

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER
0 9 - 0 0 9

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 4/1/2010
1st day of calendar qtr following approval

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 \$ 33,586,420
b. FFY '11 \$ 40,798,977

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-D, Page 20, 21

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

Attachment 4.19-D, Page 20, 21

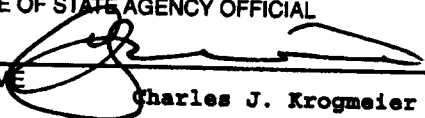
10. SUBJECT OF AMENDMENT

This request modifies the nursing facility rate setting for implementation of a nursing facility provider tax (quality assurance assessment fee).

11. GOVERNOR'S REVIEW (Check One)

- GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL



13. TYPED NAME
Charles J. Krogmeier

14. TITLE
Director

15. DATE SUBMITTED
7/8/9

16. RETURN TO

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

17. DATE RECEIVED

July 15, 2009

FOR REGIONAL OFFICE USE ONLY

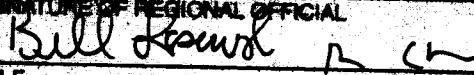
18. DATE APPROVED

3-24-10

19. EFFECTIVE DATE OF APPROVED MATERIAL

APR - 1 2010

20. SIGNATURE OF REGIONAL OFFICIAL



21. TYPED NAME

William Lasowski

22. TITLE

Deputy Director, CMSO

23. REMARKS

Pen & ink change made to block #4