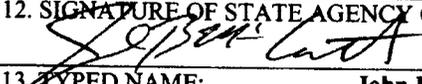
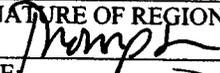


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 11 -011	2. STATE OHIO
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2011	
5. TYPE OF PLAN MATERIAL (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: 42 CFR part 447, Subpart C		7. FEDERAL BUDGET IMPACT: a. FFY 2011 \$ 28,027 (in thousands) b. FFY 2012 \$ 115,788 (in thousands)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, 5101:3-2-07.4, Basic methodology for determining prospective payment rates, page 12		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-A, 5101:3-2-07.4, Basic methodology for determining prospective payment rates, page 12 (TN 09-015) Attachment 4.19-A, 5101:3-2-07.4 Basic methodology for determining prospective payment rates, page 15 (TN 09-015) [DELETE]	
10. SUBJECT OF AMENDMENT: Inpatient hospital rate (continuation)			
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: 9/16/11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: FEB 17 2012	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2011		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Penny Thompson		22. TITLE: Deputy Director, CMCS	
23. REMARKS:			