DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE 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: **09-009**

2. STATE **NEVADA**

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE **July 1, 2009**

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:
State Plan Under Title XIX of the Social Security Act; ~~42 CFR 440~~
42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 (-$878,991.63)
b. FFY 2010 (-$3,278,233.48)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Page 4

10. SUBJECT OF AMENDMENT:

Correct the date emergency transportation rates were set. Decrease the hourly rate from $18.52 per hour to $17.00 per hour for personal care services as approved by the State of Nevada legislative body.

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:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Michael J. Willden

14. TITLE:
Director, Department of Health and Human Services

15. DATE SUBMITTED:
JUN 26 2009

16. RETURN TO:
John A. Liveratti, Chief
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
JUNE 26, 2009

18. DATE APPROVED:
9.24.2009 SEP 24 2009

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JULY 1, 2009

20. SIGNATURE OF REGIONAL OFFICIAL:
for GLORIA NAGLE

21. TYPED NAME:
GLORIA NAGLE, Ph.D., MPA

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR

23. REMARKS:

Pen and ink change to box #6

FORM HCFA-179 (07-92)