TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **09 – 016**	2. STATE: **OHIO**
	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: 1 August 2009	

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 440.110	7. FEDERAL BUDGET IMPACT: a. FFY2009 $ 0 b. FFY2010 $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A Pre-Print Page 4 Item 11, Pages 1 through 6 of 6 Attachment 4.19-B Reference Pre-Print Page 4 of Attachment 3.1-A Item 11, Page 1 through 3 of 3	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A Pre-Print Page 4 Item 11, Pages 1 through 5 of 5 Attachment 4.19-B Reference Pre-Print Page 4 of Attachment 3.1-A Item 11, Pages 1 through 3 of 3

10. SUBJECT OF AMENDMENT:
Change in the State Plan to reflect provisions of Amended Substitute House Bill 1 (128th Ohio General Assembly) requiring nursing facilities (NFs) to arrange for therapy services for their residents in return for an additional per diem amount

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:	16. RETURN TO:
13. TYPED NAME: **MAUREEN M. CORCORAN**	**Becky Jackson** **OHP/Bureau of Policy and Benefit Management** **Ohio Department of Job and Family Services** **P.O. Box 182709** **Columbus, OH 43218**
14. TITLE: **INTERIM STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: 9/29/09	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)