

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>10 - 014 REVISED #2</b>	2. STATE <b>OHIO</b>
<b>FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES</b>		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 1, 2011	
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"/> <b>AMENDMENT</b>			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1905 (a) of the Social Security Act		7. FEDERAL BUDGET IMPACT: a. FFY 2012 \$3,398.67 thousands b. FFY 2013 \$3,398.67 thousands	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.19-B, Item 2-C, Page 6 of 6 Attachment 4.19-B, Item 2-C, Page 6a of 6 (NEW)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Attachment 4.19-B, REFERENCE PRE-PRINT PAGE 1 OF ATTACHMENT 3.1-A, Item 2-C, Page 6 of 6 (TN 06-003)	
10. SUBJECT OF AMENDMENT: Federally Qualified Health Centers (FQHCs): Alternative payment methodology for public/government operated FQHCs.			
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: <i>Tracy Plouck</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: <b>TRACY J. PLOUCK</b>			
14. TITLE: <b>STATE MEDICAID DIRECTOR</b>			
15. DATE SUBMITTED: <b>12/29/10</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>12-29-10</b>		18. DATE APPROVED: <b>04-07-11</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>10-01-11</b>		20. SIGNATURE OF REGIONAL OFFICIAL: <i>Verlon Johnson</i>	
21. TYPED NAME: <b>Verlon Johnson</b>		22. TITLE: <b>Associate Regional Administrator</b>	
23. REMARKS:			

**Instructions on Back**