


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <u>1 0 — 0 1 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 <p style="text-align: center;">July 1, 2010</p>	
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 <u>\$ 1,795,614 (3m)</u>	
		b. FFY '11 <u>\$ 6,445,896</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT <p style="text-align: center;">Attachment 4.19-A, Page 25d, 25e <i>26f</i></p>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <p style="text-align: center;">Attachment 4.19-A, Page 25d, 25e <i>NEW PAGE</i></p>	
10. SUBJECT OF AMENDMENT <p style="text-align: center;">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.</p>			
11. GOVERNOR'S REVIEW (Check One) <i>DOH</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	
13. TYPED NAME CHARLES J. KROGMEIER		CHARLES J. KROGMEIER DIRECTOR DEPARTMENT OF HUMAN SERVICES 1303 EAST WALNUT 5TH FLOOR DES MOINES IA 50319-0114	
14. TITLE DIRECTOR			
15. DATE SUBMITTED <i>9-3-10</i>			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: <i>05-24-11</i>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2010		20. SIGNATURE OF REGIONAL OFFICIAL: <i>Bill Leonard RW</i>	
21. TYPED NAME: <i>William Lasowski</i>		22. TITLE: <i>Deputy Director, CMCS</i>	
23. REMARKS: <i>Pen & ink change made in block # 8 and 9</i>			