

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

**12-34**

2. STATE

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

4. PROPOSED EFFECTIVE DATE

**\*\* ~~July 1, 2012~~ 20 July, 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 Subpart B**

7. FEDERAL BUDGET IMPACT:

a. FFY 2012 (\$23.94)b. FFY 2013 (\$90.58)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

**Attachment 4.19-B, Item 5, Page 2a(1)****Attachment 4.19-B, Item 5, Page 2a(2)****Attachment 4.19-B, Item 6, Page 2****Attachment 4.19-B, Item 6, Page 2a**9. PAGE NUMBER OF THE SUPERSEDED PLAN  
SECTION OR ATTACHMENT (If Applicable):**Same (Pending TN 12-25)****Same (TN 10-15)****Same (TN 10-15)****None (New Page)****10. SUBJECT OF AMENDMENT: The purpose of this State Plan amendment is to reduce the reimbursement rates for physician and certified registered nursing assistant rendered anesthesia services by 3.4 percent in order to avoid a budget deficit.**

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:

**August 17, 2012**

16. RETURN TO:

**J. Ruth Kennedy, Medicaid Director****State of Louisiana****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:

**20 August, 2012**

18. DATE APPROVED:

**22 August, 2013****PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

**20 July, 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 and Ink Change made per State's RAI submission Dated 7/15/13 changing the effective date of the amendment to 7/20/12**