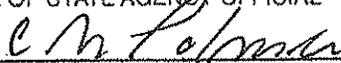


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER	2. STATE
		1 3 — 0 0 6	IOWA
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
		4. PROPOSED EFFECTIVE DATE <p style="text-align: center;">April 1, 2013</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 Section 1902(r)(2) of the Social Security Act * CFR 1902 (a) (10) (A) (ii) (XII)		7. FEDERAL BUDGET IMPACT a. FFY <del>14</del> '13 * \$ (<100,000) b. FFY <del>15</del> '14 * \$ (<100,000)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 2.6-A, Page 12c Supplement 8a to Attachment 2.6-A, Page 1		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 2.6-A, Page 12c Supplement 8a to Attachment 2.6-A, Page 1	
10. SUBJECT OF AMENDMENT <p>This request is for the Medicaid for Employed People with Disabilities (MEPD) program eligibility requirements so that social security cost-of-living adjustments will be counted only in eligibility and premium determinations based on subsequently published federal poverty levels. *</p>			
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			
14. TITLE DIRECTOR			
15. DATE SUBMITTED 6-21-13			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED June 21, 2013		18. DATE APPROVED September 13, 2013	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL April 1, 2013		20. SIGNATURE OF REGIONAL OFFICIAL /s/	
21. TYPED NAME James G. Scott		22. TITLE Associate Regional Administrator for Medicaid and Children's Health Operations	
23. REMARKS  * Pen and Ink changes made per state request via e-mail dated 9.11.13.			