DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 11-010

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, 2011

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

42 CFR 440.130(d)

7. FEDERAL BUDGET IMPACT

a. FFY '11 $ ~~1,206,023~~ 0

b. FFY '12 $ ~~4,847,039~~ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-B, Page 1c, 1d, 5, 5a, 12, 13, 13a

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 4.19-B, Page 1c, 1d, 5, 5a, 12, 13, 13a

10. SUBJECT OF AMENDMENT

Transition of Remedial Services to Medicaid Managed Care. Program name is also changing to Behavioral Health Intervention Services. Reimbursement is changing from retrospective cost settlement to prospective fee for service payment methodology.

11. GOVERNOR'S REVIEW *(Check One)*

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

12. SIGNATURE OF STATE AGENCY OFFICIAL: C M Palmer

13. TYPED NAME: CHARLES M. PALMER

14. TITLE: DIRECTOR

15. DATE SUBMITTED: 6/20/11

16. RETURN TO

CHARLES M. PALMER
DIRECTOR
DEPARTMENT OF HUMAN SERVICES
1305 EAST WALNUT 5TH FLOOR
DES MOINES IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 20, 2011

18. DATE APPROVED: February 28, 2012

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2011

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

Pen and ink change per 2/3/12 e-mail from State.

FORM CMS-179 (07/92)

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