Provider Bulletin

Reference Number: B2600543

Oct 2026

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Did You Know?

Enter the Provider ID in the Call Center System

Providers should enter the provider ID when contacting the Provider Services Call Center. Entering the provider ID into the system eliminates the need to give the ID verbally to the agent, ensuring a quicker resolution.

All Providers

Update Address for Internal Revenue Service (IRS) Form 1099



Providers are encouraged to ensure the Internal Revenue Service (IRS) 1099 form mailing address on file with Health First Colorado (Colorado's Medicaid Program) is accurate by January 1, 2027. Providers may add, view or modify the IRS 1099 form mailing address through the Provider Maintenance option in the Provider Web Portal. A confirmation letter will be sent to all linked provider service locations when an update is completed.

The letter will contain:

- The provider service location ID (Health First Colorado Provider ID)
- Information about the user who completed the change
- Details of the address changes made (previous and new)

Note: The IRS 1099 form mailing address is linked to the associated tax ID. If multiple provider IDs share the same tax ID and one provider changes the 1099 address, that address will change for all providers with that tax ID.

Visit the Provider Maintenance - Provider Web Portal Quick Guide web page and view Address Changes for instructions on how to update an address in the Provider Web Portal.

Immigrant Eligibility Changes



Starting October 1, 2026, federal changes to Medicaid eligibility will affect some immigrants who currently qualify for Health First Colorado. Many members will not be affected, and those whose coverage is changing will receive a letter before the change takes effect.

The following resources are available to help providers understand the changes and assist members:

- The Immigrant Eligibility Flowchart provides a quick reference for understanding which immigrant populations may be affected by federal changes and which populations may continue to qualify for coverage.
- The Community Partner Reference Guide provides additional information for providers and partner staff to use when assisting members.
- Providers can review the non-citizen eligibility letter that members began receiving in June 2006 as a reference when assisting members who received it.

Providers can also help members prepare for October 1, 2026, by encouraging them to:

- **Check whether the changes may** apply using the Immigrant Eligibility Screener.
- **Keep their contact information current** through Colorado PEAK, the Health First Colorado app or their county human services office.
- **Use their coverage now** to schedule medical, dental and behavioral health appointments and refill prescriptions.
- **Watch for official letters** from Health First Colorado and respond to requests they receive.
- **Connect with trusted community support** for help understanding the changes and coverage options.

Visit the H.R. 1 Communications Toolkit for immigrant eligibility resources and Immigrant Eligibility Changes web page for official member 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 of Health Care Policy and Financing (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 with multiple identified locations must send one (1) DRA Declaration with an attachment listing all Service Location Provider IDs, National Provider Identifiers (NPIs) and Tax IDs covered by the DRA Declaration.

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.

All Providers That Use a Trading Partner

Electronic Data Interchange (EDI) Vendor Transition

The final phase of the Electronic Data Interchange (EDI) transition will be implemented in **Fall 2026**. With the implementation of this final phase, EDI transactions, including batch processing, will transition from the Medicaid Management Information System (MMIS), operated by Gainwell Technologies, to the new EDI platform operated by Edifecs (a Cotiviti business). **Note**: Edifecs (a Cotiviti business) is referred to as Cotiviti.

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.

The EDI transition will be implemented in three (3) stages:

- **January 7, 2026**: New X12 File Naming Standards changes went into effect.
- **June 24, 2026**: The first EDI implementation phase went live and introduced:
    - A new agreement for trading partners.
    - A new platform for trading partners to exchange files with the Department.
    - New login credentials for the platform, issued after the agreement is acknowledged.
    - The new Trading Partner Enrollment and Testing Site.
- **Fall 2026**: The final EDI phase will be implemented, transitioning EDI transactions to the Edifecs platform.

Trading Partners That Have Not Yet Completed Enrollment

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

If the trading partner has not yet enrolled, they must:

- Contact the Provider Services Call Center to verify the email address originally registered with Health First Colorado before beginning enrollment.
- 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.

What is staying the same?

- Gainwell Technologies remains the MMIS vendor and fiscal agent.
- Active trading partners will retain their existing TPIDs.
- Providers may continue to use the Provider Web Portal to submit individual claims, maintain enrollment, verify individual eligibility and more.
- Providers and trading partners will contact the Provider Services Call Center with questions about claims, the Provider Web Portal or EDI.

EDI Resources and Support

Refer to the Electronic Data Interchange (EDI) Support web page for EDI resources, including training webinars, quick guides, companion guides, instructions, other supporting materials and Frequently Asked Questions to find more information about the EDI transition.

Providers and trading partners are also encouraged to sign up for targeted communications to receive future EDI information and updates.

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 Inpatient Hospital Transitions (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

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 (1) 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 September 1, 2026.

Questions about this change may be directed to the Utilization Management team at hcpf_um@state.co.us.

Long-Term Home Health and Private Duty Nursing Providers

Care Coordination Guidance from Home Health Agencies and Case Management Agencies

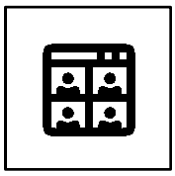
Guidance is being provided to support consistent care coordination between Home Health Agencies and Case Management Agencies. The guidance outlines expectations for timely communication, information sharing and documentation when coordinating services across a member's care team, including when the 56-Hour Weekly Caregiver Limit may affect services. The guidance does not establish new requirements, but is intended to promote consistent practices, reduce gaps or duplication in services and support person-centered care across Health First Colorado programs. Refer to the Weekly Caregiver Limit: Phase 2 article below for more information.

Refer to the following resources:

- Care Coordination Guidance for Home Health Agencies
- Care Coordination Guidance for Case Management Agencies

Contact the Home Health inbox at homehealth@state.co.us with questions about this guidance.

Prior Authorization Request (PAR) Submission Training for Acentra



Acentra Health will provide benefit-specific Prior Authorization Request (PAR) submission training for all providers and Durable Medical Equipment (DME) Benefit Specific PAR Training. The training dates and times are listed below in Mountain Time:

- DME Provider Benefit Specific Training October 14, 2026, 9:00 a.m.
- DME Provider Benefit Specific Training October 14, 2026, 12:00 p.m.
- Portal Registration and PAR Submission Training October 28, 2026, 9:00 a.m.
- Portal Registration and PAR Submission Training October 28, 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

Medicaid Reentry and Community Health (M-REACH) Phase 2

The Department is engaging with local correctional facilities to implement Phase 2 of the Medicaid Reentry and Community Health (M-REACH) program. **Phase 2 is anticipated to launch on July 1, 2027, pending approval of Facility Readiness Assessments for Cohort 1 facilities**.

Phase 2 will expand M-REACH to participating local correctional facilities. The updated timeline provides additional time to prepare jails and partners for implementation. Guidance from the Department will continue to be shared,

and training and technical assistance will be offered to participating facilities as the July 2027 launch approaches.

M-REACH expands Health First Colorado and Child Health Plan *Plus* (CHP+) coverage for eligible individuals transitioning from correctional facilities back into the community. Eligible members can receive certain services through M-REACH prior to release, including case management and medication-assisted treatment as well as a 30-day supply of prescription medications upon release.

Refer to the Medicaid Reentry and Community Health (M-REACH) web page for more information.

New: Behavioral Health Recovery Residence Policy

The Supportive Services Sustainability Strategy is being implemented 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 that holds 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 to their RAE or RAEs 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 RAEs with any concerns about past billing and allowability. Contact hcpf_bhbenefits@state.co.us with any questions about this policy.

National Provider Identifier (NPI) Required

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 National Provider Identifier (NPI) number that will be listed on the claim. An NPI number is obtained through the National Plan and Provider Enumeration System (NPPES) web site.

Email hcpf_bhbenefits@state.co.us with any questions.

Dialysis

Hemodiafiltration

Effective for claims with a date of service on or after July 1, 2026, hemodiafiltration will be considered a covered dialysis treatment and may be reported using revenue code 0829 and procedure code 90999.

Refer to the Dialysis Billing Manual for more information regarding hemodiafiltration.

Contact Sahara Karki at Sahara.Karki@state.co.us with any questions.

Durable Medical Equipment

Code K0739 with U1 Modifier Re-alignment Between Rate Types

It has been determined that code K0739 with Durable Medical Equipment (DME) Rate Non-Rural (DRN) rate type and U1 modifier and DME Rate Rural (DRR) rate type and U1 modifier to be out of alignment. The correct rates with effective dates are as follows:

Procedure Code	Rate Type	Modifier	Effective 7/1/2025	Effective 10/1/2025	Effective 4/1/2026	Effective 7/1/2026
K0739	DRN	U1	$29.64	$29.17	$16.64	$16.31
K0739	DRR	U1	$37.05	$36.46	$20.80	$20.39

Claims with dates of service on or after October 1, 2025, will be automatically reprocessed to reflect the correct rate. Contact the Provider Services Call Center with any questions.

DMEPOS Billing Manual Updates

Conditional Prior Authorizations

The following information provides clarification about the prior authorization and utilization requirements for the Healthcare Common Procedure Coding System (HCPCS) below.

The Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) HCPCS table (below) may have previously indicated that a Prior Authorization Request (PAR) was required; however, the published information did not clearly explain that a PAR is only needed when a member needs more than the monthly or yearly limit allows.

Providers may request authorization for utilization above the standard limit through the PAR process when additional units or services are medically necessary. If additional units are approved, claims may be submitted up to the quantity and for the dates of service authorized on the approved PAR. The HCPCS table has been updated to reflect the PAR requirement as conditional PARs and a note has been added to denote when a PAR is needed. Specific updates are noted in the DMEPOS Revision Log located in the Durable Medical Equipment, Prosthetic, Orthotic and Supplies Billing Manual.

Existing Limits Not Previously Published

A discrepancy has been identified between the published DMEPOS HCPCS code table and the claims system configuration for some Oxygen and Respirator-related HCPCS. The Colorado interChange is set up to enforce limits on the table below; however, these limits were not reflected in the published DMEPOS HCPCS code table. The DMEPOS HCPCS table has been updated with the information below.

Oxygen and Respiratory Care

HCPCS	Published Limit	Effective Date
A7027	6 units per year	07/01/2015
A7028	6 units per year	07/01/2015
A7029	6 units per year	07/01/2015
A7030	6 units per year	07/01/2015
A7032	6 units per year	07/01/2015
A7033	6 units per year	07/01/2015
A7034	6 units per year	07/01/2015
A7035	6 units per year	07/01/2015
A7036	6 units per year	07/01/2015
A7044	6 units per year	07/01/2015
A7045	6 units per year	07/01/2015
E0465	2 units per month	07/01/2009
E0466	2 units per month	07/01/2009
E0467	2 units per month	01/01/2019

Additional updates are forthcoming and will be communicated through the Provider Bulletin.

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

Home and Community-Based Services (HCBS), Community First Choice (CFC)

Case Management Agency Pre-Transition Activities

Coordination activities for members are being strengthened earlier in the transition process to help members successfully move from facility-based care to the community. The Case Management Agency (CMA) Pre-Transition Activities initiative builds on existing case management responsibilities by beginning certain activities earlier in the transition process for members transitioning from facilities. Case managers are expected to participate in pre-transition planning and support, including Home and Community-Based Services (HCBS)/Community First Choice (CFC) service planning, establishing post-discharge services and collaborating with county partners to confirm member eligibility.

Case management agencies may ask HCBS and CFC provider agencies to confirm referral capacity and commit to providing services prior to Prior Authorization Request (PAR) approval for members receiving CMA Pre-Transition support as part of this process. This confirmation is intended to support transition planning and **does not** authorize or require the provider agency to begin services before the PAR is approved. Identifying provider capacity in advance helps ensure authorized services can begin as soon as possible after the member is discharged from the facility, once the PAR is approved.

The program requires that members discharge from facilities ***only*** after community-based services and supports are secured. It also promotes communication and collaboration among Transition Coordination Agencies (TCAs), nursing facilities and case management agencies.

Refer to Operational Memo 26-044, located on the 2026 Memo Series Communications web page, for more information.

Contact Amy Dearmore at Amy.Dearmore@state.co.us with questions or feedback regarding CMA Pre-Transition Activities.

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. Providers must download their licenses from this portal.

Effective 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 • CES – Children's Extensive Support Waiver	• CMHS – Center for Mental Health Services

• 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

Home and Community-Based Services, Home Health

Weekly Caregiver Limit: Phase 2



Phase 2 of the Weekly Caregiver Limit takes effect January 1, 2027, establishing a **70-hour-per-week limit per caregiver, per member, for the following services**:

- Community First Choice – Homemaker*
- Community First Choice – Personal Care*
- Community First Choice – Health Maintenance Activities*
- Long-Term Home Health – Nursing Services
- Long-Term Home Health – Home Health Aide Services

* Applies to all service delivery models within Community First Choice (CFC).

Beginning November 1, 2026, Provider Agencies and Consumer-Directed Attendant Support Services (CDASS) employers may submit Phase 2 exception requests for caregivers who will need to exceed the 70-hour limit. Provider agencies and CDASS employers with caregivers currently providing more than 70 hours per week should begin planning now to come into compliance or, when appropriate, submit an exception request.

Another request does not need to be submitted during Phase 2 if a caregiver was approved for an exception during Phase 1. The existing exception remains in effect until its expiration date, which is outlined in the Approval letter provided by the Department.

Impacted providers are encouraged to identify affected members early and use the Tips for Weekly Caregiver Limit Exception Request Applications when preparing an exception request. Requests should clearly explain why the member's needs require a single caregiver to exceed the weekly limit and include member-specific supporting information.

Refer to the Long-Term Services and Supports web page to learn more about the Weekly Caregiver Limit, Phase 2 timelines and the exception process.

Hospice Providers

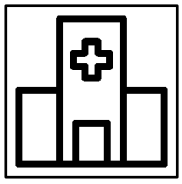
Rate Update Effective October 1, 2026

Any current hospice rates below the 2026-2027 Medicaid Hospice minimum rates posted by the Centers for Medicare & Medicaid Services (CMS) are being increased up to the published CMS Medicaid hospice rates with the hospice wage indexes applied effective October 1, 2026, to comply with the Colorado Medicaid State Plan. This rate increase does not affect every county due to the different Hospice wage index changes instituted by CMS. Rates at or above the current CMS benchmark will remain unchanged.

The fee schedule for Hospice rates effective October 1, 2026, is published on the Provider Rates and Fee Schedule web page under the Hospice category.

Hospital

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 newsletter.

- The next Hospital Stakeholder Engagement meeting will be **Friday, November 6, 2026, from 9:00 a.m. to 11:00 a.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.

Billing for Vaccines Acquired Through the Vaccines for Children (VFC) Program

Effective January 1, 2027, outpatient hospital claims that report an administered vaccine acquired through the Vaccines for Children (VFC) program will require an SL modifier on the claim detail line. Only members under the age of 19 years are eligible for administration of vaccines provided by the VFC Program.

The Enhanced Ambulatory Patient Groups (EAPG) module update for VFC program functionality became available on September 24, 2026.

Refer to the Immunizations Billing Manual for more information.

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.

Immunizations

Updates and Reminders

All medically necessary immunizations and vaccines that are recommended via shared clinical decision making are benefits for all Health First Colorado members without cost sharing.

Health First Colorado members under 19 years of age are eligible to receive all immunizations available from the federal Vaccines for Children (VFC) Program at VFC-enrolled provider offices. All vaccines that are part of the VFC Program are only reimbursable when administered to members under 19 years of age and when administered by a VFC-enrolled provider using VFC vaccine products. Health First Colorado will not reimburse providers for the cost of vaccines that are available through the VFC Program or for the cost of vaccines that the provider receives at no cost. Providers must enroll with VFC, as well as Health First Colorado, and use VFC vaccines to receive reimbursement for administering vaccines to members under 19 years of age.

Members enrolled in Health First Colorado's Managed Care Organizations (MCOs) must receive immunization services through a provider in the MCO's network.

A product code and an administration code must always be included on any claims for vaccination.



Rates can be found in the Immunization Rate Schedule on the Provider Rates & Fee Schedule web page. Further vaccine billing guidance may be found in the Immunizations Billing Manual.

Contact Christina Winship at Christina.Winship@state.co.us with any vaccine policy questions. Contact the Provider Services Call Center for assistance with claims and billing.

Nursing Facilities

Memo Reminder

Effective October 15, 2026, the Department will begin imposing civil money penalties on post-payment reviews and compliance reviews.

Refer to Informational Memo IM 26-006, Civil Money Penalties (CMP) Impositions, located on the 2026 Memo Series Communications web page, for more information.

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

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 that 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) that 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 Actual 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 Actual Acquisition Cost (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 St, 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 the email listed above with general inquiries.

Note: All submitted invoice data will remain strictly confidential. The prescription volume information submitted by most pharmacy types will be used to determine their dispensing fee for the 2027 calendar year.

Physician-Administered Drug (PAD) Providers

Prior Authorization Update

Effective October 1, 2026, Yartemlea® (narsoplimab), Healthcare Common Procedure Coding System (HCPCS) code J1289 will be added to the list of Physician-Administered Drugs (PADs) that require prior authorization.

In addition, Appendix Y criteria for Omvoh® (mirikizumab-mrkz), HCPCS code J2267, Kisunla® (donanemab-azbt), HCPCS code J0175, and Benlysta (belimumab), HCPCS code J0490, have been updated. The changes are consistent with the U.S. Food and Drug Administration (FDA) labeling and aligned with the Department's Preferred Drug List (PDL).

The full list of PADs that require prior authorization can be found in 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.

All PAD PAR procedures, clinical criteria, and PADs subject to PAR 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 page.

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

Physician-Administered Drug (PAD) Providers, Physician Services, Pharmacy

New Gender-Affirming Care Rules

Effective October 13, 2026, in compliance with new federal regulations, the following services when provided for the purposes of gender-affirming care will no longer be covered benefits for members under the age of 18, including when requested under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Services not listed below, including behavioral health, evaluation and management services and laboratory services are not impacted by this federal policy change.

Surgical Services:

Gender-affirming surgery will no longer be covered for members under the age of 18. Prior authorization requests for these procedures will be denied beginning October 13, 2026.

Pharmaceutical Services:

Effective October 13, 2026, all estrogen, testosterone and Luteinizing Hormone-Releasing Hormone/Gonadotropin-Releasing Hormone (LHRH/GnRH) agents (such as leuprolide) will require prior authorization for members under the age of 18, and claims payment and prior authorization for these products prescribed for gender-affirming care therapy for members under the age of 18 will not be approved. Current prior authorization approvals on file for these agents with a start date prior to October 13, 2026, for members under the age of 18 will be end-dated October 12, 2026, and subject to submission of a new prior authorization request. Requests placed on or after October 13, 2026, for members under the age of 18 that are currently receiving and stabilized on an estrogen or testosterone agent for gender-affirming care treatment may receive approval to allow for tapering and discontinuation of estrogen or testosterone therapy. No claims payment for tapering continuation will be allowed after April 12, 2027.

Estrogen, testosterone or LHRH/GnRH agents prescribed for gender-affirming care therapy for members under the age of 18 will not be eligible for coverage under the EPSDT benefit effective October 13, 2026.

Medication coverage information for the Health First Colorado pharmacy benefit is available for reference on the Preferred Drug List (PDL) and Appendix P located on the Pharmacy Resources web page.

Physician-Administered Drugs (PADs):

Effective October 13, 2026, claims payment for GnRH/LHRH agents prescribed for gender-affirming care therapy for members under the age of 18 will not be allowed.

Effective October 13, 2026, all estrogen, progesterone, medroxyprogesterone and testosterone agents will require prior authorization for members under the age of 18 when prescribed for gender-affirming care. Prior authorization for testosterone, estrogen, progesterone or medroxyprogesterone therapy for members under the age of 18 who are receiving and stabilized on therapy for gender-affirming care prior to October 13, 2026, may receive approval to allow for tapering and discontinuation of therapy. No claims payment for tapering continuation will be allowed after April 12, 2027.

Medication coverage and prior authorization information for the Health First Colorado medical benefit is available for reference on Appendix Y located on the Physician-Administered Drugs web page.

Residential Treatment Providers

Prior Authorization for Residential Treatment Claims

The following information applies to Qualified Residential Treatment Providers (QRTP), Psychiatric Residential Treatment Facilities (PRTFs), and Out-of-State High-Intensity Residential Treatment (OHIRT) services (collectively “residential behavioral health treatment”) for Health First Colorado members whose services are paid directly by the Department. It

does not apply to residential services paid for by the Regional Accountable Entities (RAEs) or Child Health Plan *Plus* (CHP+).

Providers are reminded that effective November 15, 2025, all children and youth requesting authorization for residential behavioral health treatment (QRTP or PRTF/OHIRT) are required to undergo an Enhanced Standardized Assessment (ESA) for initial Health First Colorado coverage authorization. Prior authorization is also required for periods of treatment longer than 30 days.



Effective August 28, 2026, all claims submitted for treatment in a QRTP, PRTF or OHIRT with dates of service of December 15, 2025, and later will suspend to verify a prior authorization (PA) for claimed services. Staff from the Department will confirm an active PA for the dates of service referenced in the claim. Claims without the required PA will deny. Claims with the required PA will proceed to adjudication without further action from the provider.

Contact Christina Winship at Christina.Winship@state.co.us with any questions.

Transportation Providers

Facility Information



The Department is transitioning to a single statewide Non-Emergent Medical Transportation (NEMT) broker. MediDrive was selected as the broker to manage the NEMT program, including all provider credentialing, network management, trip scheduling and billing and payment. The final phase of this transition will go into effect for MediDrive statewide NEMT coverage beginning on January 1, 2027.

What facilities outside the Denver metro area 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.

All Health First Colorado-enrolled medical facilities and Regional Accountable Entities (RAEs) outside the Denver metro area should enroll with MediDrive as soon as possible using the MediDrive dedicated online facility portal.

Beginning January 1, 2027, enrolled facilities and RAEs can use the MediDrive facility portal to assist members with scheduling NEMT trips, scheduling hospital discharges, submitting standing orders and asking general NEMT questions.

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

Recent Non-Emergent Medical Transportation (NEMT) Webinar Materials

The Non-Emergent Medical Transportation (NEMT) Statewide Broker Transition Provider Webinar has passed, but the slides and recording are still available to learn about the statewide broker transition, provider enrollment and credentialing, technology and reporting expectations and key implementation dates. Visit the NEMT web page for updates and FAQs.

An NEMT Provider Toolkit is available on the on the NEMT web page with more resources and information.

Home and Community-Based Services (HCBS) Facilities and Non-Medical Transportation (NMT) providers

Home and Community-Based Services (HCBS) facilities and Non-Medical Transportation (NMT) providers cannot enroll with MediDrive, as MediDrive does not schedule NMT trips or transportation for adult HCBS services.

MediDrive only schedules Non-Emergent Medical Transportation (NEMT) trips for Health First Colorado members traveling to medically necessary, covered services provided by Health First Colorado enrolled providers and facilities.

Contact hcpf_hcbs_nmt@state.co.us for questions about NMT or adult HCBS services.

Statewide Broker Transition

Effective January 1, 2027, the Entire Non-Emergent Medical Transportation (NEMT) Program will Transition to the Statewide Broker MediDrive

Starting January 1, 2027, all Non-Emergent Medical Transportation (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 before this date as long as they are within the 365-day timely filing period.

Enrollment Information

Effective September 1, 2026, NEMT providers operating anywhere in the state may begin the enrollment process with MediDrive only if they have

completed the Health First Colorado enrollment process and have uploaded their current credentials in their ProCredEx account, including up-to-date documentation, insurance, driver rosters and vehicle rosters.

NEMT providers in all Colorado counties will need to contract with MediDrive as soon as possible. It is important to note that the statewide implementation of MediDrive managing all NEMT provider trip scheduling services will not go into 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 - NEMT providers will need to verify that their driver and vehicle rosters uploaded in ProCredEx are current before submitting the initial contracting application, to streamline the transition and reduce administrative burden. 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. ***Allow MediDrive time to contact the provider for enrollment. They are onboarding numerous NEMT providers during this time and it can take approximately a week or longer to complete the process***.

- **Critical:** NEMT 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. 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 are required 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

Operational Memo OM26-060, outlining the broker transition plan, has been published and made available on the 2026 Memo Series Communication web page. This is the third version of the operational memo series about the statewide NEMT broker transition and contains the most current information.

Information will be shared through email notifications, newsletters and the monthly Provider Bulletins as the transition continues.

A Communication Toolkit has been created by the Department to assist transportation providers in discussing the transition to a transportation broker and other program changes with members. The Communication Toolkit can be found on the NEMT web page.

Non-Emergent Medical Transportation (NEMT) Provider Enrollment Reopens

The enrollment moratorium for new Non-Emergent Medical Transportation (NEMT) providers expires on September 30, 2026. 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.

Provider Training Sessions

October 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 October:

- **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 (1) of the beginner billing training sessions.
- **Time**: One and a half (1.5) hour presentation / half (0.5) hour Q&A.

- **Provider Enrollment Training**

  Provider enrollment training gives an overview of the Health First Colorado program and guidance on the provider application process including enrollment types, common errors and enrollment with other entities (e.g., DentaQuest, Regional Accountable Entities [RAEs], Health First Colorado vendors). It also provides information on next steps after enrollment.

  - **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.

- **Member Eligibility Training**

  This focused micro-training details important aspects of member eligibility from the provider's perspective including eligibility verification, detailed eligibility types, member billing and using the Provider Web Portal to access this critical information.

  - **Audience**: This training applies to all 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: Home Health**

  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 (PTs): Home Health – PT 10.
  - **Time**: One (1) hour presentation / half (0.5) hour Q&A.

- **Provider-Specific Billing Training: Doula & Lactation**

  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: Doula - PT 79, International Board-Certified Lactation Consultant (IBCLC) – PT 70, Certified Lactation Counselor (CLC) - PT 71, Certified Lactation Educator (CLE) - PT 71, Lactation/Doula Professional Group – PT 72.
  - **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.



October 2026

Monday	Tuesday	Wednesday	Thursday	Friday
			1	2
5	6	7 Member Eligibility Training 10:00 a.m. - 11:00 a.m. MT	8	9
12	13	14	15 Provider Specific Billing Training: Doula & Lactation 10:00 a.m. - 11:30 a.m. MT	16
19	20 Provider Specific Billing Training: Home Health 1:00 p.m. - 2:30 p.m. MT	21	22 Beginner Billing Training 10:00 a.m. - 12:00 p.m. MT HCBS Beginner Billing Training 1:00 p.m. – 3:00 p.m. MT	23
26	27	28 Provider Enrollment Training 9:00 a.m. - 11:00 a.m. MT	29	30

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
Mother Cabrini Day October 5, 2026	State Offices and the Provider Services Call Center will be closed. Acentra, AssureCare, DentaQuest and 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