DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 11-014

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: August 1, 2011

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

42 CFR 440.130

7. FEDERAL BUDGET IMPACT
a. FFY '11 $ 1,396.34
b. FFY '12 $ 8,378.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Supplement 2 to Attachment 3.1-A, Page 13
Supplement 2 to Attachment 3.1-A, Page 12, 16
Supplement 2 to Attachment 3.1-A, Page 31a-31e
Supplement 2 to Attachment 3.1-A, Page 31f-31h

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Supplement 2 to Attachment 3.1-A, Page 13
Supplement 2 to Attachment 3.1-A, Page 12, 16
Supplement 2 to Attachment 3.1-A, Page 31a-31e

10. SUBJECT OF AMENDMENT

Adds a person certified by the non-governmental Iowa Board of Substance Abuse certification as an alcohol and drug counselor under the rehabilitation provisions of the CFR.

11. GOVERNOR'S REVIEW *(Check One)*

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

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME: CHARLES M. PALMER

14. TITLE: DIRECTOR

15. DATE SUBMITTED: 7-26-11

16. RETURN TO

CHARLES M. PALMER
DIRECTOR
DEPARTMENT OF HUMAN SERVICES
1305 EAST WALNUT 5TH FLOOR
DES MOINES IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 26, 2011

18. DATE APPROVED: January 8, 2013

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: August 1, 2011

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME: James G. Scott

22. TITLE: Associate Regional Administrator for Medicaid and Children's Health Operations

23. REMARKS: Per and wk charges - Per state request

FORM CMS-179 (07/92)

Instructions on Back