
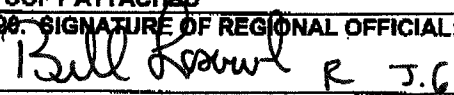


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 0 8 - 0 0 7	2. STATE: CO
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2008	
5. TYPE OF PLAN MATERIAL (Check one): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS A NEW PLAN <input checked="" type="checkbox"/> AMENDMENT X			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:		7. FEDERAL BUDGET IMPACT: a. FFY 2007-2008 \$4,527,948 (July - Sept) b. FFY 2008-2009 \$18,111,793 (Oct - Sept)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D Pages 1 - 499		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (if applicable): Attachment 4.19-D Pages 1 - 38	
10. SUBJECT OF AMENDMENT: To bring the State Plan into compliance with HB 08-1114, to be codified at 25.5-6-201 through 25.5-6-204, C.R.S. (2007) relating to setting administration and general reimbursement to a price; removing 8% per year limitation on the growth of health care costs; adding payments for cognitive loss/dementia and acquired brain injury, Level II PASRR residents, quality performance; and authority to charge and collect a provider fee.			
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 Governor's letter dated September 12, 2005 <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Colorado Department of Health Care Policy and Financing 1570 Grant Denver, Colorado 80203 Attn: Diane Taylor	
13. TYPED NAME: Sandeep Wadhwa, MD, MBA		15: DATE SUBMITTED: 09/30/08	
14. TITLE: Medicaid Director, Medical and Child Health Plan Plus Program Administration Office			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: 3-26-09	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2008		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: William Lasowski		22. TITLE: Deputy Director, CMSO	
23. REMARKS:			