TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: 1 2 - 18

	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, 2012

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)*

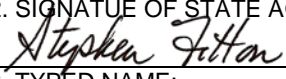|	

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.225
	7. FEDERAL BUDGET IMPACT:
	  a. FFY 2013 $ 0
	  b. FFY 2014 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Page 8a Supplement to Attachment 3.1-A, Page 35a	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A, Page 8a Supplement to Attachment 3.1-A, Page 35a

10. SUBJECT OF AMENDMENT:

This amendment removes inconsistent State Plan language regarding optional coverage of respiratory care services in accordance with 1902(e)(9)(A) through (C).

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT   ☒ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED   Stephen Fitton, Director
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL   Medical Services Administration

12. SIGNATUE OF STATE AGENCY OFFICIAL: *Stephen Fitton*	16. RETURN TO: Medical Services Administration Actuarial Division Capitol Commons Center - 7th Floor 400 South Pine Street Lansing, Michigan 48933 Attn: Loni Hackney
13. TYPED NAME: Stephen Fitton	
14. TITLE: Director, Medical Services Administration	
15. DATE SUBMITTED: October 10, 2012	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: October 10, 2012	18 DATE APPROVED: 1/8/13
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2012	20. SIGNATURE OF REGIONAL OFFICIAL: *Verlon Johnson*
21. TYPE NAME: Verlon Johnson	22. TITLE: Associate Regional Administrator
23. REMARKS:	

FORM HCFA-179(07-92)   *Instructions on Back*