

**TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER: **11 - 005 Revised**      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  
April 1, 2011

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:

42 CFR 431.107  
42 CFR Part 442, Subparts A and B  
42 CFR Part 483, Subpart B  
section 1919 of the Act  
42 CFR Part 483, Subpart D

7. FEDERAL BUDGET IMPACT:

a. FFY 2011      \$ 0  
b. FFY 2012      \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): **10-002**  
Table of Contents - Nursing Facilities (~~TN 09-024~~) (Delete)  
Table of Contents - NF Supplement 1 (~~TN 09-024~~) (Delete)  
Table of Contents - ICFs-MR (~~TN 09-029~~) (Delete) **10-002**  
Table of Contents - ICF-MR Supplement 2 (~~TN 09-029~~) (Delete) **10-002**  
Section 5111.22.001 of Att. 4.19D - NF Supp. 1 (Delete)  
Section 5101:3-3-02.3 of Att. 4.13B (Delete)  
Section 5101:3-3-02.2 of Att. 4.19D - ICF-MR Supp. 2 (Delete)  
Section 5101:3-3-02.3 of Att. 4.13C (Delete)

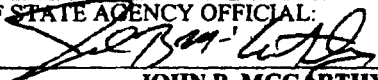
10. SUBJECT OF AMENDMENT: Removal of NF and ICF-MR provider agreement sections located in Attachments 4.19D, 4.13B, and 4.13C of the state plan.

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:



13. TYPED NAME: **JOHN B. MCCARTHY**

14. TITLE: **STATE MEDICAID DIRECTOR**

15. DATE SUBMITTED: **6.23.11**

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

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED: **SEP - 6 2011**

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL: **APR - 1 2011**

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: **Penny Thompson**

22. TITLE: **Deputy Director, CMCS**

*Per a/cid change made to block # 9  
10-002 added to replace previous transmittal number*