Provider Bulletin

Reference Number: B2600541

Aug 2026

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Did You Know?

Reminder: Electronic Data Interchange (EDI) Support Web Page

Providers that use a clearinghouse to submit batch claims are encouraged to remind their trading partners to visit the Electronic Data Interchange (EDI) Support web page for important updates.

All Providers

Program Integrity and Compliance

Providers are required to maintain complete and accurate records supporting billed services. Refer to Colorado Code of Regulations at 10 CCR 2505-10 8.076 and 8.130 (revised 2022). These requirements are further reinforced in the Provider Participation Agreement (revised 2023) that all providers are required to sign to participate in Health First Colorado (Colorado's Medicaid program). The applicable provisions of 10 CCR 2505-10, including Sections 8.076 and 8.130, were most recently revised in 2022. These requirements are further reinforced through the Provider Participation Agreement, which was updated in 2023.

Providers are required to:

- Maintain complete, accurate and legible records supporting services billed to and paid by the Department of Health and Care Policy and Finaning (the Department).
- Ensure documentation is created contemporaneously with service delivery and paid by the Department.
- Comply with Department billing manuals, provider bulletins and applicable coding standards, including CPT and HCPCS requirements.

- Retain records in accordance with applicable requirements and make them available to the Department or its designees [DS1.1] upon request.
- Cooperate with all program integrity, compliance, audit, investigation and review activities conducted by the Department or its designees.

Failure to comply may result in claim denial, recoupment of overpayments, suspension of payments or other administrative action.

Timely Filing Information

Providers have **365 days from the Date of Service (DOS)** to submit a claim. A claim is considered filed when the fiscal agent documents receipt of the claim.

Correspondence with the fiscal agent is not proof of timely filing. The claim must be submitted and received within 365 days, even if the result is a denial. Provider staffing changes and issues between the provider and the software vendor, billing agent or clearinghouse do not constitute acceptable reasons to be outside the timely filing period.

Visit the Frequently Asked Questions (FAQs) and Billing Resources web page under the Timely Filing drop-down for more information.

Timely Filing with Third-Party Liability

Medicare

- Providers can keep a claim within timely filing after the initial timely filing period of 365 days from the DOS by submitting the claim within 120 days from the Medicare Explanation of Benefits (EOB).

Commercial Insurance

- All claims, including commercial insurance information that are received more than 365 days from the DOS, must be denied per state and federal regulation (42 CFR § 447.45(d), 10 CCR 2505-10-8.043.01 and .02A). Providers are encouraged to submit claims to third-party

resources in a timely manner and to follow up to ensure prompt payment.

Timely Filing Resubmission Instructions

Providers can keep claims that do not include third-party liability within timely filing by resubmitting every 60 days after the initial timely filing period of 365 days from the DOS, even if the result is a denial.

Providers may resubmit any claim, including those with third-party liability, within 60 days if an adjustment or recoupment is initiated by the fiscal agent (Gainwell Technologies) or Health Management Systems, Inc. (HMS).

The most recent previous Internal Control Number (ICN) must be referenced on the claim if the claim is submitted beyond 365 days from the DOS.

Provider Web Portal

- Claims outside timely filing must be resubmitted with the previous ICN in the Previous Claim ICN field in the Claim Information section (Step 1). Refer to the Submitting an Institutional Claim Quick Guide and the Submitting a Professional Claim Quick Guide for more information.

Paper Claim

- **Professional CMS 1500 Claim**: Indicate a resubmission with code one (1) in Box 22 and the original ICN in the adjacent 22 box. Field 22 is a split box and needs to be designated with a single-digit code and a corresponding ICN.
- **Institutional UB-04 Claim**: Enter the type of bill into Box 4 for a resubmission. The type of bill should end in a one (1). Enter the ICN in Box 64a.

Electronic Data Interchange (EDI) Batch Claim

- Providers must qualify (2300/REF01) with F8 and use the previous ICN as the Payer Claim Control Number along with code one (1) in the 2300/CLM segment CLM05-3.

Note: Copies of **all** Remittance Advices (RAs) or correspondence documenting compliance with timely filing and 60-day rule requirements

must be maintained in the provider's files. A copy of the RA should not be included with the claim. Reconsiderations do not need to be indicated on resubmissions.

All Providers That Use a Trading Partner

Electronic Data Interchange Vendor Transition

Electronic Data Interchange (EDI) functionality, including batch processing, will move from the Medicaid Management Information System (MMIS), operated by Gainwell Technologies, to a new module operated by Edifecs (a Cotiviti business).

The first phase, X12 File Naming Standards changes, went live on January 7, 2026.

The second phase went live on June 24, 2026, and included the following changes:

- New agreement to be signed by trading partners
- New platform for trading partners to exchange files with HCPF
- New log-in credentials for the platform (to be issued once the agreement has been acknowledged)
- New Trading Partner Enrollment and Testing Site

All trading partners must register and complete enrollment in the new Edifecs Trading Partner Enrollment and Testing Site by August 31, 2026.

Before registering in the new site:

- Contact the Provider Services Call Center to verify the email address originally registered with Health First Colorado.
- Use that verified email address when enrolling in the new system to retain their current Trading Partner ID (TPID).

Note: Using a different email address will create a new/duplicate Trading Partner ID (TPID), complicating file submission and compliance validation.

Available Trading Partner Training

Providers should encourage their clearinghouse to register for one (1) of the available training sessions on the Electronic Data Interchange (EDI) Support web page.

What is staying the same?

- Providers may still use the Provider Web Portal to submit individual claims, maintain enrollment, verify individual eligibility and more.
- Providers will contact the Provider Services Call Center with any questions about claims, the Provider Web Portal or EDI.
- Active trading partners will retain the same trading partner IDs.

As a reminder, the third (and final) EDI phase is expected to be implemented in the Fall of 2026.

Trading partners are encouraged to visit the Frequently Asked Questions web page for helpful information about the Edifecs Trading Partner Enrollment and Testing Site.

Refer to the Bulletins web page and Electronic Data Interchange (EDI) Support web page for more information.

Providers and trading partners are encouraged to sign up for targeted communications.

All Providers Who Utilize the ColoradoPAR Program

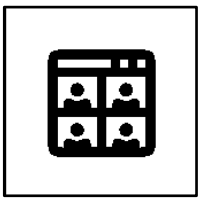
What is the ColoradoPAR Program?

The ColoradoPAR Program is a third-party, fee-for-service Utilization Management (UM) program administered by Acentra Health, Inc. Visit the Colorado Prior Authorization Request Program (ColoradoPAR) web page for more information about the ColoradoPAR Program.

Prior Authorization Request (PAR) Submission Training for Acentra

Acentra Health will provide benefit-specific Prior Authorization Request (PAR) submission training for all providers and Long-Term Home Health (LTHH) Skilled Nursing and Certified Nurse Aide (CNA) Benefit Specific PAR Training. The training dates and times are listed below in Mountain Time:

- LTHH Skilled Nursing/CNA Provider Benefit Specific Training August 12, 2026, at 9:00 a.m.
- LTHH Skilled Nursing/CNA Provider Benefit Specific Training August 12, 2026, at 12:00 p.m.
- Portal Registration and PAR Submission Training August 26, 2026, at 9:00 a.m.
- Portal Registration and PAR Submission Training August 26, 2026, at 12:00 p.m.



PAR submission training sessions are appropriate for all new users and include information on how to submit a PAR using Acentra's provider portal, Atrezzo®.

Contact COProviderIssue@acentra.com with questions or if assistance is needed when registering for Atrezzo training or accessing the portal. Visit the ColoradoPAR Training web page for additional training information.

Behavioral Health Providers

Billing Requirements for Services Delivered Under Oversight of a Rendering Provider

Pre-licensed clinicians and unlicensed professionals are only able to deliver Medicaid-reimbursable behavioral health services under the oversight of a rendering provider who holds a valid active license in Colorado. This policy

follows Medicaid billing requirements referenced and described in the Health First Colorado Behavioral Health Rendering Provider Oversight (RPO) Policy. Only a licensed practitioner of the healing arts (i.e., Licensed Psychologist, Licensed Behavioral Health Clinician, Physician, Osteopath, Physician Assistant or Nurse Practitioner) may enroll with Health First Colorado as a provider. Services must be billed under a rendering provider to reimburse for care delivered by unlicensed or pre-licensed individuals. There is no change to this policy.

Use of Modifier U9 – Effective July 1, 2026

For dates of service beginning July 1, 2026, billing providers are required to utilize Modifier U9 on all claim lines submitted for behavioral health services delivered by a pre-licensed clinician or an unlicensed professional. The Department is postponing the requirement to include identifying information regarding the service provider to January 2027, based on provider feedback.

National Provider Identifier (NPI) for Pre-Licensed Clinicians and Unlicensed Professionals

Effective January 1, 2027, all service providers delivering behavioral health services, including pre-licensed clinicians and unlicensed professionals, will be required to have an Individual NPI number. NPI numbers are obtained through the National Plan and Provider Enumeration System (NPPES) website.

For dates of service beginning January 1, 2027, when a behavioral health service is delivered by a pre-licensed clinician or unlicensed professional, the service provider's NPI must be listed in Box 19 on the claim. The use of Box 19 applies to billing providers who utilize the CMS 1500 claim form.

Questions may be submitted to hcpf_bhbenefits@state.co.us.

Final Policy Published: Clarification on Scope of Behavioral Health Peer Recovery Groups

A draft policy was published in March 2026 to clarify the scope of Behavioral Health Peer Recovery Groups. The policy outlines criteria that must be met for services facilitated by Behavioral Health Peer Support Professionals in a group setting to be covered by Health First Colorado.

A final version of the policy has been published on the Behavioral Health Peer Support Policy section of the Behavioral Health Policies web page. Everyone that took time to give thoughtful input on this policy is appreciated.

Contact hcpf_peerservices@state.co.us with any questions.

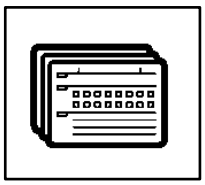
Mental Health Parity Report Released for Fiscal Year (FY25) 2025 - 2026

The annual Mental Health Parity Report for State Fiscal Year 2025-2026 was submitted on June 1, 2026, as required by C.R.S. section 25.5-5-421. The Department created this year's annual report utilizing the established process for determining mental health parity compliance based on the federal parity guidance outlined in the Centers for Medicare & Medicaid Services' Parity Toolkit and in accordance with all state requirements.

The report includes findings from the external quality review audit which evaluates Regional Accountable Entity (RAE) and Managed Care Organization (MCO) policies and procedures in operation.

The full Mental Health Parity Report and full external quality review audit can both be found on the Parity web page. The Parity web page also contains educational resources on mental health parity.

New Grant Opportunities for Comprehensive Safety Net Providers



The Substance Abuse and Mental Health Services Administration (SAMHSA) has recently released several new Notice of Funding Opportunities (NOFOs) aimed at supporting the Certified Community Behavioral Health Clinic (CCBHC) model. This could be a great opportunity for organizations interested in joining a future CCBHC cohort for the State of Colorado under the Colorado CCBHC Medicaid Demonstration or that are looking for opportunities to further expand their support of those seeking care in their communities. Applications for the next round of CCBHC expansion grants are due on August 17, 2026.

Visit the SAMHSA Grant Dashboard web page to review the full details, eligibility requirements, and deadlines for these grant opportunities. Explore these resources to see how they might support efforts to expand access to high-quality behavioral health care.

Rural Health Transformation Program Now Accepting Applications

The Colorado Rural Health Transformation Project (RHTP) team's Request for Application (RFA) is live on the RHTP web page. Applications must be submitted by 11:59 p.m. MT on August 3, 2026.

Visit the "RFA Applicant Guidance" section of the web page where resources are provided for potential applicants including guidance documents, templates, recordings of webinars and Frequently Asked Questions.

Contact hcpf_rhtp@state.co.us with any questions.

Senate Bill 26-188 Carve-In Steering Committee

The *Senate Bill 26-188 Carve-In Steering Committee* convened on July 1, 2026, in accordance with Senate Bill 26-188. The committee will support the transition of services provided in Qualified Residential Treatment Programs (QRTP), Psychiatric Residential Treatment Facilities (PRTF) and Out-of-State High Intensity Residential Treatment (OHIRT) from a fee-for-service benefit to a behavioral health capitation benefit for members who are either in the custody of a County Department of Human Services/Child Welfare or committed to the Division of Youth Services (DYS).

The committee will meet monthly and public attendance is welcome. A public comment period will be held at the end of each committee meeting. Visit the Children and Youth Behavioral Health web page for more information.

Cover All Coloradans Providers

Upcoming Changes

The Department is sharing Key Messages about changes to Cover All Coloradans, including changes that took effect on July 1, 2026, and others that will take effect January 1, 2027. These Key Messages are available as PDFs in English and Spanish, and in six (6) additional languages on the Cover All Coloradans web page.

These Key Messages provide advocates and health care providers with the information needed to raise awareness and educate community members about the upcoming changes.

Contact HCPF_coverallco@state.co.us with any questions.

Durable Medical Equipment

Osteogenesis Stimulators Reclassification

The Food and Drug Administration (FDA) has reclassified osteogenesis stimulators from Class III devices to Class II devices. Effective for dates of service on or after May 18, 2026, the KF modifier is no longer needed for Healthcare Common Procedure Coding System (HCPCS) E0747, E0748 and E0760. More information on the reclassification can be found on the Federal Register web page.

Contact Alaina.Kelley@state.co.us with any questions.

Durable Medical Equipment, Therapy

Complex Rehabilitation Technology Policy Revisions

Written feedback on revised draft policy language for Complex Rehabilitation Technology (CRT) is being accepted by the Department.

Stakeholder feedback was gathered in October and November 2025 and incorporated where possible. The revised draft policy language is now available for review. In the revised draft policy document, new or revised policy language is shown in blue text.

Stakeholders may submit feedback through August 31, 2026.

Written feedback may also be emailed to HCPF_stakeholders@state.co.us.

More information is available on the CRT stakeholder engagement web page.

Federally Qualified Health Centers (FQHCs)

Vaccine Billing Reminder

Federally Qualified Health Centers (FQHCs) are reminded that vaccines and vaccine administration are not carved out of the FQHC encounter rate. FQHCs should not bill vaccine products or vaccine administration codes separately to the Department fee-for-service on the CMS 1500 professional claim.

Vaccines provided **as part of** a qualifying FQHC visit should be included on the FQHC encounter claim, as appropriate, and reimbursed through the FQHC encounter rate. If a vaccine is provided **in addition to** a routine office visit, an additional encounter should not be billed solely for the immunization.

For vaccine-only visits, FQHCs should determine whether the service meets the definition of a billable FQHC visit under 10 CCR 2505-10 § 8.700.1.B. A vaccine-only visit may be billed as an FQHC encounter only when it meets the FQHC visit definition. If the vaccine-only visit does not meet the definition of an FQHC visit, the FQHC should not bill an encounter and should not bill the vaccine separately to the Department fee-for-service on the CMS 1500 professional claim. Costs associated with these services should be included in the FQHC's Health First Colorado cost report and will be reflected in the calculation of the FQHC encounter rate.

FQHCs that have submitted vaccine product or vaccine administration claims to HCPF fee-for-service on the CMS 1500 professional claim should:

- Review paid and pending professional claims for vaccine product and vaccine administration codes billed under FQHC provider ID.
- Void or adjust the claim through the Provider Web Portal or applicable batch process for paid fee-for-service claims.
- Submit the appropriate FQHC encounter claim, subject to timely filing and all third-party liability requirements, if the vaccine was provided

during a visit that meets the FQHC visit definition and an encounter claim was not billed.

Contact Greta Brubaker at Greta.Brubaker@state.co.us with any questions.

Home and Community-Based Services (HCBS)

Members with HCBS Waivers Display “Pending Update”

Beginning July 8, 2026, Home and Community-Based Services (HCBS) member waiver benefits that are actively being processed will display as "Pending Update.” Providers will not be able to verify coverage on the Provider Web Portal during this time. Providers may reverify after the processing window.

The eligibility processing window occurs daily between 6:00 p.m. MT and 7:30 p.m. MT, Monday through Friday, and during the last Saturday of each month.

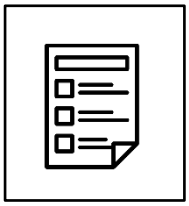
Refer to the Verify Member Eligibility and Co-Pay Quick Guide for information.

Post-Eligibility Treatment of Income (PETI) Changes Developmental Disability (DD) Waiver

Beginning August 1, 2026, Post-Eligibility Treatment of Income (PETI) will apply to residential services under the Home and Community-Based Services-Developmental Disability (HCBS-DD) waiver for members with certification start dates of July 1, 2026, or later. This includes Individual Residential Services and Supports (IRSS) and Group Residential Services and Supports (GRSS).

PETI is already used across other HCBS residential waivers and aligns HCBS-DD residential services with existing Medicaid cost-sharing practices.

A new web page dedicated to the DD PETI Initiative has been developed to support providers as implementation approaches. Residential providers can find specific information tailored to them which outlines operational changes, provider responsibilities and implementation expectations, including information on:



- Operational changes providers should expect
- Information providers will receive from Case Management Agencies (CMAs)
- Provider responsibilities related to PETI worksheets and Medicaid billing
- Member payment expectations

Residential providers should also continue to review the PETI guidance available through the DD PETI resources, including information about:

- Provider agency responsibilities related to member payments
- Standard Room and Board requirements
- “Independently Arranged Room and Board” situations
- Medicaid daily reimbursement rate calculations
- PETI exemptions for certain working members

Provider Training

A provider-focused training to support implementation will be provided that includes a slide presentation and recorded webinar covering what residential providers need to know about PETI implementation, including provider responsibilities, what to expect during implementation, PETI worksheets, member payments and Health First Colorado billing processes. Information on how to access the training will be shared as it becomes available.

Provider Office Hours

Two (2) optional office hours are available for live questions with subject matter experts. Registration is required to attend. It is recommended to also watch the companion training prior to attending the office hours. These office hours will be reserved for questions and will not have a PowerPoint presentation, leaving more time for any questions about this new process or not covered in the training itself.

- August 18th, 2026, 1:00 P.M. - 2:00 P.M. MT
- August 27th, 2026, 11:00 A.M. - 12:00 P.M. MT

Register on Zoom.

Additional Resources

Providers are encouraged to review additional resources on the new DD PETI web page.

Contact Information

Contact the Case Manager or the Questions mailbox at HCPF_HCBS_Questions@state.co.us for additional information about PETI policy for the HCBS-DD Waiver.

Contact the Provider Services Call Center with questions about claim submission.

Provider Training for New Supported Employment

The Office of Community Living will host training sessions for provider agencies and staff members involved in delivering Supported Employment Services (specialty type 679). This training will provide an overview of the new Outcome-Based Payment Model for Supported Employment, including how services will be reimbursed under the new model, related tools and requirements for the new services. These changes are targeted for implementation on September 1, 2026. This training is intended to help

providers prepare for the new service structure, documentation expectations and reimbursement approach.

The August training session will be held on August 25, 2:00 p.m. – 4:00 p.m. MT Register for the provider training session. A recording of the training session along with other training materials will be posted on the Supported Employment web page for providers who are unable to attend the live session.

Office Hours

Individual Office Hours will be offered in the weeks following the training sessions. Sign up for an individual office hour if interested.

Background

The Department of Health Care Policy & Financing is redesigning its Individual Supported Employment services to better align with Colorado's commitment to Employment First, which includes building support systems that reflect the belief that anyone can work and be successful in community-integrated jobs.

The redesign focuses on a change in payment structure for Individual Supported Employment services:

- Job Development will be reimbursed based on outcomes that focus on identifying the member's skills, interests, employment goals and conditions for job success. This approach is intended to support stronger job matches and better employment outcomes for members.
- Job Coaching services will be organized into three (3) phases, with reimbursement aligned to the member's stage of employment, Support Level and ongoing support needs. This approach is intended to help providers support members as they learn the job, maintain employment and build independence over time.

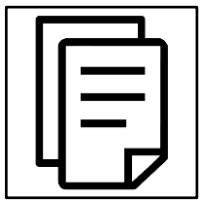
Additional background is available in the Supported Employment Outcome-Based Payment Model Fact Sheet.

Contact Adam Tucker, Supported Employment Policy Advisor, and Jenny Jordan, HCBS Benefit Specialist – Supported Employment with questions

regarding Supported Employment, including the new Outcome-Based Payment Model.

Contact the Provider Services Call Center with questions about claims submission.

Removal of Age Requirements of Direct Care Workers for Select HCBS Services



Effective July 1, 2026, select Home and Community-Based Services (HCBS) waiver services have removed age-specific minimum requirements for direct care workers. This change shifts the focus to provider qualifications and competencies rather than age. Providers may choose to employ direct care workers under the age of 18 for certain services when provider qualification requirements are met.

The following HCBS waiver services have removed a minimum age requirement:

- Children's Extensive Support (CES) Waiver
  - Respite
  - Community Connector
  - Youth Day
- Children's Habilitation Residential Program (CHRP) Waiver
  - Respite
  - Community Connector
- Supported Living Services (SLS) Waiver
  - Day Habilitation
  - Supported Employment Group
  - Prevocational Services
  - Respite
  - Mentorship
- Developmental Disabilities (DD) Waiver
  - Day Habilitation
  - Supported Employment Group
  - Prevocational Services

Each service continues to have its own provider qualification requirements. Providers may view each service's provider requirements in the approved 1915(c) waiver applications in the Approved HCBS Waiver Documents and Waiver Lifecycle section of the Home and Community-Based Services Waivers web page. Removing the minimum age requirement does not require providers to hire direct care workers under the age of 18, however, providers may do so if they comply with all applicable provider qualification requirements and Colorado labor laws.

New Weekly Caregiver Limits for Select Long-Term Services and Supports (LTSS) Services

A phased-in weekly caregiver limit for select Long-Term Services and Supports (LTSS) services is being implemented. The policy is designed to support member health and safety by reducing risks associated with caregiver fatigue while maintaining access to needed services.

What Is Changing?

Beginning July 1, 2026, caregivers providing certain LTSS services may only provide a limited number of hours to an individual member each week unless an approved exception is in place.

The weekly limits will be phased in as follows:

Effective Dates	Maximum Hours Per Caregiver, Per Member, Per Week
July 1, 2026 - December 31, 2026	84 Hours
January 1, 2027 - June 30, 2027	70 Hours
July 1, 2027, and after	56 Hours

The existing 16-hour daily caregiver limit remains in effect.

Services Subject to the Weekly Limit

The weekly caregiver limit applies to:

- Nursing Services under Long-Term Home Health (LTHH)
- Certified Nurse Aide Services under LTHH
- Homemaker services
- Personal Care services
- Health Maintenance Activities (HMA)

This includes services delivered through Agency-Based In-Home Support Services (IHSS), and Consumer-Directed Attendant Support Services (CDASS) models, as applicable.

Provider Responsibilities

Beginning July 1, 2026, provider agencies and CDASS employers are responsible for:

- Monitoring caregiver hours to ensure compliance with daily and weekly limits.
- Coordinating with other providers when caregivers serve the same member through multiple agencies.
- Maintaining required documentation.
- Submitting exception requests when applicable.
- Complying with Department review and audit requirements.

Exceptions Process

A Weekly Caregiver Limit Exception Request process has been established for members who meet specific exception criteria established in rule. Approved or pending exception requests may allow caregivers to exceed the applicable weekly limit.

Providers should submit exception requests according to Department guidance and applicable implementation timelines. Providers must coordinate with the member's Case Management Agency (CMA) during the

exception request process for members receiving case management services.

Phased Exception Submission Periods

Members currently exceeding the applicable caregiver limits should follow the phased implementation schedule established by the Department:

- **Phase 1:** Members receiving more than 84 hours per week from a single caregiver (July 2026)
- **Phase 2:** Members receiving more than 70 hours per week from a single caregiver without an approved exception (November 2026)
- **Phase 3:** Members receiving more than 56 hours per week from a single caregiver without an approved exception (May 2027)

Additional Resources

Providers should review Operational Memo HCPF OM 26-043, "Implement a Weekly Cap of 56 Hours Per Caregiver Per Member for Select Long-Term Services and Supports," for complete policy requirements, exception criteria, compliance expectations, documentation requirements and implementation timelines.

Additional guidance, forms, training materials and exception request resources will be available on the Long-Term Services and Supports web page under "Weekly Caregiver Limit."

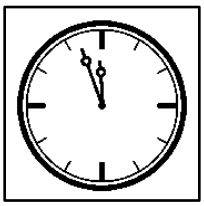
Updated Cap on Homemaker Hours for Legally Responsible Persons (LRPs) Policy Effective June 12, 2026

On June 12, 2026, the Medical Services Board (MSB) approved updates to the policy governing Homemaker services provided by Legally Responsible Persons (LRPs).

What Changed?

Under the previous policy, a member could have up to two (2) LRPs (for example, parents of minors or a spouse) who were each paid to provide up to five (5) hours per week of Homemaker services.

Effective June 12, 2026, a member may receive up to seven (7) hours per week of Homemaker services provided by LRPs.



This is a per-member cap, not a per-LRP cap. The seven (7) hours may be provided by one LRP or shared among multiple LRPs within the household, but the total combined paid LRP Homemaker hours may not exceed seven (7) hours per week.

Why Was This Change Made?

Feedback from stakeholders and the Medical Services Board indicated that the previous policy could impact single-caregiver and multi-caregiver households differently. The updated policy is intended to create a more consistent impact across households while continuing to support the sustainability goals established through the Long-Term Services and Supports (LTSS) budget actions.

Providers' Next Steps:

Refer to Operational Memo 26 - 042.

Contact hcpf_pdp@state.co.us with questions.

Home and Community-Based Services, Community First Choice, Home Health, Nursing Facility Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Required Licensure Updates to Avoid Claim Denials

Beginning October 1, 2026, Long-Term Services and Supports (LTSS) providers in the table below may experience claim denials if license effective and end dates on file with the Colorado Department of Public Health and Environment (CDPHE) do not match information on file within the Medicaid Management Information System (MMIS) maintained by the Colorado

Department of Health Care Policy and Financing (the Department) for dates of service on or after October 1, 2026.

CDPHE notifies providers of licensure updates via general email updates and specific messaging through its Colorado Health Facilities Interactive (COHFI) portal.

From August 1, 2026, providers will have sixty (60) days from the "issued on" date, for each license, to update their licensure with the Department. Notifications will be sent to the Provider Enrollment contact on file with the Fiscal Agent, Gainwell Technologies.

Providers can update the license in the Provider Web Portal by doing a Provider Maintenance Request. Refer to the Update Licenses and Clinical Laboratory Improvement Amendments (CLIA) Quick Guide for instructions on adding or updating a license.

Providers must resubmit any previously denied claims once license updates are completed. Refer to the chart below for impacted Provider Types and Specialties.

Provider Type Number and Name	**Provider Specialty Number and Name**
10 - Home Health	• 385 - Home Health
20 - Nursing Facility	• 382- Nursing Facility - Hospital Back Up Program • 392 - Nursing Facility - Regular • 392 - Nursing Facility - Swing Beds
21 - Intermediate Care Facility with IID	• 383 - ICF/IID - Private
36 - Home and Community Based Services (HCBS)/Community First Choice (CFC)	• 602 - Alternative Care Facility-CMHS/EBD • 614 - Palliative/Supportive Care - CwCHN • 615 - Skilled Respite - CES/CHRP/CwCHN • 616 - Respite (Unskilled) - CwCHN • 617 - Therapy and Counseling - CwCHN • 654 - Independent Living Skills Training - BI • 656 - In-Home Support Services Agency CFC/CHCBS/CIH/EBD

	• 666 - Personal Care/Homemaker Srvcs BI/CFC/CIH/CMHS/EBD • 673 - Residential Habilitation Services - Group Home - DD • 675 - Respite - BI/CIH/CMHS/EBD • 676 - Respite - CES/SLS • 680 - Supported Living Program - BI • 682 - Transitional Living Program - BI • 753 - Life Skills Training-CIH/CMHS/EBD/SLS

Hospital

General Updates

Appendix O and Inpatient/Outpatient (IP/OP) Update

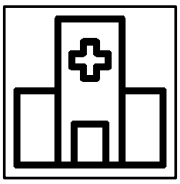
The IP/OP Billing Manual and Appendix O have been updated to reflect changes from the EAPG Version 3.18 update that went live on July 1, 2025. The Department added supplementing language to the Inpatient-Only Procedures section, which states that Solventum no longer maintains an inpatient-only procedure code list, which is effective for Colorado with its implementation of EAPG version 3.18 effective July 1, 2025.

APR-DRG Version 42 Update

The Information on the APR-DRG Version 42 Update was presented by the Department to hospital stakeholders during the May 1, 2026, Hospital Engagement Meeting. The DRAFT APR-DRG V42 Weight Table along with Estimated Payment Differentials for Major Diagnostic Category (MDC) and System/Hospitals were posted to the Inpatient Hospital Payment web page on May 4, 2026, for a 15-day hospital review which ended on May 19, 2026. The Department sent the weight table to Gainwell to begin inputting and

testing the version update. Contact Andrew Abalos and Diana Lambe at Andrew.Abalos@state.co.us and Diana.Lambe@state.co.us with any questions.

Hospital Stakeholder Engagement Meetings



Bi-monthly Hospital Engagement meetings will be hosted by the Department to discuss current topics regarding ongoing rate reform efforts and operational concerns. Sign up to receive the Hospital Stakeholder Engagement Meeting newsletters.

- The next Hospital Stakeholder Engagement meeting is set for **Friday, September 11, 2026, from 1:00 p.m. to 3:00 p.m. Mountain Time** and will be hosted virtually.

Visit the Hospital Stakeholder Engagement Meeting web page for more details, meeting schedules and past meeting materials.

Contact Della Phan at Della.Phan@state.co.us with any questions or topics to be discussed at future meetings. Advanced notice will provide the Facility Rates Section time to bring additional Department personnel to the meetings to address different concerns.

Rural Health Clinic Stakeholder Engagement Meeting

A meeting for Rural Health Clinics (RHCs) has been scheduled for October 1, 2026, from 1:00 p.m. to 2:00 p.m. Mountain Time. Topics of discussion will include an overview of the Rural Health Clinic payment methodology for both hospital-based and freestanding RHCs and operational concerns impacting RHC billing or payment.

Visit the Rural Hospital and Rural Health Clinic web page for more details, meeting schedules and past meeting materials.

Contact Andrew Abalos at Andrew.Abalos@state.co.us with any questions or topics requested for discussion at this meeting.

State Fiscal Year 2027 Across-the-Board (ATB) Rate Decrease

House Bill (HB) 26-1410 (2026-27 Long Bill), signed May 8, 2026, authorizes a 2.0% decrease to fee-for-service hospital rates, effective July 1, 2026. These rate decreases will be applied to hospital-specific All Patient Refined Diagnosis-Related Group (APR-DRG) and Enhanced Ambulatory Patient Grouping (EAPG) base rates. Long-Term Acute Care, Spine/Brain Injury, mental health and rehabilitation hospitals per diem rates will also decrease by 2.0%.

The 30-day review ended on July 4, 2026. The Department will work with its fiscal agent to implement these rates to the Medicaid Management Information System (MMIS) to reduce administrative burden on the Department and hospitals. Claims with a last date of service on or after July 1, 2026, for inpatient APR-DRG claims and claims with first date of service on or after July 1, 2026, for per diem and outpatient EAPG claims will then be reprocessed. The process should be concluded by mid-August. An email will notify all stakeholders when the process is complete. Sign up to receive the Hospital Engagement Meeting newsletters.

- The Inpatient Hospital Payment web page for a listing of inpatient hospital base rates. Contact Diana Lambe at Diana.Lambe@state.co.us with any questions regarding Inpatient APR-DRG base rates.
- The Outpatient Hospital Payment web page for a listing of outpatient hospital base rates. Contact Sean Paschke at Sean.Paschke@state.co.us and Andrew Abalos at Andrew.Abalos@state.co.us with questions regarding outpatient EAPG base rates.

The Inpatient Hospital Per Diem Reimbursement Group web page for a listing of mental health, rehabilitation, long-term acute care and spine/brain

injury hospital base rates. Contact Della Phan at Della.Phan@state.co.us and Andrew Abalos at Andrew.Abalos@state.co.us with questions regarding these rates.

Hospital Specialty Drug Policy: Prior Authorization Update

For Approved hospital specialty drugs which are carved out from either the All-Patient Refined Diagnosis Related Group (APR-DRG) or the Enhanced Ambulatory Patient Group (EAPG) payment methodology fall under the Hospital Specialty Drug Policy.

Uplizna ® (inebilizumab-cdon), Healthcare Common Procedure Coding System (HCPCS) code J1823, has been added to the approved hospital specialty drug list effective May 14, 2026. The entire list of specialty drugs subject to this policy is listed on Appendix Z: Hospital Specialty Drugs List.

Member-specific prior authorization requests (PARs) must be submitted directly to the Department of Health Care Policy & Financing at HCPF_PharmacyPAD@state.co.us and approved prior to administration of the specialty drug.

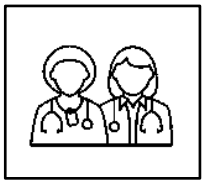
Resources including Appendix Z, coverage standards, request forms and submission requirements are listed on the Physician Administered Drug (PAD) Provider Resources web page under the Hospital Specialty Drug Policy drop-down.

Refer to the Physician-Administered Drugs and Inpatient/Outpatient (IP/OP) Billing Manuals and the PAD Provider Resources web page for additional policy information.

Contact HCPF_PAD@state.co.us with additional questions.

Nursing Facilities

Memo Reminder



Nursing Facilities are encouraged to bookmark the Memo Series web page.

This page includes the Memo Instructions for Nursing Facility Claims When 5615s are Not Available reminding facilities they are allowed to submit claims with an estimated patient payment while waiting on a 5615 from the eligibility site.

There will be a new Memo coming out explaining the private room pay rate in the near future.

Primary Care Medical Providers, Physician Services

Colorado Medicaid eConsult Platform

The Colorado Medicaid eConsult platform managed by Safety Net Connect (SNC) will end effective August 31, 2026. The last day to submit an eConsult through this platform will be August 25, 2026. Providers currently enrolled with, or in the process of enrolling with, this platform have received additional information about this transition. Unfortunately, utilization of this platform was too low to achieve the savings expected. Given current budget constraints and competing funding priorities, the Department has decided to discontinue funding a Medicaid-specific eConsult platform beyond August 31, 2026.

Providers are still encouraged to utilize eConsults to support more timely and efficient access to specialty care and care management for members. eConsults submitted through Department-approved platforms will continue to be reimbursed. Refer to the Telemedicine and eConsult Billing

Manual for more information. Contact HCPF_eConsult@state.co.us with questions or concerns regarding this transition.

Physician-Administered Drug (PAD) Providers

Prior Authorization Update

The Appendix Y criteria for Spravato ® (esketamine), Healthcare Common Procedure Coding System (HCPCS) codes J0013, G2082 and G2083, have been updated. The changes are consistent with the U.S. Food and Drug Administration (FDA) labeling and guidance from the federally recognized drug compendia identified in Section 1927(g(1)(B)(i) of the Social Security Act.

The full list of PADs that require prior authorization can be found on Appendix Y: Physician Administered Drug Medical Benefit Prior Authorization Procedures and Criteria.

Providers must ensure that a member-specific prior authorization request (PAR) is submitted directly to the Department's Utilization Management vendor, Acentra and approved prior to administration of the PAD. Approval of a PAR does not guarantee Health First Colorado payment.

All PAD prior authorization (PA) procedures, clinical criteria and PADs subject to PA requirements can be found on Appendix Y: Physician Administered Drug Medical Benefit Prior Authorization Procedures and Criteria, accessible via the PAD Provider Resources web page.

Additional information regarding PAD PA requirements can be found via ColoradoPAR: Health First Colorado Prior Authorization Request Program and the Physician Administered Drug Provider Resources web pages.

Contact HCPF_PAD@state.co.us with all other PAD questions.

Physician Services

Developmental and Social-Emotional Screening Coding and Billing

Health First Colorado covers developmental screening for children ages 0–five (5) years, up to 65 months, when completed using a standardized, validated developmental screening tool during the child's periodic visits.

Health First Colorado may also cover medically necessary developmental screenings outside of the 0–five (5) age range when documentation supporting medical necessity is included in the member's medical record for audit purposes.

Providers are reminded to ensure that internal billing systems are updated to include the appropriate modifiers and Z diagnosis codes, and to support documentation of screening outcomes, delays, referrals or other findings.

Updated Rate Reminder

The June 2026 Health First Colorado Provider Bulletin B2600539 states that, retroactive to April 1, 2026, the rate for code 96110+EP is $18.39 and the rate for 96110 without modifier is $10.38. Claims after April 1, 2026, are to be reprocessed to reflect the new rates. Refer to the Provider Rates and Fee Schedules web page for more rate information.

Coding and Billing Guidance

Code	Billing Guidance
96110EP	Use for developmental and social-emotional screening tools outside of Autism Spectrum Disorder-specific screening tools. This is the primary code for most approved screening tools. Requires applicable Z diagnosis codes. May be billed once per day and may be billed with 96127 and 96110 when appropriate.

96110	Use for a secondary screener on the same day. Requires applicable Z diagnosis codes. May be billed once per day and may be used with 96110EP and 96127 when appropriate.
96127	Use to track Autism Spectrum Disorder screening only, including tools such as the Modified Checklist for Autism in Toddlers (M-CHAT). Requires applicable Z diagnosis codes. May be billed once per day and may be used with 96110EP and 96110 when appropriate.

Key Billing Reminders

- Code 96110+EP should generally be used by providers for most developmental and social-emotional screening tools.
- Use 96127 only for Autism Spectrum Disorder-specific screening, such as M-CHAT.
- Use 96110 only when billing a secondary screener on the same day.
- All applicable screening codes require appropriate Z diagnosis codes.
- Codes 96110EP, 96110 and 96127 may each be billed once per day and may be billed together when appropriate.

When a screening identifies a concern or abnormality, providers should document the result and discuss referral for further developmental, behavioral or specialty evaluation with the parent or caregiver.

Well-Child Visit Allowances for Members Under Age 21

Health First Colorado does not limit the number of well-child visits members under age 21 may receive in a calendar year or within any rolling 365-day period. This policy aligns with the American Academy of Pediatrics Bright Futures Periodicity Schedule.

As an example, if a child misses a scheduled well-care visit and another visit is scheduled earlier than usual within the same calendar year or 365-day period, both visits are allowed.

Health First Colorado also allows coverage when well-child visits are provided by different enrolled providers. This may occur when a child's placement or caregiver changes. For example, if a child is in the custody of the county, receives a well-child visit from one provider and is later moved to a different home and receives a well-child visit from a different provider, both visits are allowed when provided as well-child care.

Contact Gina Robinson at Gina.Robinson@state.co.us or HCPF_EPSDT@state.co.us with any questions.

Remote Patient Monitoring Rate Correction

Two (2) Remote Patient Monitoring procedure codes were identified by the Department as having been loaded in the claims payment system with incorrect rates. The impacted codes are 99445 and 99470.

The incorrect rates are being inactivated effective January 1, 2026, and the corrected rates are being added to the system. Claims for the impacted codes with dates of service on or after January 1, 2026, will be reprocessed as applicable.

Providers do not need to take action for claims that are eligible for automatic reprocessing. Adjustments will be reflected on future remittance advices once reprocessing is complete. Providers should review future remittance advices for any claim adjustments related to these codes.

Contact Morgan Anderson at Morgan.Anderson@state.co.us and Sahara Karki at Sahara.Karki@state.co.us with questions about the Remote Patient Monitoring benefit.

Rural Health Clinics

Remote Patient Monitoring Billing Guidance for Rural Health Clinics

The Department is clarifying how Telehealth Remote Monitoring, also referred to as Remote Patient Monitoring (RPM), is reimbursed when furnished by Rural Health Clinics (RHCs) to Health First Colorado members.

Billing guidance

- RPM remains a covered and allowable service for RHCs when all applicable coverage, medical necessity, documentation, technology and supervision requirements are met.
- RPM services furnished by an RHC must be reimbursed through the existing RHC Prospective Payment System (PPS) methodology.
- RHCs should not bill RPM services separately from the RHC payment methodology for separate fee-for-service reimbursement.
- RHCs should review internal billing instructions, claim submission workflows and billing vendor guidance to ensure RPM billing reflects this clarification.

Background

Senate Bill 24-168 directed the Department to engage rural providers and other stakeholders to identify sustainable reimbursement options for Telehealth Remote Monitoring services. Stakeholders provided feedback on qualifying conditions, covered services, reimbursement methodologies, technology requirements and provider supervision standards.

Stakeholder input supported consideration of a reimbursement approach that would have allowed RPM services furnished by RHCs to be reimbursed separately from the RHC per-visit encounter rate. It was determined by RPM services provided by RHCs cannot be carved out of the RHC payment methodology and reimbursed separately on a fee-for-service basis,

after further review and consultation regarding federal Medicaid requirements. This includes discussions related to a potential State Plan Amendment submission to the Centers for Medicare & Medicaid Services.

The Department will not move forward with a proposed carve-out payment approach that would have allowed RPM services furnished by RHCs to be reimbursed separately from the RHC encounter payment. RPM remains a covered and allowable service for RHCs that is reimbursed through the RHC PPS payment methodology.

Provider action

RHCs and billing staff should update internal guidance as needed, ensure RPM services furnished by RHCs are not billed for separate fee-for-service reimbursement, share this clarification with billing vendors or clearinghouses as applicable and monitor future Provider Bulletins and billing manual updates for additional RPM billing guidance.

Questions

Contact Janelle Gonzalez at Janelle.Gonzalez@state.co.us with RHC questions and the Telemedicine and eConsult Billing Manual for additional information on the RPM benefit.

Therapy

Change of Provider Form Reminder and Information

Physical, occupational and speech therapy providers are reminded that when a new member presents for an evaluation and has received therapy services within the past year, the provider must determine whether the member has seen another therapist within the last 365 days. If the member has received services from another provider during that time, the provider should obtain a Release of Information (ROI) to coordinate care or complete a Change of Provider Form, as appropriate.

The Change of Provider Form must be completed and must include the name of the previous provider, not the individual therapist, **if the member will**

not be returning to the previous therapist. The member or caregiver must sign and date the form. The provider should also ensure that the last date of service with the previous provider is before the new provider's start date of service.

The new provider must obtain the other provider's current plan of care to support care coordination as part of the Prior Authorization Request (PAR) submission **if the member will continue receiving services** from the current or previous therapist. The new provider must ensure that the requested treatment is not duplicative of services already being provided.

The Prior Authorization Request should be submitted as soon as the evaluation and plan of care are complete and before billing occurs. The new provider must include the applicable care coordination documentation when submitting the PAR, such as the previous provider's current plan of care if the member is continuing treatment with another therapist, and the completed Change of Provider Form when applicable.

Review the Change of Provider Form Tips resource for tips on completing the change of provider form.

Transportation Providers

Enrollment Information

Non-Emergent Medical Transportation (NEMT) providers that were previously part of the Transdev network, as well as those who were on the Transdev waitlist with a service address within the nine (9) metro counties, may begin the enrollment process with MediDrive only if their credentials are current. Enrollment with MediDrive is available only to providers that previously completed credentialing and revalidation and have up-to-date documentation, including insurance, driver rosters and vehicle rosters.

Providers that have not previously completed the credentialing process will need to wait until the moratorium ends later this year before re-enrolling and credentialing. More information will be provided when it is available.

How to Begin - Start the application at MediDrive enrollment.

What Needs to Be Done – To streamline the transition and reduce administrative burden, providers previously active in the Transdev network or on the Transdev waitlist will need to verify, and if needed, correct their driver and vehicle rosters uploaded in ProCredex before submitting the initial contracting application. Simply complete the application with company information. Only complete **one** (1) application per company through MediDrive. MediDrive will contact the provider to complete the contracting process.

- **Critical**: Providers must contract with MediDrive using the exact same business name and National Provider Identifier (NPI)/Medicaid ID that was used to enroll with Health First Colorado. Do **not** contract under any "doing business as" (dba) names.

Keeping Records Current – All driver and vehicle rosters must remain current and complete in the ProCredEx system through this transition. This includes all required:

- Licensing
- Insurance – which must ***always*** be kept active while enrolled as a Health First Colorado-enrolled NEMT provider.
- Vehicle inspections
- Driver credentials and certifications
- Any other compliance documentation

Routine roster maintenance and credentialing with ProCredEx will begin after July 1, 2026.

NEMT providers operating outside the broker service area **should not enroll with or seek credentialing from MediDrive at this time**. Transition resources are currently focused on the existing nine (9) county metro network. Providers should continue to keep all credentialing information and requirements up to date in ProCredEx to remain compliant with Department rules and support a smoother contracting process with MediDrive when the time comes. Additional information will be provided as it becomes available.

Contact NEMT@state.co.us with any questions regarding the new application process with MediDrive.

Non-Emergent Medical Transportation (NEMT) Communications

All actively enrolled Non-Emergent Medical Transportation (NEMT) providers should expect communications from the Department in the coming weeks regarding new broker timelines, key transition information and enrollment details.

Operational memo OM26-029, outlining the broker transition plan, has been published and made available on the memo series web page.

Information will be shared by the Department through email notifications, newsletters and the monthly Provider Bulletin as the transition begins and continues.

MediDrive Enrollment for Transdev Network Providers *Only*

Effective July 1, 2026, MediDrive became the Non-Emergent Medical Transportation (NEMT) broker in the following nine (9) Denver metro area counties: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer and Weld.

Effective Fall 2026

- The statewide broker model will expand to all remaining counties in Colorado.
- At that time, NEMT services across Colorado will be managed by MediDrive.

Facilities may notice updates to transportation coordination and management. These changes are intended to improve reliability, reduce confusion and create a smoother experience for members, providers and facility staff.

What facilities can expect

- A dedicated MediDrive facility support team to assist with transportation coordination.
- A secure online portal: facility.medidrive.com for managing transportation requests.
    - Reduced hold times on phone-based scheduling
- Enhanced support for:
    - Hospital discharges
    - Standing orders
    - General transportation coordination and questions

Contact MediDrive via email or by phone at 720-452-3025 with questions regarding Denver metro area trips. Refer to the Non-Emergent Medical Transportation policy page for more information about the transition.

New Process for Out-of-State Non-Emergent Medical Transportation (NEMT) Requests

Out-of-state and specialized Non-Emergent Medical Transportation (NEMT) requests will now be made through the MediDrive facility portal. All requests will be made online; no more paper forms. The Department will still have final approval for all requests of this type.

Out-of-state and specialized transport requests will require a completed online form and letter of medical necessity, most recent clinical notes and a prior authorization (PAR) for the services or treatment if applicable. These requests must be submitted at least five (5) days prior to travel.

Contact facilityco@medidrive.com or call MediDrive at 720-452-3025 with questions about the MediDrive facility portal.

Contact NEMT@state.co.us with questions about out-of-state or specialized transportation.

Women's Health

Doula Benefit Update

The Health First Colorado doula benefit launched on July 1, 2024, and the Department has continued investing in efforts to strengthen Colorado's Medicaid doula workforce and improve members' access to high-quality, community-based maternal health services.

The Department has awarded organizations through the Doula Workforce Advancement Fund to support newly trained doulas as they become enrolled Health First Colorado providers, building on the success of the Doula Training Scholarship Program. These organizations will help scholarship recipients successfully enroll as Health First Colorado providers, gain mentored hands-on experience, establish sustainable community-based practices and begin delivering covered doula services to Health First Colorado members.

Partnering with these organizations will help strengthen Colorado's doula workforce and expand access to culturally responsive maternal health services for Health First Colorado members:

- Cuenta Conmigo Cooperative
- Elephant Circle – Doula Program
- Families Forward Resource Center – Doula Program
- NoCo New Horizons Doula Collective
- Peaceful Birth
- Road to Me Recovery Foundation
- Roots Family Center – Doula Program
- Sanctuary CARES

Coming Later This Summer: The Health First Colorado Doula HUB

The **Health First Colorado Doula HUB**, a new online learning opportunity designed to support current Health First Colorado doula providers, will be launching later this summer.

The Doula HUB will offer six self-paced instructional just-in-time modules covering key topics to help doulas successfully enroll and practice as Health First Colorado Providers. Participants will complete knowledge checks to reinforce learning throughout the training and finish with a final quiz to demonstrate understanding of the material.

Doulas who successfully complete the training will receive a **Certificate of Completion** recognizing their successful completion of the entirety of the curriculum and preparedness to serve as Health First Colorado providers.

The Doula HUB offers trusted, on-demand learning and practical resources to support provider enrollment, documentation, billing and ongoing program requirements for both newly approved and more experienced Health First Colorado doula providers.

Provider Training Sessions

August 2026 Schedule

Providers are invited to sign up for provider training sessions. All sessions are held via webinar on Zoom, and registration links are shown in the calendar below. *The availability of training sessions varies monthly.* Descriptions of available training sessions, calendar registration links and training-specific slide decks are available on the Provider Training web page.

The following training sessions focused on Health First Colorado will be offered in August:

- **HCBS Beginner Billing Training**

This introduction to billing Health First Colorado is specific to Home and Community-Based Services (HCBS) providers (provider type 36). Billing information curated to unique needs of this provider type includes Department website navigation, prior authorizations, identifying member eligibility, HCBS resources and a claim submission demonstration on the Provider Web Portal specific to HCBS providers.

- Audience: Any Home and Community Based Services provider (provider type 36) that submits claims, is new to billing Health First Colorado services or that needs a refresher billing course.
- Time: One and a half (1.5) hour presentation / half (0.5) hour Q&A

- **Beginner Billing Training**

  Beginner billing training provides a high-level overview of Department website navigation, member eligibility, prior authorizations, claim submission, Provider Web Portal use and more. This training is appropriate for providers who submit either professional claims (CMS 1500) or institutional claims (UB-04). *[NOTE: Separate training is offered for Home and Community-Based Services (HCBS) providers.]*

  - Audience: This training is designed for providers at various stages of the initial enrollment process with Health First Colorado.
  - Time: One and a half (1.5) hour presentation / half (0.5) hour Q&A

- **Billing Medicare and Third-Party Liability**

  This focused micro-training addresses billing Medicare and third-party liability (TPL) (e.g., commercial and private insurance) as primary payers, including detailed information on Medicare lower-of pricing logic and timely filing guidelines.

  - Audience: This training is not relevant to Home and Community-Based Services (HCBS) and Non-Emergent Medical Transportation (NEMT) providers. This training applies to all

other provider types and is recommended after attending beginner billing training.

- Time: One (1) hour presentation / half (0.5) hour Q&A

- **Trading Partner EDI Training**

  Electronic Data Interchange (EDI) functionality, including batch processing, will move from the Medicaid Management Information System (MMIS), operated by Gainwell Technologies, to a new module operated by Edifecs (a Cotiviti business). Trading partners are encouraged to register for training sessions to ensure proper onboarding and enrollment. Each training session is limited to 50 participants, and spaces are filled on a first-come, first-served basis. **Providers should not register for this training**.

  - Audience: This training is designed for trading partners that process batch transactions on behalf of Health First Colorado providers.
  - Time: One and a half (1.5) hour presentation / half (0.5) hour Q&A

Live Webinar Registration

Click the title of the desired provider training session in the calendar to register for a webinar. An automated response will confirm the reservation. Webinars may end early. Time has been allotted for questions at the end of each session.

gust 2026

Monday	Tuesday	Wednesday	Thursday	Friday
3	4 HCBS Beginner Billing Training 1:00 p.m. - 3:00 p.m. MT	5	6	7
10	11 Beginner Billing Training 1:00 p.m. - 3:00 p.m. MT	12	13	14 Billing Medicare & Third-Party Liability 11:00 a.m. - 12:00 p.m. MT
17	18	19	20	21
24	25	26	27	28
31				

Note: All training sessions offer guidance for Health First Colorado only. Providers are encouraged to contact the Regional Accountable Entities (RAEs), Child Health Plan *Plus* (CHP+) and Medicare for enrollment and billing training specific to those organizations. Training for the Care and Case Management (CCM) system will not be covered in these training sessions. Visit the CCM System web page for CCM-specific training and resources.

Refer to the Provider Web Portal Quick Guides located on the Quick Guides web page for more training materials on navigating the Provider Web Portal.

Upcoming Holidays

Holiday	Closures
Labor Day September 7, 2026	State Offices, Acentra, AssureCare, DentaQuest and the Provider Services Call Center will be closed. MedImpact will be open. Capitation and payment cycles will run as normal beginning Friday night and will not be delayed. However, the receipt of warrants and Electronic Funds Transfers (EFTs) may be delayed due to processing at the United States Postal Service or at providers' individual bank.

Provider Services Call Center

1-833-468-0362