

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <u>1 2 — 0 1 1</u>	2. STATE IOWA
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
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		4. PROPOSED EFFECTIVE DATE September 1, 2012	
COMPLETE BLOCKS 8 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION	7. FEDERAL BUDGET IMPACT a. FFY '12 \$ <u>(\$31,516)</u> b. FFY '13 \$ <u>(\$378,179)</u>		
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-A, Page 17b	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.19-A, Page 17 <i>New Page</i>		
10. SUBJECT OF AMENDMENT Iowa SF 2366 required implementation of a hospital inpatient reimbursement policy to provide combining of an original claim for an inpatient stay with a claim for a subsequent inpatient stay when a patient is admitted within 7 days of discharge for same condition. <input checked="" type="checkbox"/>			
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	15. DATE SUBMITTED 9-26-12		
14. TITLE DIRECTOR	FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED September 26, 2012	18. DATE APPROVED MAY 29 2013		
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL	20. SIGNATURE OF REGIONAL OFFICIAL 		
21. TYPED NAME	22. TITLE		
23. REMARKS			