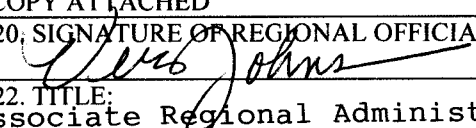


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|---|--|--|-------------------------|
| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | | 1. TRANSMITTAL NUMBER: 11 - 010 | 2. STATE OHIO |
| FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES | | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE 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)(13) of the Social Security Act 42CFR440.130(d) | | 7. FEDERAL BUDGET IMPACT: a. FFY 2011 \$ (1912) in thousands b. FFY 2012 \$ (7648) in thousands | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Item 13-d-1, Pages 1 and 2 of 2 | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT <i>(If Applicable)</i> : Attachment 4.19-B, Item 13-d-1, Pages 1 and 2 of 2 (TN 08-011) | |
| 10. SUBJECT OF AMENDMENT: Reimbursement methodology for Community Psychiatric Supportive Treatment (CPST) | | | |
| 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: | | 16. RETURN TO: | |
| 13. TYPED NAME: John B. McCarthy | | Becky Jackson OHP/Bureau of Policy and Health Plan Services Ohio Department of Job and Family Services P.O. BOX 182709 Columbus, Ohio 43218 | |
| 14. TITLE: STATE MEDICAID DIRECTOR | | | |
| 15. DATE SUBMITTED: 09-06-11 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: 09-06-11 | | 18. DATE APPROVED: DEC 05 2011 | |
| PLAN APPROVED - ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 07-01-11 | | 20. SIGNATURE OF REGIONAL OFFICIAL:  | |
| 21. TYPED NAME: Verlon Johnson | | 22. TITLE: Associate Regional Administrator | |
| 23. REMARKS: | | | |

Instructions on Back