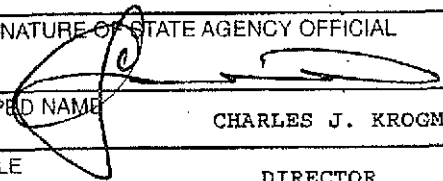



<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER <u>1 0 — 0 1 3</u>	2. STATE IOWA
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2010	
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 \$ 1,795,614 (3m) b. FFY '11 \$ 6,445,896	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Supplement 2 to Attachment 4.19-B, Page 24		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Supplement 2 to Attachment 4.19-B, Page 24	
10. SUBJECT OF AMENDMENT This implements a change in the reimbursement methodology to provide an additional \$9,900,000 in medical assistance payment to the UIHC for inpatient/outpatient hospital services. No impact to the State.			
11. GOVERNOR'S REVIEW (Check One) <i>DOT</i> <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 CHARLES J. KROGMEIER			
14. TITLE DIRECTOR			
15. DATE SUBMITTED			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED <i>September 3, 2010</i>		18. DATE APPROVED <i>May 17, 2011</i>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL <i>July 1, 2010</i>		20. SIGNATURE OF REGIONAL OFFICIAL 	
21. TYPED NAME <i>James G. Scott</i>		22. TITLE <i>Associate Regional Administrator for Medicaid and Children's Health Operations</i>	
23. REMARKS			