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: **13-09**

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
February 1, 2013

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 **2013** **($535.44)**
b. FFY **2014** **($781.42)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, Item 19, Page 1a
Attachment 4.19-B, Item 19, Page 1a
Attachment 4.19-B, Item 19, Page 2
Supplement 1 to Att. 3.1-A, Page 1F & 1F(1)
Supplement 1 to Att. 3.1-A, Page 1F(2), 1F(3), 1F(4)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same (TN 08-13)
Pending (TN 12-31)
Same (TN 09-27)
Removed (TN 09-27)
Removed (TN 08-13)

10. SUBJECT OF AMENDMENT: The SPA proposes to revise targeted case management in order to terminate Medicaid reimbursement of TCM services to first time mothers in the Nurse Family Partnership Program.

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 19, 2013

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: 25 February, 2013

18. DATE APPROVED: 28 August, 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1 February, 2013

20. [illegible] OFFICIAL

Digitally signed by Billy D. Brooks -S.
DN: c=US, o=US. Government, ou=HHS, ou=CMS, ou=People, 0.9.2342.19200300.100.1.1=2000039050, cn=Billy D. Brooks -S
Date: 2013.09.04 09:42:05 -05'00'

21. TYPED NAME:
Bill Brooks

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

23. REMARKS:

FORM HCFA-179 (07-92)