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Title of Rule: Revision to the Medical Assistance Rule concerning Transition Coordination Services & Targeted Case Management – Transition Coordination (TCM-TC), Sections 8.519.27 and 8.763
Rule Number: MSB 23-10-25-C
Division / Contact / Phone: Office of Community Living / Nora Brahe / 303-866-3566

SECRETARY OF STATE

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: Revision to the Medical Assistance Rule concerning Transition Coordination Services & Targeted Case Management – Transition Coordination (TCM-TC), Sections 8.519.27 and 8.763

3. This action is an adoption of:

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections 8.519.27 and 8.763, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.519.27 with the proposed text beginning at 8.519.27.A through the end of 8.519.27.H. Replace the current text at 8.763 with the proposed text beginning at 8.763.A through the end of 8.763.D.1. This rule is effective March 30, 2024.

*to be completed by MSB Board Coordinator

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STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of the proposed these rule revisions is to expand eligibility for the Targeted Case Management Transition Coordination (TCM-TC) benefit and to describe new quality assurance processes to monitor compliance with all required transition coordination service standards and training guidelines. The standard to maintain TCM-TC provider approval in accordance with the quality assurance standards and requirements is established in the rule revision.

   A change in service eligibility will increase the number of members that transition from institutional settings. Transition coordination quality and performance standards will increase the probability of successful transitions and sustained community-based living.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. §1396n(c) and The Social Security Act, §1915(c).

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023)

Initial Review	**01/12/24**	Final Adoption	**02/09/24**
Proposed Effective Date	**03/30/24**	Emergency Adoption	

DOCUMENT #

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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Medicaid members who will be affected by the proposed rule are those who have expressed interest in moving to a community-based setting through the TCM-TC benefit. Excluded are children under the age of 18 and individuals between ages 22 and 64 who are served in Institutes for Mental Disease or individuals who are inmates of correctional facilities.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The probable quantitative and qualitative impact of the proposed rule is an increase in the number of members that may transition from institutional settings. Transition coordination quality and performance standards will also increase the probability of successful transitions and sustained community-based living.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The probable costs to the Department are an increase in staff time to review provider transition coordination agencies' performance and compliance with applicable Department rules and regulations. The proposed rule changes may also increase the utilization of community-based waiver and state plan benefits and decrease the utilization of other benefits and services related to institutional care.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The Department estimates that the probable quantitative and qualitative impact and benefits of the proposed rule listed above will outweigh any probable costs of increased staff time.

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5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   None. The cost associated with an increase in Department staff time can be absorbed within existing resources.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   None. No other alternative methods were seriously considered.

8.519.27 Transition Coordination Services

8.519.27.A Definitions

1. Case Management Agency (CMA)~~means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to Section 25.5.-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department~~ means a public, private, or non-governmental non-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-based Services waivers pursuant to § 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the ~~state d~~Department.

2. Community Needs and Preferences Assessment means the assessment that is completed by the Transition Options Team to ensure a comprehensive understanding of the member~~Member~~'s health conditions, functional needs, transition needs, behavioral concerns, social and cultural considerations, educational interests, risks, and other areas that may require services and/or community resource support.

3. Community risk level means the potential for a member~~Member~~ living in a community-based arrangement to require emergency services; to be admitted to a hospital, skilled nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities; to be evicted from their home; or to be involved with law enforcement due to identified risk factors.

~~1.~~4. Corrective Action Plan means a written plan by the Transition Coordination Agency, and approved by the Department, which includes a detailed description of actions to be taken to correct non-compliance with regulations, and/or direction from the Department, and which sets forth the date by which each action shall be completed and the persons responsible for implementing the action. Corrective Action Plans may be requested by the Department at any time.

~~2.~~5. Post-transition monitoring means the activities performed by a Transition Coordination Agency (TCA) that occur after a member~~Member~~ has successfully transitioned into the community and is a recipient of home-and community-based services.

~~3.~~6. Pre-~~T~~ttransition c~~C~~oordination means the activities by the TCA that occur before a member~~Member~~ has transitioned into the community to prepare the member~~Member~~ for success in community living and integration.

~~4.~~7. Risk factors means factors that include, but are not limited to, health, safety, environmental, community integration, service interruption, inadequate support systems, and substance abuse that may contribute to an individual's community risk level. ~~and potential for readmission to an institution.~~

~~5.~~8. Risk mitigation plan means the document that records the risk mitigation planning process. Risk mitigation plans are used to complete pre-transition strategy development,- conduct post-discharge monitoring of effectiveness of risk prevention strategies,~~; to~~ document identification of additional risk factors, and ~~to~~ revise risk incident response plans.

~~6.~~ Risk mitigation planning means the process of identifying risk factors, developing options and ~~a~~actions to enhance opportunities and prevent adverse consequences that would result if risk is not managed. Risk mitigation planning includes~~and~~ identifying planned actions to take in response to an adverse consequence should a risk be realized.~~Service plan means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid~~

~~services regardless of funding source, to assist a Member to remain safely in the community and developed in accordance with the Department regulations.~~

~~7.~~9. ~~119. Transition Coordination means support provided to a Member who is transitioning from a skilled nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities, or regional center and includes the following activities: comprehensive assessment for transition, community risk assessment, development of a transition plan, referral and related activities, and monitoring and follow up activities as they relate to the transition.Transition coordination means support provided to a member who is transitioning from a skilled nursing facility, extended SNF LOC hospital stay, intermediate care facility for individuals with intellectual disabilities, or regional center and includes the following activities: comprehensive assessment for transition, community risk assessment, development of a transition plan, referral and related activities, and monitoring and follow up activities as they relate to the transition.Transition coordination means support provided to a member who is transitioning from a skilled nursing facility, extended SNF LOC hospital stay, intermediate care facility for individuals with intellectual disabilities and/or developmental disabilities (ICF-IDD), or regional center and includes the following activities: comprehensive assessment for transition, community risk assessment, development of a transition plan, referral and related activities, and monitoring and follow up activities as they relate to the t~~

10. Transition assessment means the process of capturing a comprehensive understanding of the member~~Member~~'s health conditions, functional needs, transition needs, behavioral concerns, social and cultural considerations, educational interests, risks, and other areas important to community integration and transition to a home and community-based setting.

11. Transition coordination services means support provided to a member who is transitioning from a skilled nursing facility, extended SNF LOC hospital stay, Intermediate Care Facility for Individuals with Intellectual Disabilities, or regional center and includes the following activities: comprehensive assessment for transition, community risk assessment, development of a transition plan, referral and related activities, and monitoring and follow up activities as they relate to the transition.

~~8.~~12. Transition Coordinator (TC) means a person who provides t~~T~~ransition c~~C~~oordination s~~S~~ervices and meets all regulatory requirements for a TC.

~~9.~~13. Transition Coordination Agency ~~Transition Coordination a~~(TCA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide t~~T~~ransition c~~C~~oordination pursuant to a provider participation agreement with the Department.

~~10.~~14. ~~142. Transition CoordinatorTransition coordinator (TC) means a person who provides Transition Coordination Sservices and meets all regulatory requirements for a TCtransition coordinator143.~~ Transition O~~o~~ptions T~~t~~eam (TOT) means the group of people involved in supporting and implementing the transition. The TOT ~~,~~ includes~~to include~~ the person receiving services, the TC~~transition coordinator~~, and the ~~family,~~ guardian. The TOT may~~, or authorized representative and may~~ include the home- and community- based services case manager, nursing facility social worker and~~and~~ others chosen by the individual receiving services as being valuable to participate in the transition process. The TOT works in a cooperative and supportive manner to develop and implement the transition plan and to serve in an advocacy role with~~to~~ the member.

~~11.~~15. Transition period means the period of time in which the member receives t~~T~~ransition c~~C~~oordination services for the purpose of successful integration into community living. A transition period is complete when the m~~M~~ember has successfully established community residence and is no longer in need of t~~T~~ransition c~~C~~oordination services based on the member's

community risk level, or the member or guardian requests that TCM-TC services are discontinued.~~risk mitigation plan~~

~~12.~~16. Transition plan means the written document that identifies person-centered goals, assessed needs, and the choices and preferences of services and supports to address the identified goals and needs; appropriate services and additional community supports; outlines the process and identifies responsibilities of T~~t~~ransition O~~o~~ptions T~~t~~eam members; details a risk mitigation plan; and establishes a timeline that will support an individual in transitioning to a community setting of their choosing.

17. Transition planning means the completion of the TCM-TC community needs and preferences assessment and risk mitigation plan, facilitation of a transition recommendation, and developing~~mentof~~ a transition plan,~~ risk mitigation plan and dischrgetransition plan~~ in coordination with the T~~t~~ransition O~~o~~ptions T~~t~~eam.

~~13.~~18. Transition recommendation means a recommendation made by the transition options team regarding transition. The recommendation is made solely on availability of necessary supports and services identified by the community needs and preference assessment and the risk mitigation plan.

8.519.27.B Qualifications of Transition Coordination Agencies

1. In order to be approved as a TCA~~transition coordination agency~~, the agency shall meet all of the following qualifications:

    a. Have a physical location in Colorado.

    b. Be a public or private not-for-profit or for-profit agency.

    c. Demonstrate proof the agency has employed staff that meet TC~~transition coordinator~~ qualifications.

    d. Have a minimum of two years of agency experience in assisting at-risk~~high-risk, low income~~ individuals with~~to~~ accessing~~obtain~~ medical, social, education and/or other services. ~~Transition coordination agencies~~ TCAs providing transition coordination in Colorado prior to December 31, 2018 are exempt from this requirement.

    e. Provide transition coordination services to members who select the agency and also reside in the county/counties for which the agency has elected to provide services.

    f. Possess the administrative capacity to deliver transition coordination.

    g. Have established community referral systems and demonstrate ~~linkages and referral~~ ability to make community referrals for services with other agencies.

    h. Demonstrate ability to meet all applicable requirements contained within Section ~~8.125, 8.130,~~ 8.519.27, Section 8.763, the Medicaid State Plan, and the provider participation agreement.

    ~~i.~~ Financial reserves shall match one month of expenditures associated to the number of members expected through that catchment area and provide stability for TC~~transition coordinator~~s, members and service providers.

    ~~j.~~i. All agencies are required to submit an audited financial statement or equivalent to the Department for review upon request.~~annuall~~

~~k.~~j. Possess and maintain adequate liability insurance (including automobile insurance, professional liability insurance, and general liability insurance) to meet the Department's minimum requirements.

8.519.27.C Functions of all Transition Coordination Agencies

1. In order to be approved~~certified~~ ~~approved~~ as a TCA~~Transition Coordination Agency~~, the agency shall perform all of the following functions:

a. TCAs must be in compliance with all required agency performance standards and training guidelines to be in good standing with the Department. Failure to comply with required standards and training guidelines may result in suspension of referrals until a ~~corrective plan~~Corrective Action Plan is submitted by the TCA and approved by the Department.

~~a.~~b. TCAs~~ransition coordination agencies~~ shall be responsible for~~to~~ maintaining sufficient documentation, as defined in TCM-TC training, of all transition coordination activities performed and to support claims within the Department-designated data system and internal agency records.

~~b.~~c. TCAs~~ransition coordination agencies~~ may not provide guardianship services for any member for whom they provide transition coordination services.

~~c.~~d. TCAs~~ransition coordination agencies~~ shall be responsible for~~to~~ maintaining, or having~~e~~ access to, information about public and private, state and local services, supports and resources and shall make information available to the member and/or persons inquiring upon their behalf.

~~d.~~e. TCAs~~ransition coordination agencies~~ shall respond to referrals for transition coordination support within two business days and specify whether the referral is accepted or not by completing the Transition Services Referral Form.

~~e.~~f. TCAs~~ransition coordination agencies~~ shall assign and meet ~~schedule the first visit~~ with the member within 10 state business days after accepting a referral.

~~f.~~g. TCAs~~ransition coordination agencies~~ shall assign one primary person who ensures transition coordination is provided to~~on behalf o~~ the member.

~~g.~~h. TCAs~~ransition coordination agencies~~ shall provide coordination in accordance with state business days as defined in § 24-11-101(1), C.R.S.

~~h.~~i. TCAs ~~ransition coordination agencies~~ shall maintain all documents, records, communications, notes, and other materials that relate to any work performed.

~~i.~~j. TCAs ~~ransition coordination agencies~~ shall possess appropriate financial management capacity and systems to document and track services and costs in accordance with state and federal regulations.

~~j.~~k. TCAs shall ~~In accordance with reporting requirements of the Department's data system,~~ maintain and update records of persons receiving transition coordination ~~i~~n accordance with reporting requirements of the Department's data system.

~~k.~~l. TCAs~~ransition coordination agencies~~ shall establish and maintain working relationships with community- based resources, supports, and organizations, hospitals, service providers, and other organizations that assist in meeting the needs of members.

~~l.~~m. TCAs~~ransition coordination agencies~~ shall have a system for recruiting, hiring, evaluating, and terminating employees. Transition coordination agencies' employment policies and practices shall comply with all federal and state laws.

~~m.~~n. TCAs~~ransition coordination agencies~~ shall ensure staff have access to statutes and regulations relevant to the provision of authorized services and shall ensure that appropriate employees are oriented to the content of statutes~~statues~~ and regulations.

~~n.~~o. TCAs shall provide transition coordination for members without discrimination on the basis of race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression, or disability.

~~o.~~p. TCAs~~ransition coordination agencies~~ shall provide information and reports as required by the Department including, but not limited to, data and records necessary for the Department to conduct operations.

~~p.~~q. TCAs~~ransition coordination agencies~~ shall allow access by authorized personnel of the Department, or its contractors, for the purpose of reviewing services and supports funded by the Department and shall cooperate with the Department in evaluation of such services and supports.

~~q.~~r. TCAs~~ransition coordination agencies~~ shall establish agency procedures sufficient to execute t~~T~~ransition c~~C~~oordination according to the provisions of these regulations. Such procedures shall include, but are not limited to:

i. ~~1.~~ Referral m~~M~~anagement;~~.~~

ii. ~~2. Transition~~ Assessment of community needs and preferences;~~.~~

iii. ~~3.~~ Transition p~~P~~lanning;~~.~~

iv. ~~4.~~ Risk m~~M~~itigation p~~P~~lanning; ~~that identifies potential risk factors.~~

v. ~~5.~~ Service and support coordination for non-Medicaid transition-related services and supports;~~.~~

vi. ~~6.~~ Monitoring of the transition and transition plan review;~~.~~

vii. ~~7.~~ Denial and discontinuation of t~~T~~ransition c~~C~~oordination s~~S~~ervices;~~.~~

viii. ~~8. In the cas~~Management of interstate TCM-TC transfers; and ~~to another provider area, transition coordination may be transferred to the provider in the new geographic region with any remaining billable units.~~

ix. ~~9.~~ Complaint p~~P~~rocedure that includes the requirement to share information, such as points of contact within the agency, to members, families and referring agencies who may wish to file a complaint.~~.~~

8.519.27.D Qualifications of Transition Coordinators ~~Transition Coordinators~~

~~1.~~ TC~~Transition coordinator~~s must be employed by an approved TCA~~transition coordination agency~~. TC~~Transition Coordinator~~ minimum experience:~~1. Bachelor's degree in a human behavioral science or related field of study.~~

~~2.~~

~~3. a. Copy of degree or official transcript must be kept in the TCtransition coordinator's personnel file.~~

~~4. 2. If an individual does not meet the minimum requirement, the TCAtransition coordination agency shall request a waiver from the Department and demonstrate that the individual meets one of the following:~~

~~5. a. Experience working with LTSS population, in a private or public agency or lived experience, may substitute for the required education on a year for year basis; or~~

~~1. b. A combination of LTSS experience and education, demonstrating a strong emphasis in a human behavioral science field.~~

a. A bachelor's degree; or

b. Five years of relevant experience in the field of LTSS, which includes Developmental Disabilities; or

c. Some combination of education and relevant experience appropriate to the requirements of the position.

d. Relevant experience is defined as:

i. ~~1.~~ Experience in one of the following areas: long-term care services and supports; gerontology; physical rehabilitation; disability services; children with special health care needs; behavioral science; special education; public health or nonprofit administration; or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and,

~~i.~~ii. ~~2.~~ Completed coursework and/or experience related to the type of administrative duties performed by case managers may qualify for up to two years of required relevant experience.

~~ii.~~iii. ~~3.~~ For members for whom the TC~~transition coordinator~~ is providing transition coordination, TC~~transition coordinator~~s may not:

1) ~~a.~~ Be related by blood or marriage to the member.~~.~~

2) ~~b.~~ Be related by blood or marriage to any paid caregiver of the member.~~.~~

3) ~~c.~~ Be financially responsible for the member.~~.~~

4) ~~d.~~ Be the member's legal guardian, authorized representative, or be empowered to make decisions on the member's behalf through a power of attorney.~~.~~

8.519.27.E Training

1. TC~~Transition coordinator~~s must complete and document the following trainings within 90 days from the date of hire and prior to providing transition coordination services independently, and thereafter on an annual basis:

a. ~~1.~~ Assessment of community needs/preferences and risk factors;~~.~~

b. ~~2.~~ Transition p~~P~~lanning;~~.~~

c. ~~3~~ Risk mitigation plan development, monitoring and revision;~~.~~

d. ~~4.~~ Referral for non-Medicaid services;~~.~~

e. ~~5.~~ Monitoring services;~~.~~

f. ~~6.~~ Case documentation;~~.~~

g. ~~7.~~ Person-centered approaches to planning and practice; and~~.~~

h. ~~8.~~ Housing voucher application and housing navigation services~~.~~

8.519.27.F Functions of Transition Coordinators~~transition coordinators~~

1. TC~~Transition coordinator~~s shall ~~also~~ perform each of the following activities when providing Transition Coordination Services. These activities are the only activities billable under transition coordination:

   a. ~~1.~~ Coordinate ~~ion of the~~ T~~t~~ransition O~~o~~ptions T~~t~~eam (TOT) activities including ~~: members of the TOT are convened to work in a cooperative and supportive manner to develop and implement the transition plan, and to serve in an advocacy role to the individual. Responsibilities of team members are to~~:

      i. ~~a.~~ Facilitate completion of an assessment which identifies preferences, needs and any risk factors the member~~esident~~ may have in a ~~home or~~ community-based setting within six weeks of first meeting with the member.~~accepting a referral.~~

      ii. ~~b.~~ Facilitate ~~Facilitate~~~~Participate in the~~development of a risk mitigation plan to address identified risk factors within eight~~six~~ weeks of accepting a referral.~~.~~

      iii. ~~c.~~ ~~I~~identify~~ication of~~supports and services that will be required to address the member~~individual~~'s needs, preferences, and risk factors.~~.~~

      iv. ~~d. Conduct service brokering for non-Medicaid services to determine if the identified necessary supports and services are available at the frequency~~ Solidify a transition recommendation from the TOT within six ~~eight (8)~~ weeks of ~~TCA~~ first meeting with the member ~~acceptance of the referral~~ but not before the first TOT meeting.

      ~~v. from the TOT within 10 weektransiti.on coordination agency| from the first TOT meetingbut not before the first TOT meeting,unless the member member chooses to opt out of transition services.~~

      ~~vi.~~v. ~~d~~f. Facilitate completion of a transition plan if the member chooses to proceed with the transition.~~.~~

   b. Conduct ~~Conduct~~ p~~P~~re-transition coordination includinges~~s~~:

      i. Facilitate completion of transition assessment, risk mitigation, and transition plans.~~.~~

ii. Complete, as needed, housing voucher application, including assistance to obtain necessary documents.~~.~~

iii. Collaborate, as needed, with housing navigation services to obtain a voucher and locate housing.~~.~~

iv. Assist member to create a transition budget.~~.~~

v. Collaborate with housing navigation services, Division of Housing, voucher administrators, and property managers to establish ~~Collaborate with housing navigation services, Division of Housing, voucher administrators and property managers to establish Facilitate~~ a community-based living arrangement.~~.~~

vi. Coordinate any medication, home modification, and/or durable medical equipment needs with the nursing facility or HCBS case manager ~~as needed~~ prior to discharge to ensure that all components of the transition~~of transition~~ plan are in place prior to ~~a~~ discharge.~~.~~

vii. Assist member in preparing for discharge, including being present at the nursing facility on the day~~on day~~ of discharge to ensure requirements of discharge plan are addressed.~~.~~

viii. Meet with the member at their~~new~~ home on the day of discharge to ensure that providers and ~~s~~services needed upon discharge ~~a~~re in place and the household set-up is complete.~~.~~

~~c.~~ ~~c.~~ Conduct ~~Conduct~~ p~~P~~ost-transition monitoring that~~shall~~ meets ~~t~~he member's need as documented ~~based on the member's community risk level as documented~~ in the risk mitigation plan and occurs~~and. Occur~~ at the frequency and type to meet the member's community risk level ~~documented in the:~~. Post-transition monitoring includes:

c.

i. Ensuring that members receive services in accordance with their transition plan and risk mitigation plan.

ii. Provision of support services to aid in sustaining community-based living

iii. Response to risk incidents and notifying the CMA and Adult Protection Services (APS) as required.

iv. Revision of risk mitigation plan as needed.

v. Assessing the need for independent living skills training.

vi. Problem-solving community integration issues.

vii. Supporting community integration activities

viii. Monitoring service provision, to include contacting guardians, providers, and case management agencies.

ix. Requesting that member completes a TCM-TC satisfaction survey prior to discharge and at the end of the transition period to evaluate the member's experience of the following:

1) Transition planning.

2) Transition plan implementation.

3) Transition coordination process.

4) Level and adequacy of services provided.

5) Overall member satisfaction.

~~d. a. The transition coordinatorshal~~

~~e.~~d. ~~b. Revising~~ Monitoring and follow-up activities include making necessary changes to ~~the transition plan and risk~~ the risk mitigation plan ~~as neec. The level of monitoring shall occur at the frequency and type to meet the member's community risk level. b~~d. ~~Post-transition m~~monitoring ~~P~~Post-transition monitoring may include as determined by the community risk level:

i. Face-to-face in the member's residence.~~.~~

ii. Face-to~~-~~ face in the community~~in community~~.

~~iii.~~ Telephone~~,~~ ~~or~~ electronic, video or virtual communication.~~.~~

~~iii.~~

~~1. 2. 4. Post-transition monitoring includes:~~

~~a. E~~ensuring~~e~~ that members receive services in accordance with their transition plan and risk mitigation plan. and monitor that necessary the quality and adequacy of the services and supports are being provided to members.

~~a. Provision ofde support services to aid in sustaining community-based living..~~

~~b. Responsed to risk incidents and notifying fy the CMA and Adult Protection Services (APS) as required.case manager.~~

~~c. Revision ofe risk mitigation plan as needed..~~

~~d. Assessing the need for independent living skills training..~~

~~e. Problem solvinge community integration issues..~~

~~f. Supporting community integration activities..~~

~~g. Monitoring service provision, to include contacting guardians, providers, and case management agencies..~~

~~h. Requesting that Complete member completes a TCM-TC satisfaction survey prior to discharge and at the end of the transition period to evaluate the member's experience of the following:~~

~~i. TransitionService planning..~~

~~ii. Transition plan implementation..~~

~~iii. Transition coordination process..~~

~~iv. Level and adequacy of services provided..~~

~~v. Overall member satisfaction..~~

~~5.~~ Post-transition monitoring may not duplicate services for Life Skills Training (LST), defined in 10 C.C.R. 2505-10, § 8.553.3; Transition Setup defined in 10 C.C.R. 2505-10, § 8.553.4; Home Delivered Meals, defined in 10 C.C.R. 2505-10, § 8.553.5; and Peer Mentorship, defined in 10 C.C.R. 2505-10, § 8.553.6.

8.519.27.GF ~~Certification of~~ Transition Coordination Agencies Approval

1. A TCA shall maintain Department provider approval~~certification~~ in accordance with quality assurance standards and requirements set forth in the Department's rules and direction. Department approval is needed for continued receipt of TCM-TC referrals.

    a. Approval ~~Certification~~ as a TCA shall be based on an evaluation of the agency's performance in the following areas:

        i. The frequency of requests for TCA changes and/or complaints received by the Department pertaining to agency performance;

        ii. The agency's compliance with program requirements, including compliance with transition coordination standards adopted by the Department;

        iii. The agency's performance of administrative functions, including, timely reporting, program management, on-site visits to individuals, community coordination and outreach and individual monitoring;

        iv. Financial accountability;

        v. The maintenance of qualified and trained personnel to perform transition coordination duties;

        vi. Continual performance and quality assurance activities; and

        vii. Overall member satisfaction as indicated by member satisfaction surveys.

2. ~~1.~~ The Department or its designee shall conduct reviews of the TCA.

At least 60 days prior to expiration of the previous~~year's~~ approval date~~certification,~~ the Department shall notify the TCA of the outcome of the review, which may be approval, provisional approval, or denial of approval.~~certification~~

~~14.~~

8.519.27.HG Conflict of Interest for Transition Coordination Agencies

1. ~~If an agency provides both HCBS case management and transition coordination, the same employee must provide both services to a member who is transitioning to an HCBS setting~~If a TCA~~transition coordination agency~~ also provides services under HCBS waivers, a policy must be in place to avoid conflicts of interest and provide a free choice of providers to members. The HCBS case management agency shall be responsible for all service brokering for Medicaid HCBS services.

8.763 TARGETED CASE MANAGEMENT - TRANSITION COORDINATION

8.763.A Definitions

1. Transition coordination means support provided to a ~~client~~member who is transitioning from a congregate setting other than an assisted living facility ~~skilled nursing facility, intermediate care facility for individuals with intellectual disabilities, or regional center~~ and includes the following activities: comprehensive assessment for transition, community risk assessment, development of a transition plan, referral and related activities, and monitoring and follow up activities as they relate to the transition.

8.763.B Eligibility

1. To be eligible for Transition Coordination, ~~client~~members must be adult Medicaid recipients ~~who are eligible for Home and Community Based Services~~, who reside in a congregate setting other than an assisted living facility ~~nursing home or, Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF-IDD), or Regional Center,~~ and are willing to participate and have expressed interest in moving to a home and community-based setting. ~~Client~~Members may also be Medicaid recipients receiving Home and Community Based Services provided by the State operated Regional Centers who want to transition to a private Home and Community Based Services Provider. Services are expected to begin while an individual is living in a facility and continue through transition and integration into community living, based on the community risk assessment. Excluded are children under the age of 18.

8.763.C Services

1. Transition Coordination is provided pursuant to 10 CCR 2505-10, section 8.519.27.

8.763.D Limitations on Service

1. Transition coordination is limited to 360 ~~240~~ units per ~~client~~member per transition. A unit of service is defined as each completed 15-minute increment that meets the description of a Transition Coordination activity. When an individual has a documented need for additional units, the 360-unit cap may be exceeded to ensure the health and welfare of the ~~client~~member. The Transition Coordinator shall submit documentation to the Department including:

    1. A copy of the community risk assessment describing the ~~client~~member's current needs.

    2. The number of additional units requested.

    3. A history of transition coordination units provided to date and outcomes of those services

    4. An explanation of the additional transition coordination supports to be provided by the transition coordinator using any additional approved units.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule Concerning Specialty Drug Carveout from DRG Payments, Section 8.300.5.
Rule Number: MSB 23-12-16-A
Division / Contact / Phone: Fee for Service Rates / Andrew Abalos / 2130

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 23-12-16-A, Revision to the Medical Assistance Act Rule Concerning Specialty Drug Carveout from DRG Payments, Section 8.300.5.

3. This action is an adoption of: new rules

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.300.5, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text beginning at 8.300.5.D.3 through the end of 8.300.5.D.3. This rule is effective March 30, 2024.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule Concerning Specialty Drug Carveout from DRG Payments, Section 8.300.5.
Rule Number: MSB 23-12-16-A
Division / Contact / Phone: Fee for Service Rates / Andrew Abalos / 2130

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Currently, the Department of Health Care Policy and Financing reimburses hospitals for the provision of inpatient services to Health First Colorado members using the All-Patient Refined Diagnosis Related Groups (APR DRG) methodology, which is a prospective payment system developed by 3M which relies on statistical and clinical analysis of historic data to prospectively determine reimbursement for inpatient hospital stays. As this method relies on historic data, it does not consider hospital charge data for new-to-market specialty drugs in its reimbursement calculations. The purpose of this rule change is to allow for the reimbursement of these drugs outside of the APR DRG methodology to reduce barriers to care.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);

Initial Review — Final Adoption **02/09/24**
Proposed Effective Date **03/30/24** — Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule Concerning Specialty Drug Carveout from DRG Payments, Section 8.300.5.
Rule Number: MSB 23-12-16-A
Division / Contact / Phone: Fee for Service Rates / Andrew Abalos / 2130

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Persons benefiting from the proposed rule are Health First Colorado patients requiring the use of these specialty drugs, as the rule will increase access to these drugs. Inpatient hospitals may bear the cost of the proposed rule when providing these specialty drugs if the payment rate is less than the acquisition cost of the drug, but in general this will increase reimbursement rates associated with this drug compared to inaction. The Department will bear the costs of the proposed rule.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Inpatient hospitals may bear the cost of the proposed rule when providing these specialty drugs if the payment rate is less than the acquisition cost of the drug, but in general this will increase reimbursement rates associated with this drug compared to inaction. The benefit of this rule is a probable reduction in death relating to the illnesses and conditions within the Health First Colorado population.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The probable cost to the Department for the payment of these specialty drugs in the inpatient hospital setting is $77,831,719 annually. This has been included in the Department's FY 2024-25 R-1 request for Medical Services Premiums.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   If this rule change is not adopted, inpatient payment rates will remain unable to adequately reimburse for specialty drugs. This discrepancy will continue to present a barrier to care for Health First Colorado members requiring access to these drugs. The benefit of inaction is not incurring additional costs for the drugs. The cost of the proposed rule is the additional costs for the drugs; the benefit is increased access to specialty drugs.

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5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   The Department determined that this was the least costly and intrusive method for achieving the purpose of this proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The Department considered updating the APR DRG methodology to a new version which would include some of the costs for some specialty drugs that have recently entered the market, but this was rejected as the APR DRG methodology would not fully incorporate the costs of these drugs for several years. Additionally, the time required for implementation would not mitigate the concerns around access to care in the interim. Lastly, an ongoing method for reimbursing these drugs is required as 3M's system will always depend on historic costs and cannot reasonably foresee the utilization patterns for new to market specialty drugs.

8.300 HOSPITAL SERVICES

8.300.5 Payment for Inpatient Hospital Services

8.300.5.D APR-DRG Payment Methodology Exclusions

1. Long-acting reversible contraceptives (LARC) devices, inserted following a delivery, are excluded from the DRG Relative Weight calculation and are paid according to the Department's fee schedule.

2. Pursuant to § 25.5-5-509, C.R.S. opiate antagonists identified by the Department shall be paid according to the Department's fee schedule when dispensed to a medical assistance recipient upon discharge.

3. Effective January 1, 2024, for services meeting the criteria of an Inpatient Hospital Specialty Drug that would have otherwise been compensated through the APR-DRG methodology, a hospital must submit a request for authorization to the Department prior to administration of the drug. If the request is approved, then the payment will be negotiated between the Department and the hospital on a case-by-case basis.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medicaid Assistance Rule Concerning the Hospital Expenditure Report Data Collection, 8.4000
Rule Number: MSB 23-12-26-C
Division / Contact / Phone: Special Financing / James Johnston / 303-866-3703

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 23-12-16-C, Revisions to the Medicaid Assistance Rule Concerning the Hospital Expenditure Report Data Collection, 8.4000

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.4000, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.4000 with the proposed text beginning at 8.4000 through the end of 8.4003.C.1. This rule is effective March 30, 2024.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medicaid Assistance Rule Concerning the Hospital Expenditure Report Data Collection, 8.4000
Rule Number: MSB 23-12-26-C
Division / Contact / Phone: Special Financing / James Johnston / 303-866-3703

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The proposed rule adds a new section to Medicaid Assistance Rule Concerning Hospital Expenditure Report Data Collection, Section 8.4000. With recently enacted legislation, House Bill 23-1226: Hospital Transparency and Reporting Requirements, hospitals are required to submit quarterly financial data to the Colorado Department of Health Care Policy & Financing (HCPF) beginning with the last quarter of calendar year 2023. This rule will outline requirements and parameters for hospitals to submit quarterly financial information to HCPF, and in doing so, HCPF will reduce administrative burden for both hospitals and HCPF.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   House Bill 23-1226: Hospital Transparency and Reporting Requirements became law on August 6, 2023. With the legislation, HCPF is required to collect quarterly financial information from hospitals. To comply with this new law HCPF, is proposing rules regarding submission of this required information in an effective and timely manner.

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
   Section 25.5-4-402.8(2)(b)(IV)(A)

Initial Review — Final Adoption **02/09/24**
Proposed Effective Date **03/30/24** — Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medicaid Assistance Rule Concerning the Hospital Expenditure Report Data Collection, 8.4000
Rule Number: MSB 23-12-26-C
Division / Contact / Phone: Special Financing / James Johnston / 303-866-3703

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The proposed rule requires general, acute care hospitals to submit quarterly financial reports to HCPF on a rolling basis. Citizens of Colorado will benefit from increased financial transparency of Colorado's hospitals, which may result in reduced costs of care for Coloradans.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Multiple studies including the Institute of Medicine (US) Roundtable on Evidence-Based Medicine's The Healthcare Imperative: Lowering Costs and Improving Outcomes (2010), Health care opinion leaders' view on the transparency of health care quality and price information in the United States (2007), and The effects of mandatory transparency in financial market design (2019) have documented that increased financial transparency in economic markets reduces costs for goods and services. Within economic theory, as a market becomes more transparent, more competition is observed, and as competition increases consumers have more buying power. Increased buying power for consumers leads to a reduction in prices from producers. This rule will benefit Coloradans purchasing health care and health care services.

   Institute of Medicine (US) Roundtable on Evidence-Based Medicine; Yong PL, Saunders RS, Olsen LA, editors. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington (DC): National Academies Press (US); 2010. 10, Transparency of Cost and Performance. Available from: https://www.ncbi.nlm.nih.gov/books/NBK53921/

   Shea K, Shih A, Davis K. Health care opinion leaders' views on the transparency of health care quality and price information in the United States. 2007

   Asquith, P., Pathak, P., & Covert, T. (2019). The effects of mandatory transparency in financial market design -NBER. https://www.nber.org/system/files/working_papers/w19417/w19417.pdf

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3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   With the enactment of HB 23-1226, the General Assembly appropriated administrative resources to implement and administer the data collection and analysis. The proposed rule does not create a fiscal impact on the state's general fund.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   This proposed rule provides appropriate guidance so hospitals can submit accurate information in compliance with the new law. The proposed rules are needed to implement the legislation, create no additional costs, and there are no benefits of inaction.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   The proposed rule provides necessary guidance for hospitals to comply with the new law. The proposed rule reduces the administrative burden for both HCPF and hospitals by providing that hospitals can submit information that is already produced internally for executives and boards of directors as an alternative to completing a separate document.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   Since the legislation requires all Colorado general, acute care hospitals to provide quarterly financial information, and this proposed rule standardizes how information is to be provided in the least burdensome manner, there are no alternative methods for implementing the legislation.

8.4000

PURPOSE: To supply data for the Hospital ~~Expenditure~~ Financial Transparency Report, which is an annually prepared written report detailing uncompensated hospital costs and the different categories of expenditures, by major payer group, made by hospitals in the state.

8.4001.A DEFINITIONS

1. "Certified Financial Statements" means financial statements, along with accompanying notes, that have been prepared in accordance with Generally Accepted Accounting Principles and that have been audited by an independent certified public accountant(s) in accordance with generally accepted auditing standards.

2. "Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and certified as a critical access hospital by the Colorado Department of Public Health and Environment.

3. "DATABANK Program" means the Colorado Hospital Association program that collects hospital utilization and financial data.

4. "Enterprise Board" means the Colorado Healthcare Affordability and Sustainability Enterprise Board described at § 25.5-4-402.4(7), C.R.S..

5. "General Hospital" means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

6. "Health System" is a larger corporation or an organizational structure that owns, contains, or operates more than one hospital.

7. "Long Term Care Hospital" means a General Hospital that is certified as a long-term care hospital by the Colorado Department of Public Health and Environment.

8. "Medicare Cost Report" means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS, and the annual required submission of worksheets and schedules by Medicare certified providers used for Medicare reimbursement.

9. "Psychiatric Hospital" means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

10. "Quarterly Financial Statements" means internal unaudited financial statements including an income statement and balance sheet prepared in accordance with Generally Accepted Accounting Principles.

~~10.~~11. "Rehabilitation Hospital" means an inpatient rehabilitation facility.

8.4002 RESPONSIBILITIES OF THE DEPARTMENT AND HOSPITALS

8.4002.A STATEMENT SUBMISSION

1. For the purposes of compiling historic data for the Hospital ~~Expenditure~~ Financial Transparency Report, all General Hospitals and Critical Access Hospitals shall submit Certified Financial Statements and Medicare Cost Reports for all fiscal periods ending after January 1, 2012 through the most recently available fiscal period.

a. Hospitals shall submit within fifteen (15) days of the effective date of this rule.

2. For the purposes of ongoing data compilation for the Hospital ~~Expenditure~~ Financial Transparency Report, all General Hospitals and Critical Access hospitals shall submit their Certified Financial Statements and Medicare Cost Reports.

   a. Hospitals shall submit a Certified Financial Statement within 120 days after the end of its fiscal year, unless the Department grants an extension in writing in advance of that date.

   b. Hospitals shall submit annual Medicare Cost Reports to the Department within thirty (30) days after submitting them to CMS.

3. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from submitting Certified Financial Statements and Medicare Cost Reports.

4. For a hospital that operates within a Health System or other corporate structure, and is normally included in the Health System or other corporate structure's Certified Financial Statements

   a. The hospital may submit the Health System or other corporate structure's Certified Financial Statements if the statements separately identify the financial information for each licensed hospital operating in the state including:

      i. A statement of operations.

      ii. A balance sheet.

      iii. If available, a statement of changes in net assets (or equity).

      iv. If available, a statement of cash flows.

   b. For hospitals in which the consolidated Certified Financial Statements do not separately identify the financial information for each licensed hospital operating in the state, then the hospital shall submit the financial statements that were submitted with its Medicare Cost Report shall submit a reconciliation of the consolidated financial statement and hospital-specific revenue and expenses reported on the Medicare Cost Report pursuant to the federal centers for Medicare and Medicaid services provider reimbursement manual form 339.

5. If total revenues and total expenses on the submitted financial statements differ from the Medicare Cost Report, the hospital shall submit a reconciliation.

6. A hospital may choose to submit a written explanation of operating, investing, or financing decisions that impact the interpretation of the Certified Financial Statements or Medicare Cost Report.

7. A hospital may choose to submit a written explanation detailing changes in reporting methodology between fiscal periods that would impact the interpretation of the statements and what period may be affected. Examples of reporting methodologies that could change include:

   a. Measurements of financial assets and liabilities.

   b. Recording of retirement benefit plans.

   c. Recording of income tax expense.

d. Rates of depreciation.

8. The Department is not responsible for the review and authentication of the Certified Financial Statements and the Medicare Cost Report. The authentication of the submitted Certified Financial Statements and the Medicare Cost Report is the responsibility of the hospital or Health System.

9. Submissions shall be certified by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

8.4002.B REPORTING SUBMISSION

1. For the purposes of compiling historic data for the Hospital ~~Expenditure~~ Financial Transpareny Report, hospitals shall report utilization and financial information for fiscal periods ending after January 1, 2012 through the most recently available fiscal period if such information is available. The Department shall make available or distribute a data reporting template to all hospitals.

   a. The Department shall include instructions for completing the data reporting template, including definitions and descriptions of each reported data field, which will include at a minimum those items required by C.R.S. § 25.5-4-402.8(2)(b)(III).

   b. The Department may allow hospitals to submit data submitted to the DATABANK Program as an alternative to the Department's reporting template. The Department shall instruct hospitals what is an acceptable DATABANK Program submission.

   c. Hospitals shall return the completed reporting template to the Department within fifteen (15) days after receiving the request or on the stated due date, whichever is later.

2. For the purposes of ongoing data compilation for the Hospital Expenditure Report, hospitals shall report utilization and financial information on the hospital for the requested fiscal year. The Department shall make available or distribute a data reporting template to all hospitals.

   a. The Department shall inform hospitals of the fiscal period of the request.

   b. The Department shall include instructions for completing the data reporting template, including definitions and descriptions of each reported data field, which will include at a minimum those items required by C.R.S. § 25.5-4-402.8(2)(b)(III).

   c. Hospitals shall return the completed reporting template to the Department within thirty (30) days after receiving the request or on the stated due date, whichever is later.

3. Hospitals shall submit a roll-forward schedule detailing the changes in property, plant, and equipment balances from the beginning to the end of the reporting period.

   a. Changes shall be appropriately categorized as either purchases, other acquisitions, sales, disposals, depreciation expense or other changes. Significant amounts categorized as other changes should be separately described. The roll-forward schedule should provide details of changes by property, plant, and equipment category including, but not limited to land, buildings, buildings – accumulated depreciation, building improvements, building improvements – accumulated depreciation, leasehold improvements – leasehold improvements – accumulated depreciation, equipment, equipment – accumulated depreciation, other and other – accumulated depreciation. The beginning and ending balances on the roll-forward schedule should agree to the respective balance sheet.

4. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the reporting submission.

5. The Department shall determine the reasonableness of the data submitted by comparing it to the submitted Certified Financial Statement.

6. Submissions shall be certified by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

8.4002.C DEPARTMENT REPORTING & TRANSPARENCY

1. The Department is responsible for the compilation of the hospital submissions.

2. The Department shall consult with the Enterprise Board on the structure and format of the Hospital Expenditure Report at the Enterprise Board meetings.

3. The Department shall share the hospital's data in the Hospital ~~Expenditure~~ Financial Transparency Report and a copy of the report with the hospital a minimum of fifteen (15) days before the report is publicly available or issued to the Enterprise Board.

4. After the collection and review of the data submission, a machine-readable format of the hospital data shall be made available to the statewide hospital association at no cost to the association.

8.4003 RESPONSIBILITIES OF THE DEPARTMENT AND HOSPITALS FOR QUARTERLY REPORTING REQUIREMENTS

8.4003.A QUARTERLY STATEMENT SUBMISSIONS

1. All General Hospitals and Critical Access Hospitals shall submit Quarterly Financial Statements within ninety (90) days of the end of the calendar quarter.

2. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from submitting Quarterly Financial Statements.

3. For a hospital that operates within a Health System or other corporate structure, and is normally included in the Health System or other corporate structure's Quarterly Financial Statements, the hospital may submit the Health System or other corporate structure's Quarterly Financial Statements.

4. A hospital may choose to submit a written explanation detailing changes in reporting methodology between fiscal periods that would impact the interpretation of the statements and what period may be affected. Examples of reporting methodologies that could change include:

    a. Measurements of financial assets and liabilities.

    b. Recording of retirement benefit plans.

    c. Recording of income tax expense.

    d. Rates of depreciation.

5. The Department is not responsible for the review and authentication of the Quarterly Financial Statements. The authentication of the submitted Quarterly Financial Statements is the responsibility of the hospital or Health System.

6. Submissions shall be certified by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer.

8.4003.B QUARTERLY REPORTING SUBMISSION

1. For the purposes of ongoing quarterly data compilation for the Hospital Financial Transparency Report, hospitals shall report Quarterly Financial Statements for the requested quarter. The Department shall make available or distribute a data reporting template to all hospitals.

   a. The Department shall inform hospitals of the time period of the request.

   b. The Department shall include instructions for completing the data reporting template, including definitions and descriptions of each reported data field, which will include at a minimum those items required by C.R.S. § 25.5-4-402.8(2)(b)(IV)(A).

   c. Hospitals shall return the completed reporting template to the Department within ninety (90) days after receiving the request or on the stated due date, whichever is later.

8.4003.C DEPARTMENT QUARTERLY REPORTING & TRANSPARENCY

1. The Department is responsible for the compilation of the hospital Quarterly Financial Statement submissions.

2. The Department shall provide any analysis, report, or presentation based on the Quarterly Financial Statements to each hospital at least fifteen (15) days prior to the public release of any analysis, report, or presentation. The Department shall clearly state any analysis, report, or presentation based on Quarterly Financial Statements is unaudited when applicable.

3. After the collection and review of the Quarterly Financial Statement submissions, a machine-readable format of the hospital data shall be made available to the statewide hospital association at no cost to the association.