DO NOT PUBLISH THIS PAGE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 23-10-23-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 23-10-23-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)? Yes
   If yes, state effective date: 01/01/2024
   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 January 1, 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DO NOT PUBLISH THIS PAGE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 23-10-23-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:

   The current reimbursement methodology produces payment barriers as it does not adequately reimburse for specialty drugs. This rule change is imperatively necessary as it establishes a means for the Department of Health Care Policy and Financing to reimburse using a method that better aligns payment and cost for these drugs, allowing access to critically needed care.

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
Proposed Effective Date **01/01/24** Emergency Adoption **12/08/23**

DOCUMENT #09

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 23-10-23-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.

DO NOT PUBLISH THIS PAGE

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: Revision to the Medical Assistance Act Rule concerning Habilitative Services, Section 8.017.F.1-2
Rule Number: MSB 23-10-27-A
Division / Contact / Phone: Health Policy Office / Erica Schaler / 3195

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 23-10-27-A, Revision to the Medical Assistance Act Rule concerning Habilitative Services

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):

   Section(s) 8.017.F.1-2, 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)? Yes
   If yes, state effective date: 12/09/23
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.017 with the proposed text beginning at 8.017.F.2.a. This rule is effective December 9, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Habilitative Services, Section 8.017.F.1-2
Rule Number: MSB 23-10-27-A
Division / Contact / Phone: Health Policy Office / Erica Schaler / 3195

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 removes the 5-unit daily limit and the 48 unit per fiscal year limit from Habilitative Physical or Habilitative Occupational Therapy. Additionally, the proposed rule removes the 5 unit per date of service limit from Habilitative Speech Language Pathology services. The current rule will not align with the State Plan nor the Alternative Benefit Plan as these limits have been removed from both the State Plan and the Alternative Benefit Plan.

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:

   The current rule will not align with changes made to the state plan and the alternative benefits plan. Both the 5-unit daily limit and the 48-unit fiscal year limit have been removed from both the state plan and the alternative benefit plan pending CMS approval.

3. Federal authority for the Rule, if any:

   42 CFR 440.110

4. State Authority for the Rule:

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

Initial Review
Proposed Effective Date **12/09/23**
Final Adoption
Emergency Adoption **12/08/23**

DOCUMENT #11

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Habilitative Services, Section 8.017.F.1-2
Rule Number: MSB 23-10-27-A
Division / Contact / Phone: Health Policy Office / Erica Schaler / 3195

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 classes of persons who will be affected by the proposed rule include Medicaid members receiving Habilitative Physical or Habilitative Occupational Therapy and Medicaid members receiving Habilitative Speech Language Pathology services. The proposed rule will increase access to care by removing daily and annual limits on these services.

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

   Medicaid members have increased access to Habilitative Physical or Occupational Therapy and Habilitative Speech Language Pathology services.

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.

   Budget reviewed the proposed rule and has estimated the total annual cost to be $669,528. The state share of this expenditure is approximately $334,764.

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

   The probably cost of the proposed rule is provided in response to question #3 above. The benefit of the proposed rule is increased access to Habilitative Physical or Occupational Therapy and Habilitative Speech Pathology services. The cost of inaction is the restriction of access to these services and misalignment with the state plan and the alternative benefits plan. There is no benefit to inaction.

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

   There are no less costly methods or less intrusive methods to expand coverage of Habilitative services to Medicaid members.

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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.

   There are no alternative methods for expanding coverage of Habilitative Services for Medicaid members.

8.017 HABILITATIVE SERVICES

8.017.A DEFINITION

Habilitative services means services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in the Alternative Benefit Plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.

8.017.B COVERED SERVICES

Habilitative therapy services shall have parity in amount, scope, and duration to rehabilitative therapies and will only consist of physical, occupational, and speech-language pathology services.

8.017.C ELIGIBLE CLIENTS

Habilitative services shall only be available to the eligibility categories described in § 8.016.A.

8.017.D ELIGIBLE PROVIDERS

8.017.D.1 Habilitative Physical Therapy services shall only be provided by a licensed physical therapist who is an approved Medicaid provider or a physical therapist assistant under the general supervision of a licensed physical therapist who is an approved Medicaid provider.

8.017.D.2 Habilitative Occupational Therapy services shall be provided by a licensed occupational therapist who is an approved Medicaid provider or an occupational therapy assistant under the general supervision of a licensed occupational therapist.

8.017.D.3 Habilitative Speech Language Pathology services shall be provided by any of the following:

a. A certified speech language pathologist with a current certification issued by the Department of Regulatory Affairs;

b. A clinical fellow under the general supervision of an American Speech-Language-Hearing Association (ASHA) certified speech language pathologist; or

c. A speech language pathology assistant with an associate degree from a program in which the individual received technical training in the scope of work recommended by ASHA for speech language pathology assistants.

8.017.E PRIOR AUTHORIZATION OF SERVICES

A medical prescription is required for covered services. The provider shall be responsible for submitting a prior authorization request that includes the medical prescription to the Department's designee for all covered services in 8.017.B. Following the receipt of a complete request, the Department's designee shall approve or deny all requests for prior authorization and shall determine the length of time that the service is medically necessary. A prior authorization request shall be effective for a length of time not to exceed 12 months.

8.017.F LIMITATIONS

~~8.017.F.1. Clients accessing Habilitative Physical or Habilitative Occupational Therapy are limited to 5 units per date of service and 48 units per state fiscal year (July 1 to June 30). A unit is defined by the current procedural terminology (CPT) code.~~

8.017.F.~~2~~1 For Habilitative Speech Language Pathology:

~~a. Services are limited to 5 units per date of service. A unit is defined by the current procedural terminology (CPT) code.~~

~~b.~~a. Diagnostic procedures provided by an audiologist for the purpose of determining general hearing levels or for the distribution of a hearing device are not a covered benefit except for individuals eligible for the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

8.017.F.3 All services described in § 8.017.B Covered Services shall be provided in accordance with 42 CFR § 440.110 (2000) which is hereby incorporated by reference. The incorporation by reference of this regulation excludes later amendments to, or editions of, the reference material. The regulation is available from the U.S. Government Printing Office at http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol4/pdf/CFR-2010-title42-vol4-sec440-110.pdf. Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

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 23-10-04-A
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 23-10-04-A, 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)? Yes
   If yes, state effective date: 12/31/2023
   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 December 31, 2023.

*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 23-10-04-A
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
Proposed Effective Date **12/31/23**
Final Adoption
Emergency Adoption **12/08/23**

DOCUMENT #12

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 23-10-04-A
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.