DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 07 - 16

2. STATE: Michigan

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

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2007

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 440.20(a)

7. FEDERAL BUDGET IMPACT:
a. FFY 08 $ -0-
b. FFY 09 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement to Attachment 3.1-A, page 10

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement to Attachment 3.1-A, page 10

10. SUBJECT OF AMENDMENT:
OPH psoriasis treatment centers

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:
Paul Reinhart, Director
Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Paul Reinhart

13. TYPED NAME:
Paul Reinhart

14. TITLE:
Director, Medical Services Administration

15. DATE SUBMITTED:
October 9, 2007

16. RETURN TO:

Medical Services Administration
Program/Eligibility Policy Division - Federal Liaison Unit
Capitol Commons Center - 7th Floor
400 South Pine
Lansing, Michigan 48933

Attn: Nancy Bishop

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:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Amount, Duration and Scope of Medical an Remedial Care Services Provided to the Categorically and Medically Needy

2b. Rural Health Clinic Services

The following services are covered when furnished by a rural health clinic which has been certified in accordance with 42 CFR 481:

1) Rural health clinic services as specified in 42 CFR 440.20(b)
2) Ambulatory services, other than rural health clinic services, which are included in the Plan and are furnished in accordance with the requirements specified in the Plan.