

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

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

**12-15**

2. STATE

**Louisiana**

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

4. PROPOSED EFFECTIVE DATE

**June 1, 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 E  
42 CFR 447, Subpart B  
42 CFR 438.50 and  
Section 1932 of Social Security Act**

7. FEDERAL BUDGET IMPACT:

a. FFY 2012      **\$0.00**  
b. FFY 2013      **\$0.00**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

**Attachment 3.1-F, Page 1, 1a, 4, and 5  
Attachment 3.1-F, Page 2  
Attachment 3.1-F, Page 3, 6, 7, 8, 9, 10, and 11  
Attachment 3.1-F, Pages 12 and 13**

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 PAGE NUMBER OF THE SUPERSEDED PLAN  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

**Same(TN 11-06)  
Same (TN 06-18)  
Same (TN 06-01)  
Same (TN 10-32)**

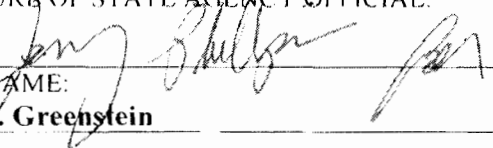
10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to terminate the CommunityCARE program due to the implementation of the BAYOU HEALTH program.**

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:

**May 24, 2012**

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:

**7 June, 2012**

18. DATE APPROVED:

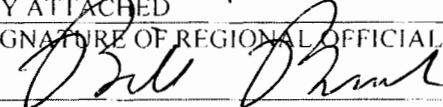
**5 September, 2012**

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

**1 June, 2012**

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

**Bill Brooks**

22. TITLE:

**Associate Regional Administrator  
Division of Medicaid & Children's Health**

23. REMARKS: