

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

1. TRANSMITTAL NUMBER:

15 - 0012

2. STATE:

Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

September 30, 2015

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 447.201

7. FEDERAL BUDGET IMPACT:

a. FFY 2015 \$0

b. FFY 2016 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4-19-A, Appendix B, Page 10

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4-19-A, Appendix B, Page 10

10. SUBJECT OF AMENDMENT:

Indigent Care Agreement (ICA) DSH Pool Distribution Update

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:
Kathleen Stiffler, Acting Director
Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kathleen Stiffler

14. TITLE:
Acting Director, Medical Services Administration

15. DATE SUBMITTED:
September 30, 2015

16. RETURN TO:

Medical Services Administration
Actuarial Division - Federal Liaison
Capitol Commons Center - 7th Floor
400 South Pine
Lansing, Michigan 48933

Attn: Erin Black

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. TYPE NAME:

22. TITLE:

23. REMARKS: