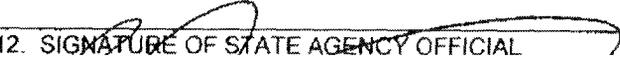


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER. 11-003	2. STATE: COLORADO
		3. PROGRAM IDENTIFICATION. TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE 1/1/2011	
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			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION 42 CFR 440.10		7. FEDERAL BUDGET IMPACT a. FFY09-10 \$0 b. FFY10-11 \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Supplement to Attachment 3.1-A: Limitations to Care and Services – 1.a. Inpatient hospital services and 1.b. Inpatient psychiatric care		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Supplement to Attachment 3.1-A: Limitations to Care and Services – 1.a. Inpatient hospital services and 1.b. Inpatient psychiatric care. TN #03-036	
10. SUBJECT OF AMENDMENT Clarifies the State's limitations on inpatient hospital services.			
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 Governor's letter dated 29 July 2009			
12. SIGNATURE OF STATE AGENCY OFFICIAL 		16. RETURN TO Colorado Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203-1818 Attn: Barbara Prehmus	
13. TYPED NAME Robert C. Douglas			
14. TITLE Legal Division Director			
15. DATE SUBMITTED 1/7/11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED 1/7/11		18. DATE APPROVED 4/1/11	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL 1/1/11		20. SIGNATURE OF REGIONAL OFFICIAL	
21. TYPED NAME D. Stephen Nose, CPA		Acting ARA, DMCHD	
23. REMARKS			

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM**

STATE OF COLORADO

Supplement to Attachment 3.1-A
Page 1 of 1

LIMITATIONS TO CARE AND SERVICES

1. Inpatient Hospital Services are benefits with the following limitations:

- (1) Inpatient hospital dialysis treatment is a benefit for inpatient clients only in these cases:
 - (a) hospitalization is required for an acute medical condition for which emergency dialysis treatments are required; or
 - (b) the client is admitted to the hospital for a non-related medical condition, and needs to receive the regular maintenance treatment that is usually received in an outpatient dialysis program; or
 - (c) placement or repair of the dialysis route (shunt or cannula).

- (2) Services that are defined as experimental by the U.S. Food and Drug Administration are not benefits.

TN No. 11-003
Supersedes TN No. 03-036

Approval Date 4/1/11
Effective Date 1/1/2011