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: **10-008**

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, 2010

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; Sec 1923 of Act
42 CFR 447.299(c) & (d), 455.300 through 455.304

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 $0
b. FFY 2011 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pages 21 - 25

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, pages 21 - ~~20~~ 25

10. SUBJECT OF AMENDMENT:
Establish a rate methodology with a maximum fixed fee for End Stage Renal Disease (ESRD) Dialysis Procedure

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 0 1 2010**

16. RETURN TO:
Marta Stagliano, Chief, Compliance
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

19. EFFECTIVE DATE OF APPROVED

21. TYPED NAME:

23. REMARKS:
Regional Office [illegible] clarifications from State per email [illegible]

CMCS

FORM HCFA-179 (07-92)