Provider Bulletin

Reference Number: B2600542

Sept 2026

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Did You Know?

Provider Affiliations

Providers who submit professional claims and report as a rendering provider are encouraged to keep affiliations updated. Providers have been given an extended grace period to make all necessary updates to affiliations to avoid future claims denials. If Explanation of Benefits (EOB) 3110 - "The rendering provider is not a group member" appears on a claim, providers should check the affiliations and make sure they are up to date. Updated affiliations are currently taking up to eight (8) days for final approval.

All Providers

Change of Ownership

Providers are reminded to notify the Department of Health Care Policy and Financing (the Department) within 35 days of any material or substantial change in information in the enrollment application, including a change in ownership. Refer to Section 3.7 of the Provider Participation Agreement (revised 2023).

A change in an Employer Identification Number (EIN) is considered a change of ownership, and a new National Provider Identifier (NPI) is required. The following provider types (PT) must complete a Change of Ownership (CHOW) form when a change in ownership occurs:

- Home Health (PT 10)
- Hospice (PT 50)
- Hospital (PT 01)
- Indian Health Services (IHS) Pharmacy (PT 62)
- Nursing Facilities (PTs 20, PT 21)
- Pharmacy (PT 09)

- Psychiatric Hospital (PT 02)

For all other provider types, the selling provider must disenroll and the purchasing provider must submit a new enrollment application. To complete disenrollment, providers can log into the Provider Web Portal and select the "Disenroll" option. New business owners are responsible for maintaining all records and assuming any liabilities associated with the previous ownership.

A legal name change alone is not considered a change in ownership. The Legal Name Change Form is located on the Provider Forms web page under the Provider Enrollment & Update Forms drop-down menu. Providers are encouraged to visit the Enrollment FAQ section of the Provider Enrollment web page for more information.

Deficit Reduction Act of 2005

Section 6032 of the Deficit Reduction Act of 2005 (DRA) requires that providers who meet the definition of entity and who make or receive annual Medicaid payments of $5 million or more establish and disseminate certain written policies for preventing and detecting fraud, waste and abuse. The entities must also provide information to employees and contractors about the Federal False Claims Act and other applicable federal and state false claims laws, the administrative remedies for false claims and statements and the whistleblower protections afforded under such laws.

Each year the Department requires providers who are subject to Section 6032 of the DRA to provide certain documentation to show compliance with these requirements. Providers will receive an email from the Department requesting this documentation and should ensure the contact information listed with the Department's fiscal agent is current to receive this email

Providers are required to submit the DRA declaration for Federal Fiscal Year (FFY) 25-26 October 1, 2025, through September 30, 2026. Entities subject to the DRA must complete and return to the Department the signed DRA Declaration with all required documents. Entities with multiple identified locations must send one signed DRA Declaration with an attachment listing

all Service Location Provider IDs, NPIs and Tax IDs covered by the DRA Declaration.

All providers subject to the DRA for Federal Fiscal Year 2025-2026 are required to complete and return to the Department the following documents:

- **The DRA Declaration signed with an attachment listing all NPIs, service location IDs and Tax IDs covered by the DRA Declaration.**
- **A copy of the policies and procedures for detecting and preventing waste, fraud and abuse.**
- **A copy of the employee handbook specific to the laws describing the written policies and procedures regarding waste, fraud and abuse, if one exists.**
- **A copy of the rights of employees to be protected as whistleblowers.**
- **IA specific discussion of the policies and procedures for detecting and preventing waste, fraud and abuse.**

The completed **DRA Declaration** and all required documents must be emailed to hcpf_draact2005@state.co.us no later than November 2, 2026.

Contact Eileen Sandoval at hcpf_draact2005@state.co.us with questions related to the DRA.

Licensure

Providers are reminded to verify the status of their license on file with Health First Colorado (Colorado's Medicaid program). Claims with dates of service of August 1, 2026, or later will deny for Explanation of Benefits (EOB) 3385 – "Provider license not active on date of service" if an updated license is not on file.

Not all licenses can be updated automatically in the system. Providers can update the license in the Provider Web Portal by submitting 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.

Provider Revalidation Reminder

Health First Colorado and Child Health Plan *Plus* (CHP+) providers must revalidate their enrollment in the program at least every five (5) years to continue as providers.

Providers are notified of their revalidation due date by email six (6) months in advance and are encouraged to complete their revalidation application immediately after receiving their revalidation notification.

Providers are reminded to maintain accurate contact information in their provider profile, including their email addresses and mailing addresses, to ensure revalidation information is routed properly and to prevent notification delays. Providers may verify and maintain their contact information in the Provider Web Portal.

Refer to the Provider Revalidation Dates Spreadsheet for revalidation due dates by provider, provider type, provider ID and NPI. Refer to the Revalidation web page for more information.

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 the Department
- New log-in credentials for the platform (to be issued once the agreement has been acknowledged)
- New Trading Partner Enrollment and Testing Site

Trading partners that have not yet completed enrollment in the Trading Partner Enrollment and Testing Site should do so as soon as possible **to avoid disruptions to EDI file exchange**.

If a vendor has not yet enrolled:

- Contact the Provider Services Call Center to verify the email address originally registered with Health First Colorado before beginning enrolment.
- Use that verified email address when enrolling to retain the existing Trading Partner ID (TPID).
- Using a different email address may create a duplicate TPID, which can delay onboarding and complicate file submission and compliance validation.

Trading partners that have already completed enrollment do not need to register again and should continue using their assigned credentials and existing TPID.

Providers: Contact the trading partner to ensure they are aware of the information available on the Electronic Data Interchange (EDI) Support web page and have completed all required enrollment activities.

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 TPIDs.

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

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.

Inpatient Hospital Transitions (IHT)

Compliance Data Available

Hospitals participating in the IHT program may request data related to their IHT submission compliance. Quality departments and case management teams can request this information by emailing the Utilization Management (UM) inbox at hcpf_um@state.co.us.

Upcoming Update to the Non-Neonatal Intensive Care Unit (NICU) Inpatient Hospital Transitions (IHT) Questionnaire

It is anticipated that effective **October 1**, **2026**, a new question in **the Non-NICU Inpatient Hospital Transitions (IHT) questionnaire will be required**: Member discharge/transition plan – Does the hospital request outreach and assistance from the member's Regional Accountable Entity (RAE)?

Hospitals will be required to select one of the following responses before submitting the questionnaire:

- Simple discharge – RAE assistance declined
- Complex discharge – RAE assistance declined
- Complex discharge – RAE assistance requested

This required field will help RAEs identify members who need follow-up and when to contact hospitals to support complex discharges. The selected response will be included in IHT reports beginning with submissions received on or after October 1, 2026.

Contact the Utilization Management team at hcpf_um@state.co.us with questions about this change.

Pediatric Behavioral Therapy (PBT) Provider Education Update

Acentra Health and the Department remain committed to supporting timely access to medically necessary Pediatric Behavioral Therapy (PBT) services for members.

Several recurring documentation issues have been identified that may result in requests requiring additional review, pends or denials when submitted as part of a PBT treatment plan. Providers are encouraged to submit Prior Authorization Requests (PARs) with adequate time to allow for the resolution of any potential documentation issues; submissions between 14-21 days prior to the PAR start date are encouraged. The following reminders are to

help providers align submissions with current Health First Colorado criteria and facilitate more efficient reviews of requests.

Key Reminders

- Treatment plans must focus on medically necessary behavioral interventions that address the member's documented functional impairments, behavioral challenges, safety concerns, communication deficits, self-care needs and other clinically significant areas identified within the assessment.
- Treatment plans must include specific, measurable goals and objective methods for evaluating progress.
- Documentation must clearly demonstrate how requested services are medically necessary based on the member’s clinical presentation and functional needs.
- For requests involving enhanced staffing ratios, co-treatment or group therapy services, providers must ensure documentation clearly supports the clinical rationale and medical necessity for the requested service level.

The interventions listed below are not automatically prohibited or non-covered. However, naming an intervention or curriculum alone is not sufficient to demonstrate medical necessity. When these approaches are included in a PBT treatment plan, the documentation must identify the observable and measurable behavior or functional skill being addressed, explain how the intervention is supported by the member’s assessment, describe how it will be implemented within the provider’s scope of practice and specify how progress will be measured. Requests may be pended or denied when the documentation does not establish these connections.

Common Interventions Requiring Clear Clinical and Behavioral Justification During Review

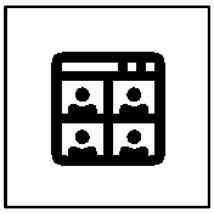
The following interventions are commonly identified during review and may require additional security under current Health First Colorado criteria when submitted as primary treatment interventions within a PBT request:

- Unspecified coping, calming, self-management, breathing and de-escalation strategies
- Self-regulation programs, Zones of Regulation, behavior relaxation training and cool-down spaces
- Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT) interventions
- Social stories and narratives
- Mindfulness, yoga and similar relaxation-based interventions
- Muscle relaxation techniques
- Sensory diets, sensory integration approaches, weighted blankets and weighted vests
- Perspective taking, social inferencing and interventions focused on emotions, feelings or other mentalistic/private events
- Journaling and positive self-talk
- Behavioral mapping and similar programs

Providers must ensure that treatment plans clearly demonstrate how interventions align with current PBT criteria and generally accepted standards of care for behavioral therapy services.

Providers may email Acentra Health at coproviderissue@acentra.com for questions or concerns related to PAR submissions. Providers may also email hcpf_um@state.co.us at any time to further escalate concerns or unresolved issues.

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:

- Portal Registration and PAR Submission Training September 23, 2026, 9:00 a.m.
- Portal Registration and PAR Submission Training September 23, 2026, 12:00 p.m.
- Pediatric Long-Term Home Health Therapies Provider Benefit Specific Training September 9, 2026, 9:00 a.m.
- Pediatric Long-Term Home Health Therapies Provider Benefit Specific Training September 9, 2026, 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

M-REACH Program Launched

On July 1, 2026, in partnership with the Colorado Department of Corrections (DOC), the Department launched the Medicaid Reentry and Community Health (M-REACH) program at select DOC facilities. This allows Health First Colorado to cover certain services for people in jails and prisons in order to improve health and transitions back into the community. Enrollment and

billing for M-REACH services is currently limited to facilities that have passed a Facility Readiness Assessment and the state staff at those facilities. This will expand over time.

Federal Medicaid rules have historically prohibited Medicaid reimbursement for services provided in carceral settings (jail, prison or youth detention facilities). Through the state's 1115 Demonstration Waiver, Colorado now has authority and federal matching funds to reimburse for select reentry services prior to release.

Through M-REACH, eligible Health First Colorado members will be able to receive:

- Targeted Case Management (TCM) services beginning up to 90 days prior to release
- Medication-Assisted Treatment (MAT) services beginning up to 90 days prior to release
- A 30-day supply of prescription medications upon release

Individuals leaving incarceration face significantly increased risks of overdose, suicide, behavioral health crises and disruptions in medical care. By allowing critical services to begin before release, M-REACH helps individuals establish connections to care, coordinate treatment, continue use of prescription medications without disruption and access needed physical and behavioral health supports before returning to their communities.

Strengthening continuity of care can improve health outcomes, reduce avoidable emergency department utilization, decrease overdose risk and support successful community reentry. The program also increases investment in services for justice-involved Coloradans by leveraging federal Medicaid funding to support care and coordination efforts.

The Department would like to thank the Colorado Department of Corrections, providers, advocates and community partners whose collaboration and dedication made this launch possible. Implementing Medicaid-funded services within correctional settings requires significant

operational changes, and the success of this effort reflects the commitment of partners across Colorado.

Work on Phase II of M-REACH is beginning, which will expand implementation efforts to local correctional facilities including county and municipal jails and Tribal detention centers.

Visit the Medicaid Reentry and Community Health (M-REACH) web page to learn more about M-REACH and Colorado's Medicaid reentry initiatives.

New: Behavioral Health Recovery Residence Policy

The Supportive Services Sustainability Strategy is being implemented by the Department to provide guidance and clarity regarding appropriate use of behavioral health supportive services, monitor utilization trends to ensure utilization aligns more closely with standards and expectations and ensure that Health First Colorado funds are spent appropriately.

A policy statement is being issued as part of this strategy to clarify that a Recovery Residence is not an eligible place of service for the delivery of Health First Colorado reimbursable behavioral health services. Visit the Behavioral Health Policies, Standards, and Billing References web page for the full policy statement and details. Effective October 1, 2026, Regional Accountable Entities (RAEs) will enforce this guidance.

Any behavioral health provider holding a certification from Ohio Recovery Housing (ORH) and is contracted with one or more RAEs must sign and submit this Attestation to the Health First Colorado Behavioral Health Recovery Residence Policy form to their RAE or RAEs by October 1, 2026, indicating that the provider will not submit claims to the RAEs, nor to fee-for-service, for any behavioral health service delivered within a recovery residence setting.

Contact the RAE with any concerns about past billing and allowability. Contact hcpf_bhbenefits@state.co.us with any questions about this policy.

Annual 1115 Substance Use Disorder Waiver Stakeholder Forum

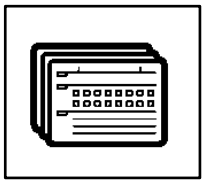
On October 7, 2026, the Department will host the Annual 1115 Expanding the Substance Use Disorder Continuum of Care (1115 SUD Waiver) Stakeholder Forum. The Department will review the most recent 1115 Waiver Annual Report during the forum and update the community about ongoing efforts and anticipated changes.

This year's forum will be held virtually Wednesday, October 7, 2026, from 11:00 a.m. - 12:00 p.m. MT. Participants can register now.

Visit the Expanding the Substance Use Disorder (SUD) Continuum of Care Waiver web page for more information on the 1115 SUD waiver. Contact hcpf_1115waiver@state.co.us with any comments or questions.

Auxiliary aids and services for individuals with disabilities and language services for individuals whose first language is not English may be provided upon request. Notify hcpf_1115waiver@state.co.us or the Civil Rights Officer at hcpf504ada@state.co.us at least one week prior to the webinar to make arrangements.

Implementation of New Limits on Supportive Services



On August 1, 2026, one of a series of policies focusing on the utilization of Supportive Services was implemented. This included the implementation of daily limits and same day billing limits to a number of codes included in the table below. Annual limits for Supportive Services were not implemented as previously proposed. Specifically, annual limits were NOT applied to procedure codes H0038, H2014 and T1017. These changes are updates to the Colorado Medically Unlikely Edits (CO MUEs) and Procedure-to-Procedure (PTP) policy shared in the June Health First Colorado Behavioral Health Updates newsletter.

The collaboration and partnership of providers and stakeholders is appreciated while working together to address increasing and unsustainable

utilization of specific codes for services that are incorporated in a number of ways as part of team-based care to preserve access to medically necessary, high-quality behavioral health services. It is recognized that these changes may require operational adjustments, and the Department remains committed to working with its partners to identify balanced, sustainable solutions that support members, providers and the long-term viability of the Health First Colorado program. The Department is sharing an additional series of daily limits and same day billing limits that will become effective October 1, 2026. Providers and stakeholders are encouraged to continue participating in provider forums and public meetings and to share feedback by email as this work moves forward. Contact the contracted RAEs with any questions.

Regional Accountable Entities (RAEs) are responsible to enforce these new daily limits (CO MUEs) and same day billing limits (PTPs). The effective date of the policy change for each is indicated in the code column with a symbol to indicate active since August 1, 2026, or effective beginning October 1, 2026.

Code ^ August 1 # October 1	Service	Daily Limits (CO MUEs)	Same Day Billing Limits (PTPs)
H0015#	Alcohol and/or drug services. Intensive Outpatient Program (IOP)		H0005, H0016, H0035, H0038, H2012, H2014, S9480, T1017, 90832, 90834, 90837, 90853
H0016#	Alcohol and/or drug services; less than 24 hours, Partial Hospitalization Program (PHP)		H0005, H0015, H0035, H0038, H2012, H2014, S9480, T1017, 90832, 90834, 90837, 90853

Code ^ August 1 # October 1	Service	Daily Limits (CO MUEs)	Same Day Billing Limits (PTPs)
H0035#	Mental Health Partial Hospitalization Program (PHP), less than 24 hours		H0005, H0015, H0016, H0038, H2012, H2014, S9480, T1017, 90832, 90834, 90837, 90853
H0036^	Functional Family Therapy (FFT) or Community Psychiatric Supportive Treatment (CPST), 15 mins		Cannot be billed on the same day as H0037, H0038, H2014
H0037^	Functional Family Therapy (FFT) or Community Psychiatric Supportive Treatment (CPST), per diem		Cannot be billed on the same day as H0036, H0038, H2014
H0038^	Self-help/peer services	12 units per day (effective since 10/1/25)	Cannot be billed on same day as H0023, H0046, H2014, H2015,

Code ^ August 1 # October 1	Service	Daily Limits (CO MUEs)	Same Day Billing Limits (PTPs)
			H2016, H2017 or H2018
H0039#	Assertive community treatment, 15 mins	16 units per day	H0040, H0036, H0037, H0005, H0015, H0016, H0038, H2012, H2014, S9480, T1017
H0040#	Assertive community treatment program, per diem		H0039, H0036, H0037, H0005, H0015, H0016, H0038, H2012, H2014, S9480, T1017
H0045^	Respite care services, not in the home, per diem		Cannot be billed on same day as S5150, S5151, T1005
H0046^#	Drop-In Center	16 units per day#	Cannot be billed on same day as H0038^, H2014^, H2030^, H2023#, H2024#, H2026#

Code ^ August 1 # October 1	Service	Daily Limits (CO MUEs)	Same Day Billing Limits (PTPs)
H2012#	Behavioral health day treatment, per hour	6 units per day	H0039, H0040, H0035, H0036, H0037, H0038, H0005, H0015, H0016, H2012, H2014, H2015, H2016, H2017, H2018, H2021, S9480, T1017, 90832, 90834, 90837, 90853
H2014^	Skills training and development	12 units per day (effective since 10/1/25)	Cannot be billed on the same day as H0038, H2015, H2016, H2017 or H2018
H2015#	Comprehensive community support services, 15 mins	16 units per day (effective since 10/1/25)	H2014, H2016, H2017, H2018, H2021, H2022 (preceding codes here effective since 10/1/25), H0038
H2016#	Comprehensive community support services, per diem	1 unit per day (effective since 10/1/25)	H2014, H2015, H2017, H2018, H2021, H2022 (preceding codes effective since 10/1/25), H0038

Code ^ August 1 # October 1	Service	Daily Limits (CO MUEs)	Same Day Billing Limits (PTPs)
H2017#	Psychosocial rehabilitation services, 15 mins	16 units per day (effective since 10/1/25)	H2014, H2015, H2016, H2018, H2021, H2022 (preceding codes effective since 10/1/25), H0038
H2021#	Community-based wrap-around services, 15 mins		H2014, H2015, H2016, H2017, H2018, H2022 (preceding codes effective since 10/1/25), H0038
H2022#	Community-based wrap-around services, per diem		H2014, H2015, H2016, H2017, H2018, H2021, H0038
H2023^#	Supported Employment, 15 mins	16 units per day#	Cannot be billed on same day as H2024, H2025^
H2024^	Supported Employment, per diem		Cannot be billed on same day as H2023, H2025, H2026

Code ^ August 1 # October 1	Service	Daily Limits (CO MUEs)	Same Day Billing Limits (PTPs)
H2025^#	Ongoing Support to Maintain Employment, 15 mins	16 units per day#	Cannot be billed on same day as H2023, H2024, H2026^
H2026^	Ongoing Support to Maintain Employment, per diem		Cannot be billed on same day as H2023, H2024, H2025, H2031
H2030^#	Mental Health Clubhouse Services, 15 mins	16 units per day#	Cannot be billed on same day as H0046, H2031^
H2031^	Mental Health Clubhouse Services, per diem		Cannot be billed on same day as H2030
H2032^	Activity Therapy, 15 mins	12 units per day (effective since 10/1/25)	Cannot be billed on same day as G0176
H2033#	Multi-systemic therapy (MST) for juveniles, 15 mins		H0039, H0040, H0036, H0037, H0005, H0015, H0016, H0038, H2012, H2014,

Code ^ August 1 # October 1	Service	Daily Limits (CO MUEs)	Same Day Billing Limits (PTPs)
			S9480, T1017, 90832, 90834, 90837, 90853
S5150^#	Unskilled Respite Care, Not Hospice, 15 mins	16 units per day#	Cannot be billed on same day as S5151, T1005^
S5151^	Unskilled Respite Care, Not Hospice, per diem		Cannot be billed on same day as S5150, T1005
S9480#	Mental Health Intensive Outpatient Program (IOP), per diem		H0039, H0040, H0035, H0036, H0037, H0005, H0015, H0016, H0038, H2012, H2014, S9480, T1017, 90832, 90834, 90837, 90853
T1005^	Respite care services, 15 mins		Cannot be billed on same day as H0045, S5150, S5151

Code ^ August 1 # October 1	Service	Daily Limits (CO MUEs)	Same Day Billing Limits (PTPs)
T1017	Targeted Case Management	4 units per day (effective since 10/1/25)	

Note that these limitations only apply to services provided to members 21 to 65 years of age under Behavioral Health Capitated Services.

Clinical Oversight and Medical Necessity

The Rendering Provider overseeing a member's treatment remains responsible for determining:

- Appropriate level of care
- Medical necessity
- Whether services are aligned with a member's diagnosis and individualized treatment plan

Extended or intensive use of supportive services may indicate the need for a higher level of care. In alignment with the Behavioral Health Administration (BHA) rules and best practice standards, supportive services remain integral to team-based treatment models such as:

- Assertive Community Treatment (ACT)
- Intensive Outpatient Programs (IOP)
- Partial Hospitalization Programs (PHP)

Services Not Impacted

These limits apply only to services covered under the Capitated Behavioral Health Benefit. They do not change benefits available through:

- 1115 Waiver Health Related Social Needs (HRSN) Demonstration

- 1115 Waiver Reentry Demonstration

Extended Home and Community-Based Services (HCBS) Waivers

The Colorado Medically Unlikely Edits and Procedure to Procedure (CO MUEs and CO PTP) policy is found on the Behavioral Health Policies, Standards, and Billing References web page. Visit this web page to view the complete list of all limits associated with this policy.

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.

Durable Medical Equipment, Pharmacy

Breast Pump Prescriptions

Effective for dates of service September 1, 2026, and later, Direct Entry Midwives (Provider Type 69) and Certified Midwives (Provider Type 80) will be authorized to directly recommend and prescribe breast pumps to a Health First Colorado member without requesting the prescription from a licensed practitioner. Durable Medical Equipment (DME) providers may submit claims when a Direct Entry Midwife or Certified Midwife orders a breast pump for an eligible member.

All claims for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) must have the National Provider Identifier (NPI) number of the provider who ordered the items to be indicated on the claim in the "Referring Provider" field. Ordering, Prescribing and Referring Providers must be enrolled with Health First Colorado, per 42 CFR 455.410(b).

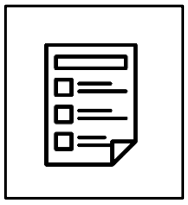
Refer to the Ordering, Prescribing, and Referring web page for additional information.

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

Home and Community-Based Services (HCBS)

2026 Workforce Reporting and Base Wage Attestation

The deadline to submit the 2026 Workforce Reporting and Base Wage Attestation was August 31, 2026.



Home and Community-Based Services (HCBS) providers delivering base wage-qualifying services that did not submit the required Workforce Reporting and Base Wage Attestation by the deadline will be publicly identified, and the Department will begin suspending claim payments until the required reporting is received.

Reporting materials and instructions were emailed on July 1, 2026, to the email address on file in the Provider Web Portal. Providers were notified that failure to comply with the Workforce Reporting and Base Wage Attestation requirements may result in an audit, corrective action, suspension of claim payments or recoupment.

Providers are urged to submit immediately if they have not already done so, as soon as possible. Payment suspension related to the reporting requirements will be lifted and claim payments will resume once the Department receives the completed Workforce Reporting and Base Wage Attestation.

Contact HCPF_BaseWage@state.co.us if the reporting email was not received, if needing the reporting materials resent or if there are questions about the reporting requirements.

Provider Training for New Supported Employment

The Office of Community Living hosted training sessions in July and August for provider agencies and staff members involved in delivering Supported Employment Services. The training provided 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.

Individual Supported Employment services are being redesigned 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 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.

Training and Resources

- A recording of the training session with other training materials is posted on the Long-Term Services and Supports Training web page under "Supported Employment" for providers who were unable to attend the previous live training.
- The following supporting materials for providers and Case Managers can be found on the Supported Employment web page:
    - Career Profile
    - Workplace Success Profile
    - Employment Exploration Plan
    - Employment Profile Packet Instruction Guide
    - Job Success and Fading Plan
    - Supported Employment Case Manager Tool
    - Training with Intent Milestone Validation Packet
- Refer to the Rates and Fee Schedule web page for information on rate schedules. Refer to the Billing Manuals web page if needing more information on specific programs.

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

Office Hours

Sign up for Individual Office Hours which will be offered in the weeks following the training sessions.

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 claim submissions.

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

Licensure Requirements

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 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 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.

Once providers obtain their license, they need to update the license in the Provider Web Portal by submitting 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.

Definitions:

• BI – Brain Injury Waiver	• CMHS – Center for Mental Health Services

• CES – Children's Extensive Support Waiver • CFC – Community First Choice • CHCBS – Children's Home and Community-Based Services Waiver • CHRP – Children's Habilitation Residential Program Waiver • CIH – Complementary and Integrative Health Waiver	• CWCHN – Children with Complex Health Needs Waiver • EBD – Elderly, Blind and Disabled Waiver • ICF/IDD – Intermediate Care Facility for Individuals with Developmental Disabilities • SLS – Supported Living Services Waiver

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

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.

Contact Andrew Abalos and Sean Paschke at Andrew.Abalos@state.co.us and Sean.Paschke@state.co.us with any questions.

APR-DRG Version 42 Update – New Effective Date, January 1, 2027

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. Note that the effective date for the APR-DRG Version 42 update originally planned for October 1, 2026, has been modified to January 1, 2027, after receiving feedback requesting additional time for impacted stakeholders to make adjustments in preparation for the change.

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. Advance 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 Department has concluded work 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 be reprocessed. An email will be sent to notify all Hospital Engagement Meeting newsletter subscribers 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.

Vaccines For Children (VFC) Update

Pricing logic for the VFC program will be added into the Grouper Plus Content Services general release update (v2026.3.0) for October 2026. This update will disallow EAPG payment for vaccines billed as acquired through the VFC program.

Contact Andrew Abalos and Sean Paschke at Andrew.Abalos@state.co.us and Sean.Paschke@state.co.us with any questions.

Prior Authorization Update for Specialty Drugs

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.

Itvisma® (onasemnogene abeparvovec-brve), Healthcare Common Procedure Coding System (HCPCS) J3405, has been added to the approved hospital specialty drug list effective July 1, 2026.

Appendix Z criteria updates have also been made for Casgevy® (exagamglogene autotemcel), HCPCS code J3392, Amvuttra ® (vutrisiran), HCPCS code J0225, and Yescarta® (axicabtagene ciloleucel), HCPCS Q2041, in accordance with the U.S. Food and Drug Administration (FDA) labeling changes.

The entire list of specialty drugs subject to this policy are listed on Appendix Z: Hospital Specialty Drugs List.

Member-specific Prior Authorization Requests (PARs) must be submitted directly to the Department at HCPF_PharmacyPAD@state.co.us and approved prior to administration of the specialty drug.

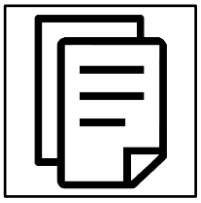
Resources including Appendix Z, coverage standards, request forms and submission requirements are listed on the Physician-Administered Drug (PAD) Provider Resources web page under the Hospital Specialty Drug Policy drop-down section.

Additional policy information can be found in the Physician-Administered Drugs and Inpatient/Outpatient (IP/OP) Billing Manuals and on the PAD Provider Resources web page.

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

Obstetrical Care Providers

Obstetrical Care Billing Update



A new Operational Memo (OM26-056) has been released in anticipation of the upcoming coding changes to maternity and obstetrical services by the American Medical Association on January 1, 2027. This memo is available on the 2026 Memo Series Communication web page and outlines changes to how antepartum care should begin to be coded for new pregnancies beginning September 1, 2026.

Providers working with pregnant members must review OM26-056 and should be prepared to work with any relevant billers or clearinghouses on the upcoming coding changes.

Pharmacy

Total Annual Prescription Volume (TAPV) Survey

Myers and Stauffer LC has been contracted by the Department to conduct the Total Annual Prescription Volume (TAPV) survey of pharmacy providers. The prescription volume information submitted by most pharmacy types will be used to determine their dispensing fee for the 2027 calendar year.

Pharmacies which meet the regulatory definition of a Government or Rural Pharmacy will have their dispensing fee determined by their pharmacy type (per 10 CCR 2505-10, Sections 8.800.1 and 8.800.13).

Myers and Stauffer will distribute the surveys to pharmacy providers starting October 1, 2026, and completed surveys must be returned to Myers and Stauffer by October 31, 2026. Pharmacy providers (other than Government or Rural Pharmacies) which do not participate in the prescription volume survey will be placed in the lowest dispensing fee tier ($8.72).

Beginning October 1, 2026, providers can submit the Colorado TAPV Survey Form via the Myers and Stauffer website under the Total Annual Prescription Volume section. Providers can also provide a submission to Myers and Stauffer via email at pharmacy@mslc.com, postal mail at 800 E. 96th Street, Suite 200, Indianapolis, IN 46240, or fax at (317) 566-3203. If not a Government or Rural Pharmacy and a survey request was not received, contact the Myers and Stauffer Pharmacy Help Desk at 800-591-1183 or at pharmacy@mslc.com to request a survey form.

Total Annual Prescription Volume	Dispensing Fee
0 – 59,999 TAPV	$13.40
60,000 – 89,999 TAPV	$11.49
90,000 – 109,999	$9.93
110,000+ TAPV	$8.72
Rural Pharmacy	$14.14
Government Pharmacy	$0.00

Contact Korri Conilogue at Korri.Conilogue@state.co.us with any questions regarding the survey.

Prescription Drug Average Acquisition Cost (AAC)

Myers and Stauffer has also been contracted to conduct ongoing acquisition cost surveys for prescription drugs. The participation of all selected pharmacy providers is strongly encouraged to ensure that AAC reimbursement rates adequately reflect the purchase conditions faced in the market today by Colorado providers. Initial surveys will be sent via postal mail on October 1, 2026, to a randomly selected group of pharmacy providers.

Purchase invoices can be submitted to Myers and Stauffer via email at pharmacy@mslc.com; postal mail at 800 E. 96th Street, Suite 200,

Indianapolis, IN 46240; or via fax at (317) 566-3203. Contact the Myers and Stauffer Pharmacy Help Desk at 800-591-1183 or at the email listed above with general inquiries.

Note: All submitted invoice data will remain strictly confidential.

Pharmacy and All Medication Prescribers

Preferred Drug List (PDL) Announcement of Preferred Products

Changes will be made for the following PDL classes effective October 1, 2026:

PDL Drug Class	Moved to Preferred	Moved to Non-preferred
Glucagon-like Peptide-1 Receptor Agonists (GLP-1 Analogues)	• Ozempic® tablet • Zepbound® KwikPen®*	None
Sodium-Glucose Cotransporter Inhibitors (SGLT inhibitors) and Combinations	• Dapagliflozin tablet (all manufacturers except ANI Pharma and Prasco Labs) effective 7/18/2026	• Farxiga® tablet
Insulins – Long Acting	• Toujeo® Solostar® and Max Solostar® effective 7/18/2026	None
Insulins – Rapid Acting	• Lyumjev® U-100 KwikPen® and Tempo Pen™ • Merilog™ vial	• NovoLog® vial • Insulin aspart vial

PDL Drug Class	Moved to Preferred	Moved to Non-preferred
Biguanides	None	• Metformin tablet (Sun Pharma, ScieGen Pharma, and Ascend Labs only) • Metformin 24hr tablet (Granules Pharma only)
Topical Contraceptives	• NuvaRing® vaginal ring	• Annovera® vaginal ring
Atypical Antipsychotics, Long-Acting Injectables	• Erzofri® syringe	None
Androgenic Agents – Topical, Injectable, Oral	None	• Testosterone gel packet (Padagis US and Northstar Rx manufacturers only)
Estrogen Agents – Topical, Injectable, Oral	• Climara patch effective 7/25/2026	None
Glucagon, Self-Administered	• Gvoke vial, syringe, HypoPen®	None

*Requires prior authorization or additional criteria to be met.

No changes will be made for the following PDL classes:

PDL Drug Class	PDL Drug Class
Insulins – Concentrated, Mixed, Short Acting, Intermediate Acting, and Mixtures	Overactive Bladder Agents
Benign Prostatic Hyperplasia (BPH) Agents	Other Hypoglycemic Combinations
Antihyperuricemics	Amylins
Prenatal Vitamins/Minerals	Dipeptidyl Peptidase 4 Enzyme inhibitors (DPP-4 Inhibitors) and Combinations

PDL Drug Class	PDL Drug Class
Phosphate Binders	Thiazolidinediones (TZDs) and Combinations
Meglitinides and Combinations	Bone Resorption Suppression and Related Agents
Growth Hormones	

Additional information may be found on the Preferred Drug List (PDL) available on the Pharmacy Resources web page.

Zepbound® (Tirzepatide) Pens

Effective October 1, 2026, the Zepbound® multidose KwikPen® formulation will be changed to preferred status with criteria listed on the Preferred Drug List (PDL). The weekly single-use Zepbound injection pens will remain non-preferred.

Members with current prior authorization (PA) approval on file for the weekly single-use Zepbound pen formulation will automatically receive PA approval for the preferred Zepbound KwikPen® to ease transition to the preferred product. Requests for continued use of the weekly single-use Zepbound injection pens will be subject to meeting non-preferred PA criteria listed on the PDL following implementation of this change. Refer to the Preferred Drug List (PDL) on the Pharmacy Resources web page for details.

Physician Services

Screening, Brief Intervention and Referral to Treatment (SBIRT) Claim Denials

Some professional claims for Screening, Brief Intervention and Referral to Treatment (SBIRT) services submitted on or after **October 9, 2024**, are

incorrectly denying with **Explanation of Benefits (EOB) 2329**: "*Benefit is limited to 2 units per State Fiscal Year*."

Providers should resubmit any claims that denied with EOB 2329. Include the SC modifier if the denied claim shows edit 2029 on the claim.

Refer to the Behavioral Health Policies, Standards, and Billing References web page in the Neuro/Psychological Testing Policy section for additional information regarding the SC modifier.

Contact Janelle Gonzalez at Janelle.Gonzalez@state.co.us with any questions.

Transportation Providers

Provider Webinar

A webinar for Non-Emergent Medical Transportation (NEMT) providers will be hosted on September 15, 2026, by the Department.

The intended audience is NEMT providers in the 55 counties that have not previously operated under a broker model.

The webinar will explain the January 2027 statewide transition to MediDrive as the single NEMT broker.

Webinar Topics

The webinar will cover:

- The statewide broker model
- Provider enrollment and credentialing requirements
- Technology and reporting expectations
- The difference between the September 1, 2026, enrollment date and the January 1, 2027, statewide implementation date

The presentation will be followed by an extended question-and-answer session. Questions may also be submitted through the registration form before the webinar.

Webinar Details

- **Date and time**: September 15, 2026, from 9:30 a.m. to 11:00 a.m. Mountain Time
- **Location**: Zoom webinar
- **Audience**: NEMT providers in the 55 counties that have not previously operated under a broker model
- **Registration**: NEMT Statewide Broker Transition Provider Webinar Registration

A unique link to join will be provided after registration. Webinar materials will be emailed to registrants at least one week before the webinar.

A recording will be posted to the NEMT web page after the webinar.

Statewide Broker Transition

Effective January 1, 2027, the Department will transition the entire Non-Emergent Medical Transportation (NEMT) program to the statewide broker MediDrive.

From January 1, 2027, forward, all NEMT trips must be scheduled and approved through MediDrive, and all provider reimbursements will be processed through MediDrive. Providers will not be reimbursed for trips that are not scheduled and approved through MediDrive. Providers will still be able to submit claims for reimbursement directly to the Department for trips performed prior to this date as long as they are within the 365-day timely filing period.

Enrollment Information

Beginning September 1, 2026, NEMT providers operating in the 55 counties outside the current broker service area may begin the enrollment process

with MediDrive only if their credentials are current in their ProCredEx account. Enrollment with MediDrive is available to NEMT providers that previously completed credentialing and revalidation and have up-to-date documentation, including insurance, driver rosters and vehicle rosters.

NEMT providers in the 55 counties outside the Denver metro area should contract with MediDrive as soon as possible starting on September 1, 2026. However, it is important to note that statewide implementation of MediDrive managing all NEMT provider trip scheduling services will not be in effect statewide until January 1, 2027. Until January 1, 2027, all providers currently outside the broker service area will continue operating as they always have.

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, 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.

Providers should continue to keep all credential information and requirements up to date in ProCredEx to remain compliant with Department rules.

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

Non-Emergent Medical Transportation (NEMT) Communications

All actively enrolled NEMT providers in the 55 counties outside the broker service area should expect communications from the Department in the coming weeks regarding broker timelines, key transition information and an invite for a stakeholder meeting with MediDrive and the Department to instruct NEMT providers on how working with the broker will work and what to expect.

Operational memo OM26-018, 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 continues.

The Department will soon publish a Communication Toolkit to assist transportation providers in discussing the transition to a transportation broker and other program changes with members. The Communication Toolkit will be published on the Department's NEMT web page.

NEMT Provider Enrollment Reopens October 1, 2026

The enrollment moratorium for new NEMT providers expires on September 30, 2026. Then, beginning on October 1, 2026, enrollment for new NEMT providers reopens.

To become an NEMT provider, complete the following steps:

- Enroll with the Department through the provider enrollment process.
- After Department enrollment is complete, complete credentialing through ProCredEx.
- Enroll with MediDrive.

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

Women's Health

Breast and Cervical Cancer Program Presumptive Eligibility Process

Effective September 1, 2026, the process for requesting Breast and Cervical Cancer Program (BCCP) Presumptive Eligibility (PE) is changing.

Beginning September 1, 2026, all BCCP PE requests must be submitted electronically using the BCCP PE Request Form. Women's Wellness Connection (WWC) and Non-WWC sites will no longer request BCCP PE by calling the Office of Information & Technology (OIT) Presumptive Eligibility (PE) Hotline.

Note: The BCCP PE Request Form is intended for authorized PE requesters at WWC and Non-WWC sites. The PE requester is an individual at the organization who completes and submits the BCCP PE request on behalf of the member. Requests submitted directly by members or patients will not be processed.

To ensure timely and accurate processing of BCCP PE requests:

- Complete all required fields on the request form.
- If not a Women's Wellness Connection (WWC) site, enter the name of the health care organization or provider where indicated.
- Review the completed form for accuracy before submitting.

- Within **one to two business** days of submitting the BCCP PE request, the PE requester will receive an encrypted email containing the eligibility determination results.

Contact hcpf_bccp@state.co.us with questions about completing the BCCP PE Request Form or the updated process.

Provider Training Sessions

September 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 September:

- **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**: Staff who submit claims, are new to billing Health First Colorado services or who need a billing refresher course should consider attending one of the beginner billing training sessions.
- **Time**: One and a half (1.5) hour presentation / half (0.5) hour Q&A.

- **Intermediate Billing Training**

  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.

- **Provider-Specific Billing Training: Physical, Occupational and Speech Therapy**

  Provider-specific training delivers an overview of benefits, covered services and provider eligibility unique to each provider type.

  - **Audience**: This training applies to the following provider types: Physical Therapist - PT 17; Occupational Therapist - PT 28; Speech Therapist - PTs 27, 42; Rehabilitation Agency - PT 48.
  - **Time**: One (1) 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.

September 2026

Monday	Tuesday	Wednesday	Thursday	Friday
	1	2	3	4
7	8	9	10	11
14	15	16 HCBS Beginner Billing Training 9:00 a.m. - 11:00 a.m. MT and 1:00 p.m. - 3:00 p.m. MT	17	18
21	22	23	24 Beginner Billing Training 1:00 p.m. - 3:00 p.m. MT	25
28	29 Provider-Specific Training: Physical, Occupational and Speech Therapy 1:00 p.m. - 2:30 p.m. MT	30 Intermediate Billing Training 1:00 p.m. - 2:30 p.m. MT		

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 banks.

Provider Services Call Center

1-833-468-0362