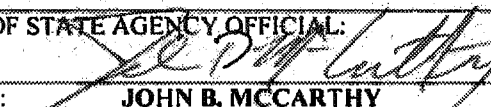


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 11 - 002 (REVISED)	2. STATE OHIO
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
		4. PROPOSED EFFECTIVE DATE February 1, 2011	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES			
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: 42 USC Section 1396a(a)(10)(D) 1902(a)(10)(D) of the Social Security Act Section 6407(d) of the Affordable Care Act 42 CFR 440.70		7. FEDERAL BUDGET IMPACT: a. FFY 2011 \$ 855 (in thousands) b. FFY 2012 \$ 1,219 (in thousands)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Item 7 pages 1 through 6 of 6 Attachment 4.19-B, Item 7-a page 1 of 1 Attachment 4.19-B, Item 7-b page 1 of 1 Attachment 4.19-B, Item 7-c page 1 of 1 Attachment 4.19-B, Item 7-d page 1 of 1		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 3.1-A, From Pre-print Page 3, Item 7, page 1 of 1 (TN 06-012) Attachment 4.19-B, Item 7 page 1 of 4 (TN 09-035) Attachment 4.19-B, Item 7 page 2 of 4 (TN 09-035) Attachment 4.19-B, Item 7 page 3 of 4 (TN 09-035) Attachment 4.19-B, Item 7 page 4 of 4 (TN 09-035)	
10. SUBJECT OF AMENDMENT: Face-to-face encounter provisions under the home health benefit			
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 Medicaid Director	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Becky Jackson Ohio Department of Medicaid P.O. BOX 182709 Columbus, Ohio 43218	
13. TYPED NAME: JOHN B. MCCARTHY			
14. TITLE: STATE MEDICAID DIRECTOR			
15. DATE SUBMITTED: 3/30/2011			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: March 30, 2011		18. DATE APPROVED: November 6, 2013	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: February 1, 2011		20. SIGNATURE OF REGIONAL OFFICIAL: /s/	
21. TYPED NAME: Verlon Johnson		22. TITLE: Associate Regional Administrator	
23. REMARKS:			

Instructions on Back