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: 12-07

2. STATE: Nebraska

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, 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:

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 $11,597
b. FFY 2013 $46,387

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B-
Item 4b page 1; Item 5 page 2; Item 6a page 1-2; Item 6b page 1; Item 9 page 2; Item 12d; Item 20 page 1 of 2; Item 21 page 1 of 2
* Item 3, Page 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B-
Item 4b page 1; Item 5 page 2; Item 6a, page 1 and page 2 of 2; Item 6b page 1; Item 9 page 2 of 4; Item 12d; Item 20 page 1 of 2; Item 21 page 1 of 2 * Item 3, Page 2

10. SUBJECT OF AMENDMENT:
Clinical Laboratory Fee Schedule Increase and Reimbursement for Injectable Medications at Medicare Fee Schedule Rates

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:
Governor has waived review

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Vivianne M Chaumont

13. TYPED NAME:
Vivianne M. Chaumont

14. TITLE:
Director, Division of Medicaid and Long-Term Care

15. DATE SUBMITTED:
September 26, 2012

16. RETURN TO:

Nancy Keller
Division of Medicaid & Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South
Lincoln, NE 68509

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:
September 26, 2012

18. DATE APPROVED:
April 25, 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2012

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
James G. Scott

22. TITLE:
Associate Regional Administrator
for Medicaid and Children's Health Operations

23. REMARKS:

* Pen and Ink change per e-mail from state dated 3.20.13.