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: 13 — 006

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: April 1, 2013

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
Section 1902(r)(2) of the Social Security Act *
CFR 1902(a)(10)(A)(ii)(XII)

7. FEDERAL BUDGET IMPACT
a. FFY ~~'14~~ '13 * $ (<100,000)
b. FFY ~~'15~~ '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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

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. *

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
C M Palmer

13. TYPED NAME: CHARLES M. PALMER

14. TITLE: DIRECTOR

15. DATE SUBMITTED: 6-21-13

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: 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.

FORM CMS-179 (07/92)

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