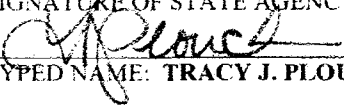
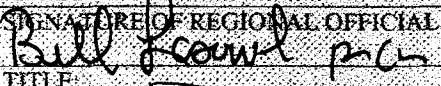


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-024	2. STATE OHIO
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE October 16, 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 2010 \$0 b. FFY 2011 \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Table of Contents, Medicaid State Plan – Nursing Facilities Table of Contents, Attachment 4.19D - NF Supplement 1 Section 5111.232.000 Section 5111.232.001		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Table of Contents, Medicaid State Plan – Nursing Facilities Table of Contents, Attachment 4.19D - NF Supplement 1 Section 5111.232.000 Section 5111.232.001 Section 5101:3-3-541, Supplement 3 to Attachment 3.1A, Pages 1-26 Section 5101:3-3-545, Supplement 3 to Attachment 3.1A, Pages 1-16	
10. SUBJECT OF AMENDMENT: This amendment sets forth the provisions of Ohio's Amended Substitute House Bill 1 regarding the correction period for Minimum Data Set version 2.0 (MDS 2.0) submissions from Nursing Facilities (NFs) set forth under Supplement 1 of Attachment 4.19D of the state plan. This amendment also deletes obsolete sections 5101:3-3-541 and 5101:3-3-545 from Attachment 3.1A, Supplement 3.			
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: TRACY J. PLOUCK			
14. TITLE: STATE MEDICAID DIRECTOR			
15. DATE SUBMITTED: 12.31.09			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: 3-30-10	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 16 2009		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: William Lasowski		22. TITLE: Deputy Director, CMSO	
23. REMARKS: PEN AND INK CHANGE - BOX 9 - PER MARCH 25, 2010 EMAIL FROM THE STATE TO CMS			

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