

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 12-005	2. STATE NEVADA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION		4. PROPOSED EFFECTIVE DATE July 1, 2012
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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 447, 434, 438 and 1902(a)(4), 1902(a)(6) and 1903	7. FEDERAL BUDGET IMPACT: a. FFY 2012 \$0 b. FFY 2013 \$0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <u>Attachment 4.19-A p. 35-36</u> <u>Attachment 4.19-B p. 21</u> <u>Attachment 4.19-D p. 17</u>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <u>NEW</u> <u>Attachment 4.19-B p. 21</u> <u>NEW</u>

10. SUBJECT OF AMENDMENT:
Compliance with regulations with respect to non-payment for provider preventable conditions.

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: 	16. RETURN TO: Marta Stagliano, Chief, Compliance DHCFP/Medicaid 1100 East William Street, Suite 101 Carson City, NV 89701
13. TYPED NAME: Michael J. Willden	
14. TITLE: Director, Department of Health and Human Services	
15. DATE SUBMITTED: APR 19 2012	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JUL 18 2012
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL -1 2012	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, CMCS

23. REMARKS: