



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: AL-12-013	2. STATE Alabama
FOR: HEALTH CARE FINANCING ADMINISTRATION		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 November 1, 2012	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.50; 447.252		7. FEDERAL BUDGET IMPACT: a. FFY 13 \$2,312,503(cost)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, pages 4 and 7		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B, pages 4 and 7	
10. SUBJECT OF AMENDMENT: The primary purpose for this amendment is to increase DME provider reimbursement to 80% of Medicare's allowable amount effective November 1, 2012.			
11. GOVERNOR'S REVIEW (<i>Check One</i>):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Governor's designee on file via letter with CMS	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Stephanie McGee Azar Acting Commissioner Alabama Medicaid Agency 501 Dexter Avenue Post Office Box 5624 Montgomery, Alabama 36103-5624	
13. TYPED NAME: Stephanie McGee Azar			
14. TITLE: Acting Commissioner			
15. DATE SUBMITTED: 11-1-12			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 11/01/12		18. DATE APPROVED: 01/29/13	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 11/01/12		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns	
23. REMARKS: Approved with the following changes to item 7 as authorized by State Agency e-mail dated 01/17/13: Block # 7 Changed to read: FFY13 \$3,213,000 and FFY14 \$3,590,000			