

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	1. TRANSMITTAL NUMBER <u>0 9 - 0 1 7</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 October 1, 2010 <del>2009</del>	

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)

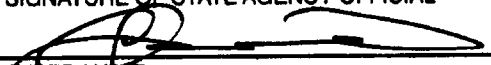
6. FEDERAL STATUTE/REGULATION CITATION	7. FEDERAL BUDGET IMPACT a. FFY '10 _____ \$ 0 b. FFY '11 _____ \$ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-A, Page 26g	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) None

10. SUBJECT OF AMENDMENT

This State Plan Amendment clarifies Medicaid reimbursement for inpatient hospital care provided to Indian Health Service and Tribal 638 providers.

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 	16. RETURN TO Charles J. Krogmeier Director Department of Human Services 1305 East Walnut, 5th Floor Des Moines, IA 50319-0114
13. TYPED NAME Charles J. Krogmeier	
14. TITLE Director	
15. DATE SUBMITTED	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED November 22, 2009	18. DATE APPROVED 02-18-10
--	-------------------------------

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL 02-1-2009	20. SIGNATURE OF REGIONAL OFFICIAL Bill Brown R CM
21. TYPED NAME William Lasowski	22. TITLE Deputy Director, CMSO

23. REMARKS  
Per & ink change made to block # 4.