

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**  
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 15 - 0009	2. STATE: Michigan
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE July 1, 2015	

TO: REGIONAL ADMINISTRATOR  
HEALTH FINANCING ADMINISTRATION  
DEPARTMENT OF HUMAN SERVICES

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:	7. FEDERAL BUDGET IMPACT: a. FFY 2015 \$0 b. FFY 2016 \$0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.1-A, 35a – 35h  Attachment 4.19-B, Pages 2.a.1 – 2.a.8	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  New pages

10. SUBJECT OF AMENDMENT:  
Establish a reimbursement system for hospital stays that meet certain short stay conditions.

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      Kathleen Stiffler, Acting Director  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL      Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:  


13. TYPED NAME:  
Kathleen Stiffler

14. TITLE:  
Acting Director, Medical Services Administration

15. DATE SUBMITTED:  
July 21, 2015

16. RETURN TO:  
  
Medical Services Administration  
Actuarial Division - Federal Liaison  
Capitol Commons Center - 7<sup>th</sup> Floor  
400 South Pine  
Lansing, Michigan 48933

Attn: Erin Black

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:	18. DATE APPROVED:
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**PLAN APPROVED – ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPE NAME:	22. TITLE:

23. REMARKS: