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: **11-23**

2. STATE: **Louisiana**

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 21, 2011**

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 440.170 and
42 CFR 447 Subpart B

7. FEDERAL BUDGET IMPACT:

a. FFY **2011** **$3,169.69**
b. FFY **2012** **$13,100.50**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Item 24a, Page 1b
Attachment 4.19-B, Item 24a, Page 1b (1)
Attachment 4.19-B, Item 24a, Page 1b (2)
* ~~**Attachment 4.19-B, Item 24a, Page 1b (3)**~~
* ~~**Attachment 4.19-B, Item 24a, Page 1b (4)**~~

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

None (New Page)
None (New Page)
None (New Page)
~~**None (New Page)**~~
~~**None (New Page)**~~

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to establish supplemental payments for emergency medical transportation services rendered by land and air ambulance providers.**

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 does not review state plan material.**

12. SIGNATURE OF STATE AGENCY OFFICIAL:

[redacted]

13. TYPED NAME: **Bruce D. Greenstein**

14. TITLE: **Secretary**

15. DATE SUBMITTED: **September 29, 2011**

16. RETURN TO:

Don Gregory, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 30 September, 2011

18. DATE APPROVED: 4 June, 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 21 September, 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

[redacted]

21. TYPED NAME: Bill Brooks

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS: * Pen and Ink change made per State's E-mail Dated 23 May, 2012 requesting Attachment 4.19-B Item 24a pages 3 & 4 be removed from the submission package.

FORM HCFA-179 (07-92)