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: **12-51**

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: **August 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:
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY **2012** **($848.71)**
b. FFY **2013** **($3,211.00)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Item 2a, Page 1	**Same (TN 10-74)**
Attachment 4.19-B, Item 2a, Page 1a	**Same (TN 10-74)**
Attachment 4.19-B, Item 2a, Page 1a(1)	**Same (TN 10-74)**
***Attachment 4.19-B, Item 2a, Page 2**	**Same (TN 10-74)**
***Attachment 4.19-B, Item 2a, Page 2a**	**Same (TN 10-74)**
Attachment 4.19-B, Item 2a, Page 6a	**Same (TN 10-74)**
	* ~~Same (TN 10-74)~~ 12-49
	* ~~Same (TN 10-74)~~ Deleted from Submission

10. SUBJECT OF AMENDMENT: **The purpose of this SPA is to reduce the reimbursement rates paid to outpatient, non-rural, non-state and children's specialty hospitals by 3.7 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: **September 13, 2012**

16. RETURN TO:

J. Ruth Kennedy, 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: 13 September, 2012

18. DATE APPROVED: 22 August, 2013

PLAN APPROVED – ONE COPY ATTACHED

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

20. REGIONAL OFFICIAL:
Digitally signed by Billy D. Brooks -S
DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, ou=People, 0.9.2342.19200300.100.1.1=2000039050, cn=Billy D. Brooks -S
Date: 2013.08.29 12:54:40 -05'00'

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 10/2/12 removing Attachment 4.19-B Item 2a, page 2a from submission package. Corrected Superseding page for Attachment 4.19-B Item 2, page 2 to 12-49 approved 8/22/13.