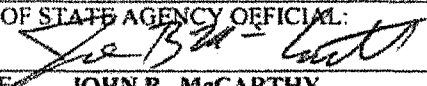



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 12 - 012	2. STATE OHIO
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2012	
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"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42CFR430.12(c); 42CFR440.225, 42CFR440.130(d); 1905 (a)(13) of the Social Security Act		7. FEDERAL BUDGET IMPACT: a. FFY 2012 \$2369 \$8968 thousands b. FFY 2013 \$9477 \$8968 thousands <i>HP</i>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Item 13-d-2, Page 14 of 19 Attachment 3.1-A, Item 13-d-2, Page 14a of 19 (NEW)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A, Item 13-d-2, page 14 of 19 (TN 11-029)	
10. SUBJECT OF AMENDMENT: Rehabilitative services provided by alcohol and other drug treatment programs: Inclusion of Medication Assisted Treatment as a component of the Medical/Somatic service			
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: 		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: JOHN B. McCARTHY			
14. TITLE: STATE MEDICAID DIRECTOR			
15. DATE SUBMITTED: 6/26/12			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 6/26/12		18. DATE APPROVED: 9/21/12	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2012		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Alan Freund		22. TITLE: Acting Associate Regional Administrator	
23. REMARKS:			

Instructions on Back
FORM CMS-179 (07-92)