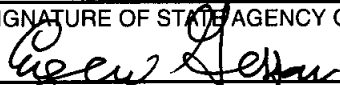
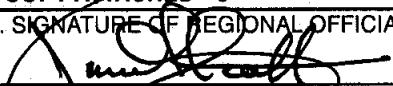


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <u>0 8 — 0 3 1</u>	2. STATE IOWA
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE JANUARY 1, 2009	
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 '09 \$ 0 b. FFY '10 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Supplement 2 to Attachment 4.19-B, Page 26 / 26a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Supplement 2 to Attachment 4.19-B, Page 26	
10. SUBJECT OF AMENDMENT To modify the IowaCare PIP payments to comply with the terms and conditions of the 1115 Medicaid Demonstration project entitled IowaCare (project No. 11-W-00189/7). The fiscal impact is zero because there are no outpatient claims for the MHIs for IowaCare. +			
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 Eugene I. Gessow Director Department of Human Services Hoover State Office Building 1305 East Walnut 5th Floor Des Moines, IA 50319-0114	
13. TYPED NAME Eugene I. Gessow			
14. TITLE Director			
15. DATE SUBMITTED 12-23-08			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED December 23, 2008		18. DATE APPROVED February 17, 2009	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL January 1, 2009		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			