

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER <u>1 1 — 0 2 8</u>	2. STATE <u>IOWA</u>
	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 <u>November 1, 2011</u>	

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 '12 \$ (9,560,782) <u>11,952,275</u> b. FFY '13 \$ (10,429,944) <u>10,395,134</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT <u>Attachment 4.19-A, Pages 1, 4a, 5, 12, 12a, 14, 18</u>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <u>Attachment 4.19-A, Pages 1, 4a, 5, 12, 12a, 14, 18</u>

10. SUBJECT OF AMENDMENT

Implement the required triennial inpatient hospital rebase and recalibration as required by rule.

11. GOVERNOR'S REVIEW (Check One)

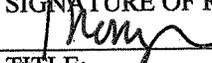
GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO CHARLES M. PALMER DIRECTOR DEPARTMENT OF HUMAN SERVICES 1305 EAST WALNUT 3TH FLOOR DES MOINES IA 50319-0114
13. TYPED NAME CHARLES M. PALMER	
14. TITLE DIRECTOR	
15. DATE SUBMITTED	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: AUG 13 2012
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: NOV -1 2011	20. SIGNATURE OF REGIONAL OFFICIAL: 
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21. TYPED NAME: <u>Penny Thompson</u>	22. TITLE: <u>Deputy Director, CMES</u>
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23. REMARKS:

Per 9 ink changes made to box 7 and Plan page 18 has been changed to 12