

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 10-009	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 Date July 1, 2010	
5. TYPE OF PLAN MATERIAL (Check One): <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 (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Section 431.53		7. FEDERAL BUDGET IMPACT: a. FFY 10 \$311,277.28 budget neutral (total dollars) b. FFY 11 \$401,244 budget neutral (total dollars)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-D, Page 1		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-D, Page 1	
10. SUBJECT OF AMENDMENT: To establish an improved method of reimbursement for approved transportation expenses through the use of electronic benefit transfer (EBT) for eligible Medicaid recipients requesting transportation assistance. Effective March 1, 2010, the voucher system was replaced with an EBT system. The NET payment methodology and reimbursement rates were not affected by this change.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO: Carol H. Steckel Commissioner Alabama Medicaid Agency 501 Dexter Avenue Post Office Box 5624 Montgomery, Alabama 36103-5624	
13. TYPED NAME: Carol H. Steckel			
14. TITLE: Commissioner			
15. DATE SUBMITTED: 6-22-10			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 06/22/10		18. DATE APPROVED: 08/11/10	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/10		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Opns	
23. REMARKS:			