| 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<br>CENTERS FOR MEDICARE & MEDICAID SERVICES<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE<br>October 16, 2009 | |

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: | 7. FEDERAL BUDGET IMPACT: |
|---|---|
| Section 1902 (a)(13)(A) of the Social Security Act | a. FFY 2010 $0<br>b. FFY 2011 $0 |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: |
| Table of Contents, Medicaid State Plan – Nursing Facilities<br>Table of Contents, Attachment 4.19D - NF Supplement 1<br>Section 5111.232.000<br>Section 5111.232.001 | Table of Contents, Medicaid State Plan – Nursing Facilities<br>Table of Contents, Attachment 4.19D - NF Supplement 1<br>Section 5111.232.000<br>Section 5111.232.001<br>~~Section 5101:3-3-541, Supplement 3 to Attachment 3.1A, Pages 1-26~~<br>~~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)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ 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: **TRACY J. PLOUCK** | **Becky Jackson**<br>**OHP/Bureau of Policy and Benefit Management**<br>**Ohio Department of Job and Family Services**<br>**P.O. BOX 182709**<br>**Columbus, Ohio 43218** |
| 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: Bill Lasowski pcn |
| 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

Instructions on Back

FORM CMS-179 (07-92)