FORM CMS-179 (07/92)

	1. TRANSMITTAL NUMBER 2. STATE	
TRANSMITTAL AND NOTICE OF APPROVAL OF	1 0 - 0 1 3 IOWA	
STATE PLAN MATERIAL		
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	
CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	July 1, 2010	W-1744
5. TYPE OF PLAN MATERIAL (Check One)		
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDE	· · · · · · · · · · · · · · · · · · ·	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMEND	MENT (Separate transmittal for each amendment)	
6. FEDERAL STATUTE/REGULATION CITATION	7. FEDERAL BUDGET IMPACT a. FFY '10 \$ 1,795,614 (3m)	
	b. FFY <u>*11</u> \$ <u>6,445,896</u>	<del></del>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	9, PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)	
Supplement 2 to Attachment 4.19-B, Page 24	Supplement 2 to Attachment 4.19-B, Page 24	
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10. SUBJECT OF AMENDMENT		
This implements a change in the reimbursement m \$9,900,000 in medical assistance payment to the services. No impact to the State.	UIHC for inpatient/outpatient hospital	8
11. GOVERNOR'S REVIEW (Check One) NOIL	, v	
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