

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:

12-07

2. STATE

Louisiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

February 10, 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:

42 CFR 447, Subpart F,  
42 CFR 438.60

7. FEDERAL BUDGET IMPACT:

a. FFY 2012 \$ 0  
b. FFY 2013 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Item 2a, Page 2a  
\*Attachment 4.19-B, Item 2a, Page 2b Page 2b  
Attachment 4.19-B, Item 2.a, Page 3

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 PAGE NUMBER OF THE SUPERSEDED PLAN  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

Same (TN 10-52)  
None (New Page)  
Same (TN 09-13)

10. SUBJECT OF AMENDMENT: The purpose of this amendment is to amend the provisions governing the reimbursement methodology for outpatient hospital services in order to continue medical education payments to state-owned hospitals when the hospitals are reimbursed by prepaid risk-bearing managed care organizations (MCOs) for outpatient surgeries, clinic services, rehabilitation services, and other covered outpatient hospital services.

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:

13. TYPED NAME:

Bruce D. Greenstein

14. TITLE:

Secretary

15. DATE SUBMITTED:

February 14, 2012

16. RETURN TO:

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

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

16 February, 2012

18. DATE APPROVED:

3 May, 2012

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

10 February, 2012

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Bill Brooks

22. TITLE: Associate Regional Administrator

Division of Medicaid & Children's Health

23. REMARKS: \* Pen & Ink change made per State's e-mail dated 4/16/2012 changing Attachment 4.19-B, Item 2a, 2h to Attachment 4.19-B, Item 2a, Page 2b.

\* Pen & Ink change made per State's e-mail dated 4/16/12, CMS 179  
Block 6, adding the Federal statute/Regulation Citation of 42 CFR  
438.60