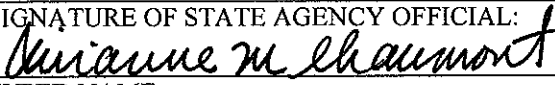


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 12-07	2. STATE Nebraska
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2012	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> 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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B- Item 4b page 1; Item 5 page 2; Item 6a, page 1 and page 2 of 2; Item 6b page 1; Item 9 page 2 of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): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Governor has waived review <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Nancy Keller Division of Medicaid & Long-Term Care Nebraska Department of Health & Human Services 301 Centennial Mall South Lincoln, NE 68509	
13. TYPED NAME: Vivianne M. Chaumont			
14. TITLE: Director, Division of Medicaid and Long-Term Care			
15. DATE SUBMITTED: September 26, 2012			
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.			