

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 10 - 008 <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 July 1, 2011	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>):			
<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 (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 1905(a)(19) of the Social Security Act; 1915(g)(2) of the Social Security Act; 42CFR430.12(c); 42CFR440.169; 42CFR440.225; 42CFR440.18		7. FEDERAL BUDGET IMPACT: a. FFY 2011 \$ 3600 K b. FFY 2012 \$ 14500 K	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Item 19-a, Target Group C: DD, Pages 1 and 2 of 2		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B, Reference Pre-Print Page 8 of Attachment 3.1-A, Item 19, Page 1 of 1 (TN# 05-026) Appendix A to Attachment 4.19-B, preprint page 8, Attachment 3.1-A, Item 19, Pages 1 of 3 (on six pages) (TN# 05-004)	
10. SUBJECT OF AMENDMENT: Methods and standards for payment of Targeted Case Management services provided to certain Medicaid eligible individuals who are determined to have mental retardation or other developmental disability according to Section 5126.01 of the Ohio Revised Code.			
11. GOVERNOR'S REVIEW (<i>Check One</i>):			
<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: <i>Tracy J. Plouck/mc</i>		16. RETURN TO: Becky Jackson OHP/Bureau of Policy and Health Plan Services 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: 12.22.10			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 12-22-10		18. DATE APPROVED: JUL 19 2011	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07-01-11		20. SIGNATURE OF REGIONAL OFFICIAL: <i>Verlon Johnson</i>	
21. TYPED NAME: Verlon Johnson		22. TITLE: Associate Regional Administrator	
23. REMARKS:			

Instructions on Back