Associate Regional Administrator for Medicaid and Children's Health Operations</p>
23. REMARKS	