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 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 - 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:

1. 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;
2. 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

3. 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+) - As specified in Article 8 of Title 25.5, C.R.S.

8.970.2.C. Cost-Effective Care - Provides or Arranges for Primary Care that is appropriate and at a reasonable average cost per patient Visit and/or Encounter.

8.970.2.D. Eligible Patient is a Low-Income, Uninsured Individual 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 eligible for 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.E. 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.F. Medical Assistance Program (Medicaid) - As specified in Article 4 of Title 25.5, C.R.S. Enrollment in Medicaid excludes individuals from being counted as Low-Income, Uninsured Individuals under 25.5-3-602(3), C.R.S.

8.970.2.G. Monies - Money appropriated, transferred, or credited to the Provider Stabilization Fund created in the state treasury. Consisting of:

1. Money credited to the fund as a loan from the unclaimed property trust fund pursuant to CRS 38-13-801 (6);
2. Money appropriated, transferred, or credited by the general assembly;

3. Gifts, grants, or donations the state department may receive from public or private sources for the fund.

8.970.2.H. Outside Entity - 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.I. Primary Care - 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.

8.970.2.J. Quality Assurance Program - Formalized plan and processes designed to ensure the delivery of quality and appropriate Comprehensive Primary Care in a defined medical setting. This can be demonstrated by obtaining a certification or accreditation through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). If such certification or accreditation is

not available, then at a minimum, the Quality Assurance Program shall be comprised of elements that meet or exceed the following components:

1. Establishment of credentialing/re-credentialing requirements for medical personnel;

2. Surveying and monitoring of patient satisfaction;

3. Establishment of a grievance process for patients, including documentation of grievances and resolutions;

4. Development of clinic operating policies and scheduled performance monitoring;

5. Review of medical records to check for compliance with established policies and to monitor quality of care;

6. Assessment of state and federal regulations to ensure compliance;

7. Establishment of patient safety procedures; and

8. Establishment of infection control practices.

8.970.2.K. Safety Net Provider - 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 (per 27-50-101(11), C.R.S);
2. A Rural Health Clinic (per 42 U.S.C sec 1395x(aa)(2);
3. A Federally Qualified Health Center (per 42 U.S.C. sec 1395x(aa)(4); or
4. A health-care provider delivering primary care services with at least 50% of their caseload consisting of individuals enrolled in Medicaid, Medicare, CHP+, or Low-Income, Uninsured Individuals.

8.970.2.L. Sliding Fee Schedule - A tiered co-payment system that determines the level of 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 shall only be financial status and the number of members in the patient's family unit.

8.970.2.M. Third Party Payments or Third Party Payer - 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.N. Unduplicated User/Patient Count - 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 were not documented 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.O. Visit/Encounter - An appointment with medical personnel (physicians, physician assistants, dentists, behavioral health workers, etc.) in which the patient received health related services and/or products (e.g., pharmaceuticals or radiology) and the appointment is customarily billable to a Third Party Payer.

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.;

2. Have a Quality Assurance Program in place as specified in Section 8.970.2.J.; and

3. 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 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 include the number of patients eligible for the Medical Assistance Program and the Children’s Basic Health Plan and the number of patients considered to be Eligible Patients;

3. Provide certification that the Unduplicated User/Patient Count identified in Section 8.970.4.B.2 has been verified by an Outside Entity; and

4. Provide documentation that the provider has a Quality Assurance Program as defined in Section 8.970.2.J.

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

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

8.970.4.E. Safety Net Providers who are eligible for the Primary Care Fund 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 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;

3. Provide Safety Net Provider 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 25.5-3-606.
4. Act as consultation to the Department on obtaining federal matching money to the funds in the Provider Stabilization fund.

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.