

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER  
1 0 - 0 1 7

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  
September 1, 2010

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

7. FEDERAL BUDGET IMPACT  
a. FFY '10 \$ 0  
b. FFY '11 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  
Attachment 4.19-A, Page 26d

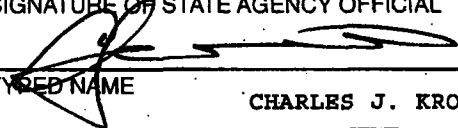
9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)  
Attachment 4.19-A, Page 26d

10. SUBJECT OF AMENDMENT

This request removes language that limits reimbursement for public hospitals to no more than cost.

11. GOVERNOR'S REVIEW (Check One)

- GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 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  
9/29/10

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED:  
06-06-11

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
SEP - 1 2010

20. SIGNATURE OF REGIONAL OFFICIAL:  


21. TYPED NAME:  
William Lasowski

22. TITLE:  
Deputy Director, CMCS

23. REMARKS: