DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-019

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 11-018

2. STATE: Alabama

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: October 1, 2011

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 441.30

7. FEDERAL BUDGET IMPACT:
a. FFY 11 Cost to Agency $.00
b. FFY 12 Cost to Agency $.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
State Plan Amendment 3.1A page 2.5, Attachment 3.1-A page 2.5a, Attachment 3.1-A page 3, Attachment 3.1-A page 3.6, Attachment 4.19-B page 2a, Preprint page 27

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
State Plan Amendment 3.1A page 2.5, Attachment 3.1-A page 2.5a, Attachment 3.1-A page 3, Attachment 3.1-A page 3.6, Attachment 4.19-B page 2a, Preprint page 27

10. SUBJECT OF AMENDMENT:
This amendment will define services an optometrist is legally authorized to perform as physicians' services under this plan and are reimbursed whether furnished by a physician or an optometrist.

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: Governor's designee on file via letter with CMS

12. SIGNATURE OF STATE AGENCY OFFICIAL:
R. Bob Mullins Jr.

13. TYPED NAME:
R. Bob Mullins, Jr., MD

14. TITLE:
Commissioner

15. DATE SUBMITTED: 9-16-11

16. RETURN TO:
R. Bob Mullins, Jr., MD
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, Alabama 36103-5624

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/15/11

18. DATE APPROVED: 12/07/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/11

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Glaze

21. TYPED NAME:
Jackie Glaze

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

23. REMARKS:

FORM HCFA-179 (07-92)