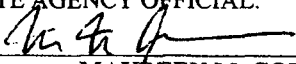



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-014 <i>Revised</i>	2. STATE OHIO
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE August 1, 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: Section 1902 (a)(13)(A) of the Social Security Act		7. FEDERAL BUDGET IMPACT: a. FFY 09 <u>\$952,477</u> b. FFY 10 <u>\$4,353,098</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Table of Contents, Medicaid State Plan, ICFs-MR Table of Contents, Attachment 4.19D, ICFs-MR Supplement 2 Section 5101:3-3-17.5 Section 5101:3-3-19.1 (new) Section 5101:3-3-78 (new) Section 5101:3-3-82.1 Section 5101:3-3-86 Section 5101:3-3-90		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Table of Contents, Medicaid State Plan, ICFs-MR Table of Contents, Attachment 4.19D, ICFs-MR Supplement 2 Section 5101:3-3-17.5 Section 5101:3-3-19 (delete) Section 5101:3-3-78 Section 5101:3-3-82.1 Section 5101:3-3-86 Section 5101:3-3-90	
10. SUBJECT OF AMENDMENT: This amendment implements the provisions of Ohio's Amended Substitute House Bill 1 regarding SFYs 2010 and 2011 intermediate care facilities for the mentally retarded (ICFs-MR) reimbursement. This amendment also delineates covered Medicaid services for ICF-MR providers, the revised ICF-MR outlier rate for SFY 2010, the methodology for establishing the total prospective rate for ICFs-MR, the reimbursement methodology for the ICF-MR franchise permit fee, and provisions for ICF-MR providers new to the Medicaid program.			
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: Becky Jackson OHP/Bureau of Policy and Benefit Management Ohio Department of Job and Family Services P.O. BOX 182709 Columbus, Ohio 43218	
13. TYPED NAME: MAUREEN M. CORCORAN			
14. TITLE: INTERIM STATE MEDICAID DIRECTOR			
15. DATE SUBMITTED: 9.24.09			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: 05-31-11	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG - 1 2009		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: William Lasowski		22. TITLE: Deputy Director, CMCS	
23. REMARKS:			

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