

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <u>1 3 — 0 0 2</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, 2013	
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 Section 2703 of PPACA		7. FEDERAL BUDGET IMPACT a. FFY '13 <u>\$ 1,034,959.00</u> b. FFY '14 <u>\$ 8,369,843.00</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Health Home State Plan Amendment submitted through the MMDL web portal.		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Health Home State Plan Amendment submitted through the MMDL web portal.	
10. SUBJECT OF AMENDMENT Health home model for adults with SMI and children with SED delivered by a team of health care professionals trained in providing health home services that is whole-person, patient centered and comprehensive to improve health, etc.			
11. GOVERNOR'S REVIEW (Check One)			
<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 M. PALMER DIRECTOR DEPARTMENT OF HUMAN SERVICES 1305 EAST WALNUT 5TH FLOOR DES MOINES IA 50319-0114	
13. TYPED NAME CHARLES M. PALMER			
14. TITLE DIRECTOR			
15. DATE SUBMITTED March 21, 2013			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED March 30, 2014		18. DATE APPROVED June 18, 2013	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2013		20. SIGNATURE OF REGIONAL OFFICIAL /s/	
21. TYPED NAME James G. Scott		22. TITLE Associate Regional Administrator for Medicaid and Children's Health Operations	
23. REMARKS			