

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

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

**10-34**

2. STATE

**Louisiana**

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

4. PROPOSED EFFECTIVE DATE

**August 2, 2010**

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 430.12(b)**

7. FEDERAL BUDGET IMPACT:

a. FFY **2010**      **\$0.00**  
b. FFY **2011**      **\$0.00**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

**Pre-Print 89**

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 PAGE NUMBER OF THE SUPERSEDED PLAN  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

**Same (TN 08-01)**

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is designate Tony Keck as the person authorized to sign Form 179 to submit changes to the Medicaid State Plan.**

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:

**Alan Levine**

14. TITLE:

**Secretary**

15. DATE SUBMITTED:

**July 29, 2010**

16. RETURN TO:

**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: **29 July, 2010**

18. DATE APPROVED: **30 September, 2010**

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

**2 August, 2010**

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

**BILL Brooks**

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

23. REMARKS:

Revision: HCFA-PM-97-4  
AUGUST 1991

(BPD)

OMB No. 0938-

State/Territory: LOUISIANA

Citation 7.4 State Governor's Review

42 CFR 430.12(b)

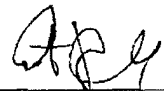
The Medicaid agency will provide the opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

- Not applicable. The Governor- -
- Does not wish to review state plan material.
- Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

DEPARTMENT OF HEALTH AND HOSPITALS  
(Designated Single State Agency)

Date: 8/2/2010

  
\_\_\_\_\_  
(Signature)

STATE	<u>Louisiana</u>
DATE REC'D	<u>7-29-10</u>
DATE APP'D	<u>9-30-10</u>
DATE EFF	<u>8-2-10</u>
HCFA 179	<u>10-34</u>

SECRETARY  
\_\_\_\_\_  
(Title)

TN# 10-34 Approval Date 9-30-10 Effective Date 8-2-10

Supersedes  
TN# 08-01

Superseded By 08-01