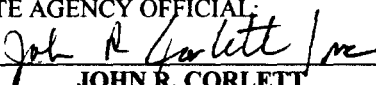



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-006	2. STATE OHIO
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 01, 2009	
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: 42 CFR 440; 42 CFR 441; 42 CFR 447		7. FEDERAL BUDGET IMPACT: a. FFY 2009 \$ 0 b. FFY 2010 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: ATTACHMENT 4.19-A Ohio Administrative Code Rule 5101:3-2-50 Ohio Administrative Code Rule 5101:3-2-51		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): ATTACHMENT 4.19-A Ohio Administrative Code Rule 5101:3-2-50 Ohio Administrative Code Rule 5101:3-2-51	
10. SUBJECT OF AMENDMENT: Supplemental inpatient hospital upper limit payments for public hospitals Supplemental inpatient hospital upper limit payments for state hospitals			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Governor has delegated signature authority to ODJFS Director. Director has delegated signature authority to Medicaid Director	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME: JOHN R. CORLETT		Becky Jackson OHP/Bureau of Health Plan Policy Ohio Department of Job and Family Services P.O BOX 182709 Columbus, Ohio 43218	
14. TITLE: MEDICAID DIRECTOR			
15. DATE SUBMITTED: 6.30.09			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: 3-5-10	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR - 1 2009		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: William Lasowski		22. TITLE: Deputy Director, CMSO	
23. REMARKS:			