

Title of Rule: Creation Medical Assistance Act Rule concerning the Provider Stabilization Fund Program, Section 8.900
Rule Number: MSB 25-07-24-A
Division / Contact / Phone: Special Financing / Daniel Harper / 4427

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).

Create the Provider Stabilization Fund Program as mandated by SB 25-290. The Provider Stabilization Fund program was established to make payments to safety net providers throughout the state that are providing care to low-income uninsured individuals.

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:

Funds to make these payments with were transferred to the Department on August 1, 2025 and the Department has been tasked with making payments to providers as soon as possible. The bill dictates that the Department will consult with the advisory board on the implementation of the Provider Stabilization Fund and board approval on the rules was not reached with the board meeting that occurred on September 24, 2025. This is the earliest medical services board meeting the rules could be brought to after the board approved the rules.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

Sections 25.5-3-601 through 25.5-3-606, 2-3-1203, and 38-13-801 C.R.S. (2025);
Sections 25.5-1-301 through 25.5-1-303, C.R.S.

Initial Review
Proposed Effective Date

10/10/25

Final Adoption
Emergency Adoption

10/10/25
DOCUMENT #10

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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.

This rule will impact low-income individuals that are at or below 200% of the federal poverty level as well as comprehensive community behavioral health providers, rural health clinics, federally qualified health centers, and primary care providers. Low-income individuals will benefit from this rule as it will financially strengthen the providers that they are receiving care from. Eligible providers as listed earlier will benefit by receiving supplemental payments based on their care provided to low-income uninsured individuals.

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

This rule is intended to help providers that are providing care to low-income uninsured individuals by awarding payments based on their proportion of low-income uninsured patients compared to low-income uninsured individuals served by all eligible providers. These payments will help ensure that low-income, uninsured individuals have providers to receive care from.

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 Department was appropriated funds to hire two full time employees (FTE) to complete various aspects of the new law, the appropriation for general administration and operating expenses was \$154,405 for state fiscal year 2025-26. Other than those new FTE the department does not foresee any fiscal impact and is streamlining to keep the costs as effective as possible.

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

The Department must implement these rules in accordance with the passing of SB 25-290. The rules created here will ensure that providers have clear guidelines on what they must do to be eligible to receive a payment.

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

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The Department does not see any less costly methods to complete the work associated with the proposed rule. The 2 new full-time employees will be completing work associated with the new rules and the department is streamlining to keep the work as cost effective as possible.

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 alternatives to creating these new rules.

8.970 PROVIDER STABILIZATION FUND

8.970.1 GENERAL DESCRIPTION

8.970.1.A In accordance with Colorado Senate Bill (SB) 25-290 Stabilization Payments for Safety Net Providers, the Provider Stabilization Fund was created to make stabilization payments to eligible safety net providers. The bill directed the state treasury to establish a Provider Stabilization Fund to collect the monies to be used for payments and set forth how the funds will be allocated and designated the Department of Health Care Policy & Financing (the Department) as the administrator of the payments.

8.970.1.B The Provider Stabilization Fund provides an allocation of monies to safety net providers that serve ~~individuals~~residents of Colorado who are considered low-income and uninsured. Monies shall be allocated based on the number of eligible patients in an amount proportional to the total number of eligible patients served by all safety net providers who qualify for monies from this fund.

8.970.2 DEFINITIONS

8.970.2.A Advisory Board means ~~T~~the Provider stabilization fund advisory board created pursuant to C.R.S. § 25.5-3-605, ~~Group created by CRS 25.5-3-605 to support the state department with the implementation of the Provider Stabilization Fund. The board shall be appointed by the Governor and consist of nine members with membership as follows:~~

~~Five members who are eligible safety net providers or who represent associations of eligible safety net providers, at least two of whom must be from a rural area of the state;~~

~~Three members who are low income, uninsured individuals who are Colorado residents and who rely on safety net providers for health care or who are representatives from Colorado-based consumer advocacy organizations that work on safety net health care matters; and~~

~~One member who is an employee of the state department.~~

8.970.2.B. Children's Basic Health Plan also known as Child Health Plan Plus (CHP+) means the program ~~As specified in Article 8 of Title 25.5, C.R.S.~~

8.970.2.C. Comprehensive Behavioral Health Provider has the same meaning as ~~Comprehensive services furnished in a community setting, including a full continuum of outpatient services for mental health and substance use treatment and recovery, emergency and crisis services, care management, care coordination, and other services as defined at C.R.S. § 27-50-101(11).~~

~~8.970.2.D. Cost Effective Care Provides or Arranges for Primary Care that is appropriate.~~

8.970.2.DE. Eligible Patient means a ~~A~~ ~~Low-income, u~~ ~~Uninsured i~~ ~~individual who is a patient receiving medical services from a Qualified Provider:~~

1. ~~Whose annual household income is at or below two hundred percent (200%) of the Federal Poverty Guideline (FPG);~~

2. ~~Who is not enrolled in the Medical Assistance Program, the Children's Basic Health Plan, Medicare or any other governmental health care coverage such as through Social Security, the Veterans Administration, Military Dependency (TRICARE or CHAMPUS), or the United States Public Health Service; and~~

3. For whom there is no Third Party Payer paying or reimbursing the safety net provider for all or a portion of the amount charged for the services provided to the individual.

8.970.2.EF. Eligible Safety Net Provider - A Safety Net Provider who is identified by the Department to receive funding from the Provider Stabilization Fund.

~~8.970.2.G. Medical Assistance Program (Medicaid) - As specified in C.R.S. 25.5-4 Enrollment in Medicaid excludes individuals from being counted as Low Income, Uninsured Individuals under C.R.S. 25.5-3-602(3).~~

8.970.2.GH. Monies means funds ~~Money~~ appropriated, transferred, or credited to the Provider Stabilization Fund created in the ~~Sstate T~~reasury ~~Consisting of~~:

1. Money credited to the fund as a loan from the unclaimed property trust fund pursuant to C.R.S. § 38-13-801(6) ;
2. Money appropriated, transferred, or credited to the fund by the general assembly;
3. Gifts, grants, or donations the ~~state d~~Department may receive from public or private sources for the fund.

8.970.2.HI. Outside Entity means a ~~A~~business or professional that is not classified as an employee of the provider or the Department and does not have a direct or indirect financial interest with the provider, but has auditing experience or experience working directly with the Medical Assistance Program or similar services or grants for Eligible Patients.

8.970.2.IJ. Primary Care means ~~At a minimum entails~~ health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with patients and treat a range of health-related issues. These providers may also coordinate a patient's care with specialists and ~~m~~May include other services based on a patient's needs including dental, comprehensive behavioral health, and vision.

8.970.2.JK. Safety Net Provider means a provider as defined at C.R.S. § 25.5-3-602(8). ~~A provider meeting the definition of Safety Net Provider in SB 25-290, which can be met under any of the following conditions:~~

1. A comprehensive Community Behavioral Health provider as defined at ~~(p~~C.R.S. § ~~er~~27-50-101(11); ~~C.R.S.)~~;
2. A Rural Health Clinic as defined at ~~(per~~ 42 U.S.C § ~~see~~ 1395x(aa)(2);
3. A Federally Qualified Health Center as defined at ~~(per~~ 42 U.S.C. § ~~see~~ 1395x(aa)(4); or
4. A health-care provider ~~that is~~ delivering primary care services ~~andwith~~ at least 50% of ~~whose clienttheir~~ caseload is ~~consisting of~~ individuals who are enrolled in Medicaid, Medicare, or the Children's Basic Health Plan~~+~~, or who are Low-Income, Uninsured Individuals.

8.970.2.KL. Sliding Fee Schedule means~~A~~a tiered co-payment system that determines the level of a patient's financial participation and guarantees that the patient financial participation is below usual and customary charges. Factors considered in establishing the tiered co-payment system ~~are shall only belimited to~~ financial status and the number of members in the patient's family unit.

8.970.2.LM. Third Party Payments or Third Party Payer means—~~a~~Any individual, entity or program with a legal obligation to pay for some or all health-related services rendered to a patient. Examples include the Medical Assistance Program; the Children's Basic Health Plan; Medicare; commercial, individual or employment-related health insurance; court-ordered health insurance (such as that required by non-custodial parents); workers' compensation; automobile insurance; and long-term care insurance.

8.970.2.MN. Unduplicated User/Patient Count means—~~T~~the sum of patients who have had at least one Visit/Encounter with an eligible safety net provider during the applicable calendar year, but does not include the same patient more than once. The sum shall be calculated on a specific point-in-time occurring between the end of the applicable calendar year and prior to the submission of the application. Each patient shall be counted once under only one payment source designation (Third Party Payer or Eligible Patient). The patient's payment source designation shall be the payment source designation listed for the patient at the specific point-in-time in which the calculation is made. The sum shall not include:

1. Counting a patient more than once if the same patient returns for additional services (e.g., medical or dental) and/or products (e.g., pharmaceuticals) during the applicable calendar year;
2. Counting a patient more than once if the payment source designation changed during the applicable calendar year;
3. Persons who have only received services through an outreach event, community education program, nurse hotline, or other types of community-based events or programs and services were not recorded -on an individual basis;
4. Persons who have only received services from large-scale efforts such as mass immunization programs, screening programs, and health fairs; or
5. Persons whose only contact with the provider is to receive Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) counseling and vouchers are not users and the contact does not generate an encounter.

8.970.2.NO. Visit/Encounter means—~~A~~an appointment with medical personnel (physicians, physician assistants, nurse practitioners, dentists, behavioral health workers, etc.) in which the patient received health related services and/or products (e.g., pharmaceuticals or radiology) and the appointment included primary care that is customarily billable by a safety net provider..

8.970.3 PROVIDER ELIGIBILITY

8.970.3.A. Safety Net Providers who provide Primary Care to Eligible Patients and who meet all the requirements established for the Provider Stabilization Fund as of the date the application form is submitted to the Department shall receive monies appropriated to the Provider Stabilization Fund. Specifically, the provider shall:

1. Meet one of the conditions of a Safety Net Provider as specified in Section 8.970.2.K.; and
2. Submit a completed application form according to stated guidelines as specified under Section 8.970.4.

8.970.4 APPLICATION

8.970.4.A. The application form shall be available to providers annually and posted for public access on the Department's website at least 30 calendar days prior to the ~~application~~~~response~~ due date.

8.970.4.B. At a minimum, the application form shall require responses that:

1. Demonstrate how the provider meets the criteria of a Safety Net Provider as defined in Section 8.970.2.K.;
2. Provide an Unduplicated User/Patient Count covering the applicable calendar year which, at a minimum, ~~shall~~ includes the number of patients -enrolled ~~infer~~ the Medical Assistance Program and the Children's Basic Health Plan and the number of patients considered to be Eligible Patients; and
3. Provide certification that the Unduplicated User/Patient Count identified in Section 8.970.4.B.2 has been verified by an Outside Entity.

8.970.4.C. Providers ~~must~~~~shall~~ complete and provide an ~~application~~~~response~~ annually. The ~~application~~~~response~~ ~~must~~~~shall~~ be made in compliance with all specifications in the application form, including format, data and documentation. ~~Responses to the Applications form must~~~~shall~~ be submitted directly to the Department by the required ~~response~~ deadline.

8.970.4.D. All providers who submit an ~~response to the~~ application ~~form~~ will ~~shall~~ be notified within 45 days of the ~~application~~~~response~~ deadline if the provider has met or did not meet the requirements to be a ~~become an~~ Eligible Qualified Provider.

8.970.4.E. Safety Net Providers who are eligible for the Primary Care Fund ~~are~~~~may be~~ able to use their Primary Care Fund application for the Provider Stabilization Fund. Such providers must submit the Provider Stabilization Fund Attestation Form to the Department. The attestation form shall:

1. Be available to providers annually and posted for public access on the Department's website at least 30 calendar days prior to the ~~application~~~~response~~ due date;
2. Provide attestation that the Safety Net Provider wishes to use the data from their Primary Care Fund application for the Provider Stabilization Fund ~~application~~;
3. Provide Safety Net Provider ~~contact~~ information and be signed by a representative of the Safety Net Provider.

8.970.5 DISBURSEMENT

8.970.5.A. Eligible Safety Net Providers are determined on a state fiscal year basis and shall receive only those monies received by the Provider Stabilization Fund during that same state fiscal year. Monies disbursed shall include all monies defined in 8.970.2.G.

8.970.5.B. Payments shall be based on the number of Eligible Patients in each Eligible Safety Net Provider's Unduplicated User/Patient Count in an amount proportionate to the total number of Eligible Patients from all Eligible Safety Net Providers' Unduplicated User/Patient Counts.

8.970.5.C. The schedule for the disbursement of monies to all Eligible Safety Net Providers shall be dependent on the source and when the funds are available to the Department, with a schedule as follows:

1. Money received by the Department as a loan from the unclaimed property trust or money appropriated, credited, or transferred by the general assembly shall be distributed to eligible providers no later than March 31 in State Fiscal Year 2025-26 and by September 30 in following State Fiscal Years.

2. Money received as a gift, grant, or donation shall be distributed in the first month of the quarter following the quarter the money was received. (Example: Money gifted, granted, or donated between July 1 and September 30 would be distributed by October 3. Money received as a gift, grant, or donation during State Fiscal Year 2025-26 Quarters One and Two (July 1, 2025 - December 31, 2025) would be distributed no later than March 31, 2026.

8.970.6 ADVISORY BOARD

8.970.6.A. Advisory Board function and duties

1. Collaborate with the Department to seek, accept and expend gifts, grants or donations from private or public sources.

2. Collaborate with the Department to annually allocate money appropriated by the general assembly to the Provider Stabilization Fund.

3. Assist the Department with the annual Provider Stabilization Fund report as defined in C.R.S. § 25.5-3-606.

4. Act as consultation to the Department on obtaining federal matching money to the funds in the Provider Stabilization fund.

5. Support the Department with the implementation of the Safety Net Stabilization fund program.

8.970.6.B. Advisory Board appointment details. The advisory board was created by 25.5-3-605 to support the Department with the implementation of the Provider Stabilization Fund. Board members shall be appointed by the Governor with initial appointments being made no later than August 1, 2025. The Advisory Board shall elect a Chair and Vice-Chair from the provider and consumer members as defined in 8.970.2.A.1-2.

8.970.6.C. Advisory Board Membership Tenure, Compensation and Frequency of meetings shall be the following:

1. Advisory Board members shall serve a three-year term.

2. Advisory Board members shall serve without compensation or expense reimbursement.

3. Advisory board meetings shall be held quarterly or as determined necessary by the Chair.

8.970.6.D. Sunset Provisions. The Provider Stabilization Fund Advisory Board will be repealed, effective September 1, 2031, subject to review under the Colorado "Sunset" law.