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: **09-006**

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
September 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
Section 1928(c)(2)(C)(ii) of the Social Security Act (OBRA 93)

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 (1 Month) $0
b. FFY 2010 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19(m), Page 66(b)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19(m), Page 66(b)

10. SUBJECT OF AMENDMENT:

Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program.

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:
JUL 01 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: JULY 1, 2009

18. DATE APPROVED: 9.29.2009 SEP 29 2009

PLAN APPROVED – ONE COPY ATTACHED

19. *EFFECTIVE DATE OF APPROVED MATERIAL*: SEPTEMBER 1, 2009

20. *SIGNATURE OF REGIONAL OFFICIAL*: FOR GLORIA NAGLE

21. TYPED NAME: GLORIA NAGLE, PhD, MPA

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR

23. REMARKS:

FORM HCFA-179 (07-92)