COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B2500530

Oct 2025

Table of Contents

Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

Did You Know?

An update to a previously paid claim can be submitted as an adjustment. Providers should not void the claim and rebill unless the claim was billed in error or for an incorrect member. All adjusted claims should be sent electronically, not by paper. Adjustments can be sent via the Provider Web Portal or via batch through the provider's clearinghouse.

All Providers

Deficit Reduction Act (DRA) of 2005 Due November 1, 2025

Section 6032 of the Deficit Reduction Act of 2005 (DRA) requires that providers that meet the definition of entity and that 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.

Providers subject to Section 6032 are required each year by the Department of Health Care Policy & Financing (the Department) to supply certain documentation to show compliance with these requirements. Providers will receive an email from the Department requesting this documentation and should ensure that 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) 2024-2025 (October 1, 2024, through September 30, 2025). Entities with multiple identified locations must send one (1) DRA Declaration with an attachment listing all Service Location Provider IDs, 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 3, 2025.

Contact Eileen Sandoval at HCPF_DRAAct2005@state.co.us with questions related to the DRA.

Electronic Data Integration (EDI) Vendor Transition

Providers that use a clearinghouse or billing agent to submit X12 batch transactions on their behalf will need to ensure that the vendor is aware of these changes below.

Electronic Data Integration (EDI) functionality, including batch processing and trading partner enrollment, will transition from the Medicaid Management Information System (MMIS) operated by Gainwell Technologies to a new module operated by Cotiviti (formerly Edifecs).

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.
- Provider Services Call Center agents have access to the EDI systems and have been trained to assist providers with questions about EDI.
- Trading partners will retain the same trading partner IDs.

What is changing?

- File naming conventions will be different and will be required.
    - Trading partners will need to change the name of the files they submit.
    - Trading partners will need to configure internal systems to accept responses in a new format.
- Refer to the Trading Partner reference letter for details. Existing trading partners will need to test and sign a new agreement.
- New login credentials will be issued to upload and retrieve files.

More detailed information will be shared in future Provider Bulletins.

Refer to the Electronic Data Interchange (EDI) Support web page and Colorado Medicaid Enterprise Solutions (CMES) Transition web page for more information.

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

Pharmacy Benefit Management System (PBMS) Transitioning

The Department is transitioning components of its Pharmacy Benefit Management System (PBMS) from Prime Therapeutics (formerly Magellan) to MedImpact. Implementation is planned for October of 2025 and February of 2026.

What providers should know:

- The Opioid Risk module **is not changing** and will continue to be managed by OpiSafe.
- MedImpact will implement and manage four (4) new PBMS modules:
    - The core PBMS (February 2026)
    - Rebate (October 2025)
    - Preferred Drug List (October 2025)
    - Real-Time Benefit Tool (February 2026)
- Contact information for the PBMS, including the call center phone number, fax number and the mailing address for paper claims will change. Information will be provided closer to the transition date. The information will be on the Provider Contacts web page.

- The Bank Identification Number/Processor Control Number (BIN/PCN) for pharmacy claim submission will **remain the same.** Pharmacies will continue to submit their claims as usual.

Why is the PBMS vendor changing?

Prime Therapeutics' contract expires this winter, and the Department is required by state and federal regulations to solicit competitive bid proposals from vendors on a regular basis. Through a competitive bid process, the Department selected MedImpact to implement four (4) of the five (5) PBMS modules.

Visit the Colorado Medicaid Enterprise Solutions Transition web page for more information.

Rate Reductions for Services Billed on Professional Claims

On August 28, 2025, pursuant to Article IV, Section 2 of the Colorado Constitution, and C.R.S. § 24-75-201.5, Governor Polis issued Executive Order D 2025 014 declaring insufficient revenues available for expenditures and ordering the suspension, in whole or in part, of certain State programs or services in order to meet a revenue shortfall for Fiscal Year 2025-26 and balance the state budget, the Department will reduce all fee for service rates previously increased by 1.6% as a result of legislative appropriations for FY 2025-26. This is pursuant to the Executive Order and consistent with the Governor's Office presentation to the Joint Budget Committee.

When does the rate change begin?

The rates will be reduced for dates of service on or after October 1, 2025.

Which provider types are impacted?

This will affect providers that bill using the Professional claim form (CMS 1500).

Dental services and Pediatric Behavioral Therapies will be targeted for a rate adjustment exceeding the 1.6% across-the-board decrease.

Targeted rate adjustments for Dental rates effective October 1, 2025

Procedure Code	Code Description	Rate Effective 10/01/2025
D0120	Periodic oral evaluation	$32.41
D0140	Limited Oral Evaluation Problem Focused	$44.90
D0150	Comprehensive Oral Evaluation	$51.57
D1110	Prophylaxis Adult	$82.39
D1120	Prophylaxis Child	$61.72

Procedure Code	Code Description	Rate Effective 10/01/2025
D1206	Topical fluoride varnish	$35.46
D1351	Sealant Per Tooth	$48.25
D1352	Prev resin rest, perm tooth	$83.93
D1354	Interim Caries Arresting Medicament Application, Per Tooth	$46.08
D2740	Crown, Porcelain/Ceramic substrate	$717.54
D2750	Crown Porcelain High Noble Metal	$710.70
D2751	Crown Porcelain Base Metal	$648.14
D2752	Crown Porcelain Noble Metal	$674.56
D2790	Crown Full Cast High Noble Metal	$733.98
D2794	Crown Titanium	$707.16
D2930	Prefab Stainless Steel Crown Primary	$167.72
D3310	End Therapy, anterior tooth	$675.80
D3320	End Therapy, bicuspid tooth	$775.46
D3330	End Therapy, molar	$937.37
D3346	Retreatment Root Canal Anterior	$770.31
D3347	Retreatment Root Canal Bicuspid	$882.28
D3348	Retreatment Root Canal Molar	$1,052.92
D4341	Periodontal Scaling & Root Planing	$225.20
D4342	Periodontal Scaling 1 to 3 Teeth	$160.28
D4910	Periodontal Maintenance	$125.91

Targeted Rates for Pediatric Behavioral Therapy Providers

Procedure Code	Code Description	Rate Effective 7/1/2025	Rate Effective 10/1/2025
97151*	BHV ID ASSMT BY PHYS/QHP	$882.78	$866.88
97153	ADAPTIVE BEHAVIOR TX BY TECH	$18.17	$17.20

Procedure Code	Code Description	Rate Effective 7/1/2025	Rate Effective 10/1/2025
97154	GRP ADAPT BHV TX BY TECH	$11.51	$8.81
97155	ADAPT BEHAVIOR TX PHYS/QHP	$26.62	$25.80
97158	GRP ADAPT BHV TX BY PHY/QHP	$17.83	$9.34

*The rates for 97151 were originally reported in the Special Provider Bulletin - Rate Reductions as $27.59 and $27.09 for July 1, 2025, and October 1, 2025. The rate was converted to 15-minute increments to account for the assumed number of timed units to complete service delivery to achieve the fee schedule rate. This was due to the comparison to other states' rates used for benchmarking purposes. The rate continues to be paid at an 8-hour increment at the rates listed in the table above and in the Health First Colorado fee schedule.

Targeted rate reductions for Home and Community-Based Services

Targeted rate reductions for Home and Community-Based Services (HCBS) must be approved by the Centers for Medicare and Medicaid Services (CMS) through the waiver amendment process. Providers will be notified when rate reductions for HCBS services will be effective in future bulletins.

Fee schedules may be found on the Provider Rates and Fee Schedule web page. Refer to Special Provider Bulletin - Rate Reductions for more information on the October 2025 rate reductions.

Revalidation Deadlines and Duplicate Provider Enrollment Applications

Providers should not re-enroll if the revalidation deadline was missed. The link for revalidation remains on the Provider Web Portal account associated with the provider for six (6) months after the revalidation date. If the revalidation link is no longer available, contact the Provider Services Call Center for next steps. Providers should not create duplicate enrollment records.

Upcoming Stakeholder Webinars: Member Correspondence Improvements

A series of quarterly virtual stakeholder meetings will be held to share updates on ongoing improvements to member correspondence.

The Department staff will share:

- Current projects open for feedback
- Opportunities to provide input on outreach plan for implementing work requirements
- Timelines for major projects and future meetings

The meetings will be in English and Spanish. American Sign Language (ASL) interpretation will also be provided.

Meeting dates and times:

- Thursday, October 16, 2025, from 12:00 p.m. to 1:00 p.m. MT
- Thursday, January 15, 2026, from 12:00 p.m. to 1:00 p.m. MT

Register for the meetings in advance. A unique link will be sent after registering to join the meeting.

Meeting Accommodation and Language Access Notice: 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 Ryan Lazo at HCPF_stakeholders@state.co.us at least one (1) week prior to the meeting to make arrangements.

Current Projects Open for Feedback

Materials are posted on the Member Correspondence Improvements web page. Feedback may be submitted using the online form, available in English and Spanish.

1. **Motion to Dismiss Cover Letter:** A cover letter for court motions, briefs, and other pleadings is being tested. The goal of this project is to improve readability by members while still keeping language that is legally sufficient for the courts.
    - **Files for review:** English | Spanish
2. **Health First Colorado (Colorado's Medicaid program) Dental Benefit Summary:** The member facing benefit summaries are being updated. This update includes summaries for adults, children and individuals with developmental disabilities.
    - **Files for review:**
        - Individuals with Developmental Disabilities Benefits Summary: English | Spanish
        - Adult Benefit Summary: English | Spanish
        - Children Benefit Summary: English | Spanish

Contact the Stakeholder Engagement Section at HCPF_stakeholders@state.co.us for more information or with general questions.

All Providers Who Utilize 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.

Long-Term Home Health (LTHH) Prior Authorization Request (PAR) Resumption Information

Go-Live for Prior Authorization Requests (PARs) of Registered Nurses (RNs) and Certified Nursing Assistant (CNA) services was August 1, 2025.

The requirement for a completed Skilled Care Acuity Assessment is temporarily waived.

- Paused: Nurse Assessor referrals and the Skilled Care Acuity Assessment for members seeking or receiving Long-Term Home Health (LTHH) and Private Duty Nursing (PDN).
- Still Required: Nurse Assessor referrals and the Skilled Care Acuity Assessment for members seeking or receiving Health Maintenance Activities (HMA).

Visit the Nurse Assessor web page with questions related to the Nurse Assessor, and updates on future requirements for these services.

Therapy Providers-Outpatient and Home Health Providers for Speech Therapy, Occupational Therapy and Physical Therapy

Coordination of Care for Therapy Providers

Demonstration of coordination of care and documentation that services are not being duplicated is required when a member is participating in overlapping therapy services.

Submitting the current therapy Plan of Care (POC) of the other provider with the active Prior Authorization Request (PAR) to show no overlap in goals or duplication of services will reduce pends and delays in care to the member. All therapy providers should collaborate in supplying the other provider's therapy POC for their members to ensure services are not delayed in either modality.

Acentra Provider Satisfaction Survey

The Colorado PAR Provider Survey for Pediatric Behavioral Therapies (PBT) providers that work with Acentra Health and use the Atrezzo® provider portal will open soon. The survey is set to open October 20th and remain open through November 28, 2025.

The PBT Provider Survey is an opportunity to provide feedback regarding Acentra Health services in processing PARs, customer service, provider education and timeliness.

Acentra will send email reminders to complete the survey once it is live. Look for the survey link via the announcements on the ColoradoPAR web page.

Reminder: Enhanced Standard Assessment

Effective November 15, 2025, all children and youth being considered for residential treatment (Qualified Residential Treatment Program [QRTP], Psychiatric Residential Treatment Facility [PRTF] or Out-of-State High-Intensity Residential Treatment [OHIRT]) will be required to undergo an Enhanced Standardized Assessment (ESA) for initial Health First Colorado coverage authorization. This applies when residential services are to be reimbursed directly by the Department. Continuing stay approval will also be required for periods of treatment longer than 30 days. As of November 15, 2025, any child already in an episode of care in a QRTP or a PRTF will receive an initial 30-day approval. OHIRT reviews will continue their regular 30-day review cadence. Continued stay reviews will begin December 15, 2025, and occur every 30 days thereafter.

Refer to Operational Memo 25-032: Utilization Management and Assessment Requirements for Qualified Residential Treatment Providers (QRTP) and Psychiatric Residential Treatment Facilities (PRTF) for further information.

Refer to the ColoradoPAR Training web page for information about Utilization Management, Prior Authorization and Continuing Stay Reviews.

Contact Christina Winship at Christina.Winship@state.co.us with policy or enrollment questions.

Contact Acentra at coproviderregistration@acentra.com with questions regarding Utilization Management.

Prior Authorization Request (PAR) Submission Training for Acentra

Acentra Health will provide benefit-specific Prior Authorization Request (PAR) submission training for all providers and benefit-specific training for **Qualified Residential Treatment Program (QRTP), Psychiatric Residential Treatment Facilities (PRTF)**. The training dates and times are listed below in Mountain Time:

- QRTP/PRTF Benefit Specific Training October 27, 2025, at 12:00 p.m.

- QRTP/PRTF Benefit Specific Training October 28, 2025, at 9:00 a.m.
- QRTP/PRTF Benefit Specific Training October 30, 2025, at 3:00 p.m.
- Portal Registration and PAR Submission Training October 23, 2025, at 12:00 p.m.
- Portal Registration and PAR Submission Training October 24, 2025, at 9:00 a.m.

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

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

Ambulatory Surgical Centers (ASC) and Federally Qualified Health Centers (FQHC)

Health First Colorado as Secondary Pricing Logic Update

Outpatient providers were notified in early 2025 that the Third-Party Liability (TPL) system logic was updated to fix a flaw in claims processing when coordinating benefits. The Other Insurance (OI) payments were not fully applied to the claim priced under Enhanced Ambulatory Patient Grouper (EAPG) methodology, prior to Medicaid making payment as secondary.

On May 28, 2025, the system logic pertaining to the pricing methodologies for Ambulatory Surgical Centers (ASCs) and Federally Qualified Health Centers (FQHCs) was revised to address identified flaws. It is important to note that a review of previous claims is currently underway to assess any potential overpayments made to providers when Health First Colorado adjudicated a claim as the secondary payor.

Providers can reference the Third-Party Liability section of the Provider Billing Manual for additional information and a claim example.

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

Behavioral Health Providers

Short-Term Behavioral Health

Effective July 1, 2025, Short-Term Behavioral Health (STBH) services (procedure codes 90832, 90834, 90837, 90846 and 90847) are now covered under the Managed Care Organization (MCO) capitation payments. These procedure codes were not included in rate updates effective July 1, 2025. Refer to the Provider Rates and Fee Schedules web page for all updated rates. All

affected claims with dates of service after July 1, 2025, will be mass adjusted to reflect accurate rates for the identified services above. If claims for dates of services on or after July 1, 2025, were billed using the listed procedure codes above, claims will need to be manually adjusted at the behest of the provider to receive the correct reimbursement as the lower-of billed charges payment logic applies.

Refer to the Fee-for-Service Behavioral Health Benefit Billing Manual for more information on billing Fee-For-Service Behavioral Health Services. Refer to the State Behavioral Health Services Billing Manual for more information on the requirements of billing procedure codes for behavioral health services. Visit the State Behavioral Health Services Billing Manual web page for more information on the requirements of billing procedure codes for behavioral health services.

Colorado's Certified Community Behavioral Health Clinics (CCCBHC) State Demonstration Program: Interim Process and Requirements Memo

The 2025 Colorado Certified Community Behavioral Health Clinics (CCBHC) Planning Grant year has reached the fourth and final quarter. The Behavioral Health Administration (BHA) and the Department continue to work towards developing a CCBHC plan for Colorado with ongoing stakeholder feedback and input.

BHA has released a Memorandum from BHA Commissioner Dannette R. Smith to current CCBHC expansion grant recipients and current Comprehensive Safety Net Providers (CSNPs) as a part of the CCBHC plan development and to prepare the state for potential participation in the Substance Abuse and Mental Health Services Administration (SAMHSA) 223 CCBHC Demonstration program in 2026.

The memo reviews the State's initial plan to certify a select number of providers to meet the requirements of the 223 CCBHC Demonstration. The full memo is available on the Behavioral Health Administration Memos web page.

Fee-For-Service (FFS) Integrated Care Fee Schedule

The Provider Rates and Fee Schedule web page has been updated to reflect corrections made to the Collaborative Care Model rates on the 2025-2026 State Fiscal Year Fee-For-Service Integrated Care Fee Schedule. Procedure codes 99484 and G0323 have been added. The following table details the rate corrections retroactively effective to July 1, 2025.

Procedure Code	Previous July 2025 Rate	Updated July 2025 Rate
99484	N/A	$43.31
99492	$109.27	$119.40
99493	$45.95	$109.27
99494	$43.91	$45.95
G0323	N/A	$43.91
G2214	$119.40	$44.65

All affected claims from July 1, 2025, forward will be reprocessed following this adjustment. Note that if claims for dates of services on or after July 1, 2025, were billed using the previously listed rates above, claims will need to be manually adjusted at the behest of the provider to receive the correct reimbursement as the lower of billed charges payment logic applies. Refer to the FFS Behavioral Health Benefit Billing Manual for more information on billing Fee-For-Service Behavioral Health Services. Refer to the State Behavioral Health Services Billing Manual for more information on the requirements of billing procedure codes for behavioral health services.

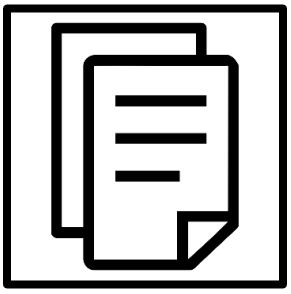
New Frequently Asked Questions (FAQ) on Institution of Mental Diseases (IMD) Service Reimbursement and Recoupment

The Institution of Mental Diseases (IMD) Frequently Asked Questions (FAQ) on Service Reimbursement and Recoupment has been released to provide clarifying information on payment for services in an IMD setting. This FAQ includes answers to many of the questions received from providers related to the payment and recuperation of payment of services in an IMD setting.

Contact HCPF_BHBenefits@state.co.us with any additional questions.

Notice of Award for Reentry State Planning Grant

Colorado has been awarded a four-year, $4.6 million Reentry State Planning Grant by the Centers for Medicare & Medicaid Services (CMS). This funding will be used to support operationalizing the Medicaid Reentry and Community Health (M-REACH) program. Efforts will focus on helping correctional facilities establish billing infrastructure, expanding Health Information Exchange and providing technical assistance for jails.



M-REACH is a new program under Colorado's 1115 "Expanding the Substance Use Disorder (SUD) Continuum of Care" Waiver (1115 Waiver). The Department continues to work with CMS to begin reimbursing for reentry services provided 90 days prior to release from incarceration. Improved continuity of care, coordination and communication expanding coverage prior to release is expected to be seen between correctional systems and the community for justice-involved members. This should result in individuals more successfully transitioning back into their communities, and reducing recidivism, death rates, emergency department visits and inpatient hospitalization for these members. It is anticipated that the program will commence January 1, 2026.

Sign up for criminal justice updates or join a future meeting with the HCPF Criminal and Juvenile Justice Collaborative. Visit the Health First Colorado and Criminal Justice Involved Populations webpage for additional information.

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Demonstration Under 1115 Waiver Receives Final CMS Approval for October 1, 2025, Go-Live

CMS approved Colorado's Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Implementation Plan on **September 2, 2025**. The state now has all necessary federal approvals needed and is moving toward an SMI/SED Demonstration go-live October 2025. This demonstration is designed to support members with an SMI diagnosis by providing smoother transitions back to community care through use of statewide standardized assessments and longer stays when medically necessary in behavioral health psychiatric hospitals in Phase 1 of the demonstration.

Join the upcoming SMI stakeholder engagement forum to learn more about the rollout and required training.

Child Health Plan *Plus* (CHP+)

Contracting Requirements for CHP+ Lactation Services

Lactation providers that wish to serve Child Health Plan *Plus* (CHP+) members must be contracted with a Managed Care Organization (MCO) in the members' service area. Note that some CHP+ MCOs operate as closed networks and are not required to add new providers unless they identify a gap in services.

Contact the MCO directly using the information on the CHP+ Provider web page to inquire about contracting.

Reminder: All providers must meet the following conditions to be eligible for reimbursement for CHP+ services:

- Have an active contract with a CHP+ MCO
- Maintain current enrollment in the Colorado interChange

Visit the CHP+ Provider Enrollment web page with questions about enrollment.

Durable Medical Equipment

Across the Board (ATB) Provider Rate Reduction and Manually Priced Percentages

Effective October 1, 2025, the across-the-board (ATB) rate increase that was approved during the 2024-2025 legislative session will be reduced to rates prior to July 1, 2025. Providers will see rates for dates of service between July 1, 2025, and September 30, 2025, reflect the rate increase that was approved during the legislative session. This rate decrease applies to

manually priced claims that follow the Manufacturer's Suggested Retail Price (MSRP) less or invoice acquisition plus methods only.

Method/Source	2025 Decrease *(1.6% Decrease- Effective Oct 1, 2025)*
Durable Medical Equipment	
MSRP less	13.78%
Invoice acquisition cost plus	24.06%
Prosthetics	
MRSP less	13.78%
Invoice acquisition cost plus	24.06%

Adaptive Car Seat and Buckle Clip Policy

Effective October 1, 2025, all prior authorization requests must follow the Adaptive Car Seat Policy found in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Billing Manual.

Adaptive Car Seats

A prior authorization request (PAR), a Complex Rehabilitation Technology (CRT) Specialized Assessment **and** a Face-to-Face (F2F) evaluation are needed For Adaptive Car Seats. HCPCS code T5001 must be used for billing purposes.

Buckle Clips

A prior authorization request is required, and providers must provide education to the member's parent or legal guardian on the use of the buckle clip and any associated risks for buckle clips. This must be documented in the prior authorization request.

Ambulation Device Billing Reminder

All Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) providers are reminded to use the appropriate HCPCS code for devices when a specific code is available, rather than billing with a miscellaneous procedure code (ex. E1399). Refer to the Durable Medical Equipment HCPCS Table for additional guidance.

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

Continuous Glucose Monitors (CGMs): Medicare Alignment Updates

Overview

Beginning November 1, 2025, all professional claims submitted for Continuous Glucose Monitors (CGMs) products and supplies must include the National Drug Code (NDC) of the product, the proper Healthcare Common Procedure Coding System (HCPCS) procedure code and modifier combination when submitting a claim. The DMEPOS Billing Manual will be updated to contain a crosswalk of the CGM product, HCPCS, and modifiers that must be used when submitting claims. For CGM products that do not have an assigned NDC, additional documentation will be required to be submitted with the claim. Providers may begin submitting NDC numbers on CGM claims at any time prior to November.

Beginning November 1, 2025, CGMs may be billed to the pharmacy benefit ***or*** as a professional claim. A new prior authorization request (PAR) will be required for providers who are submitting claims through the pharmacy benefit. CGM claims that do not have an NDC or Wholesale Acquisition Cost (WAC) must be submitted as a professional claim.

Additional information will be released in future communications. Contact Alaina.Kelley@state.co.us with questions.

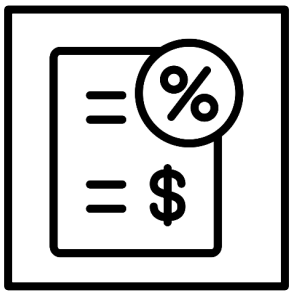
Managed Care Carveouts

Beginning November 1, 2025, all Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) providers that supply CGMs and CGM supplies, including pharmacies, will need to submit fee-for-service claims for **all** members that are enrolled in physical health managed care plan (Denver Health and Rocky Mountain Health Plans) for CGMs and CGM supplies. This is a change from the current carve-in method of CGMs supplied to children.

Pharmacists and Continuous Glucose Monitors (CGMs)

All Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) providers who supply CGMs and CGM supplies are reminded that Clinical Pharmacists may order or prescribe CGMs and their related supplies. More information can be found in the DMEPOS Billing Manual, the Pharmacist Services Billing Manual, and the Ordering, Prescribing, and Referring web page.

Contact Greta Moser at Greta.Moser@state.co.us with questions regarding Pharmacist Services.



Durable Medical Equipment, Physical and Occupational Therapy

Complex Rehabilitative Technology Policy Stakeholder Meeting

A stakeholder meeting on proposed policy updates related to Complex Rehabilitative Technology (CRT) will be hosted by the Department.

The meeting will include presentation of draft policy language, discussion to gather feedback and clarification of potential impacts. Materials will be available two (2) weeks prior to the meeting.

Proposed updates include:

- Strengthening provider qualification standards
- Establishing criteria for telemedicine evaluations
- Prohibiting supplier-therapist arrangements that create unfair business advantages

The changes are designed to support transparent, high-quality service delivery and equitable member access.

Date and time: Thursday, October 30, 2025, from 10:30 a.m. - 12:00 p.m. MT
Audience: Providers (therapists, CRT suppliers) and Utilization Management Vendor
Registration and location: Virtual via Zoom. Register in advance. A unique join link will be emailed once registered.

A recording may be requested by contacting the meeting organizer, Ryan Lazo, at HCPF_Stakeholders@state.co.us.

Meeting Accommodation and Language Access Notice
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 the meeting organizer, Ryan Lazo, or the or the Civil Rights Officer at hcpf504ada@state.co.us at least one (1) week prior to the meeting to make arrangements.

Las ayudas y servicios auxiliares para individuos con discapacidades y servicios de idiomas para individuos cuyo idioma materno no sea inglés pueden estar disponibles por solicitud. Comuníquese con organizador de reuniones, Ryan Lazo, o con el oficial de derechos civiles a hcpf504ada@state.co.us al menos una (1) semana antes de la reunión para hacer los arreglos necesarios.

Home and Community-Based Services (HCBS)

Rates Calculation Error, Retroactive Adjustment Upwards

Some waiver services' rates were incorrect in the Colorado interChange at the effective date July 1, 2025. These rates were retroactively adjusted to reflect the appropriate rates for the following procedure codes:

- S5130 U1 KX HX
- S5130 U1 SC KX HX
- 98960 U5
- H0041 U9
- H0041 U9 22
- H0041 U9 TF
- T1019 U1 KX
- T1019 U1 HR KX
- T1019 U1 KX HX
- T1019 U1 SC KX
- T1019 U1 SC KX HX
- T1019 U1 SC TF

Rates have been corrected in the Colorado interChange. Paid claims with dates of service from July 1, 2025, to August 20, 2025, were mass adjusted according to the appropriate rate. *Providers billing usual and customary will have seen claims adjustments via claims reprocessing*.

Prior Authorization Reminder

Home and Community-Based Services (HCBS) providers are reminded that all services require prior authorization. Providers must ensure that an *approved* prior authorization with the appropriate procedure codes and modifiers is on file prior to rendering services and submitting claims. Claims may deny if an approved matching prior authorization is not on file.

Providers should work with case managers to obtain the final status of a prior authorization.

Hospice Providers

Rate Update Effective October 11, 2024

Approval has received from the Centers for Medicare & Medicaid Services (CMS) for the Hospice State Plan Amendment (SPA). The Department has published the fee schedule for Hospice rates effective October 11, 2024, through September 30, 2025, to the Provider Rates

and Fee Schedule web page under the Hospice category. Reprocessing was requested for claims with Dates of Service (DOSs) on or after October 11, 2024.

Claims billed at usual and customary charges with charges exceeding the FFY 24-25 rates will be reprocessed automatically. Note that if claims for DOSs on or after October 11, 2024, were billed using the FFY 23-24 rates, claims will need to be manually adjusted at the behest of the provider to receive the correct reimbursement.

Note the timely filing requirement. Providers always have 365 days from the DOSs to submit a claim. A claim is considered filed when the fiscal agent documents receipt of the claim. Visit the Frequently Asked Questions (FAQs) and Billing Resources web page under the Timely Filing drop-down for more information.

Hospital Providers

General Updates

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, November 7, 2025, from 9 a.m. - 11 a.m. MT** and will be hosted virtually.

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

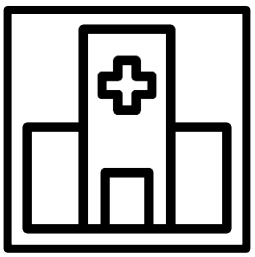
Contact Della Phan at Della.Phan@state.co.us with any questions or topics to be discussed at future meetings. Advanced notice will provide the Facility Rates Section time to bring additional Department personnel to the meetings to address different concerns.

Implementation of Inpatient Hospital APR-DRG Base Rates Effective July 1, 2025

The Department began implementation of its inpatient hospital All Patient Refined Diagnosis Related Groups (APR-DRG) base rates effective July 1, 2025, into its Medicaid Management Information System (MMIS) during September 2025. Upon completion of its implementation, the Department will reprice hospital claims with ending service dates July 1, 2025, and later using the new rate. An email will be sent to hospital stakeholders from the Department when the implementation is complete.

Implementation of Various Outpatient Hospital EAPG Rate Updates Effective July 1, 2025

The Department is working with its fiscal agent on the implementation of various rate changes impacting outpatient hospital claims effective July 1, 2025. Rate changes include the 1.6% increase to Enhanced Ambulatory Patient Grouper (EAPG) base rates effective July 1, 2025, the implementation of EAPG version 3.18, and the rate reduction to the 340B drugs paid through the EAPG methodology.



The EAPG version update is currently scheduled for completion within the fourth quarter of the calendar year. All impacted outpatient hospital claims will be identified and reprocessed to pay using the correct rates and version upon completion.

Contact Sean Paschke at Sean.Paschke@state.co.us with any questions relating to outpatient hospital rates.

Elimination of the 1.6% Across the Board (ATB) Rate Increase Effective October 1, 2025

On August 28, 2025, Governor Polis signed Executive Order D25 014 that reduces General Fund expenditures to bring Colorado's budget into balance for the current fiscal year, State Fiscal Year (FY) 2025-26. An email will be sent to hospital stakeholders in September to review the 30-day posting of new hospital rates for this change. Impacted rates include:

- Inpatient APR-DRG hospital base rates
- Outpatient EAPG hospital base rates
- Per Diem Specialty & Psychiatric hospital base rates

Contact Diana Lambe at Diana.Lambe@state.co.us with any questions relating to inpatient hospital rates. Contact Sean Paschke at Sean.Paschke@state.co.us with any questions relating to outpatient hospital rates. Contact Della Phan at Della.Phan@state.co.us with any questions relating to rehabilitation, long-term acute care or psychiatric hospital rates.

Rural Health Clinic Stakeholder Engagement Meeting

A meeting for Rural Health Clinics (RHCs) has been scheduled for November 6, 2025, from 1 p.m. to 2 p.m. MT. 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.

Healthcare Affordability and Sustainability (HAS) Supplemental Payments

The Department reconciled federal fiscal year (FFY) 2024-25 (October 1, 2024, through September 30, 2025) HAS supplemental payments in September 2025. Provided below are the hospital-specific components used in calculating several of the FFY 2024-25 HAS supplemental payments. These include the adjustment groups and factors for the Inpatient and Outpatient supplemental payments; the per-hospital and total Essential Access supplemental payment the hospital groups and requirements for the Disproportionate Share Hospital (DSH) supplemental payment; and the Hospital Quality Incentive Program (HQIP) supplemental payment measure groups and measures. More information on the supplemental payments are available on the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Information for Providers web page.

Contact Kyle Iftodi at Kyle.Iftodi@state.co.us with any questions or concerns.

Inpatient and Outpatient Supplemental Payment Adjustment Factors

Below are the Inpatient and Outpatient adjustment factors by hospital for FFY 2024-25. The Inpatient supplemental payment is calculated by multiplying Health First Colorado fee-for-service (FFS) patient days by an Inpatient dollar adjustment factor. The Outpatient supplemental payment is calculated by multiplying estimated Outpatient costs by an Outpatient percentage adjustment factor. The Inpatient and Outpatient adjustment factors for each hospital are provided in the table below.

FFY 2024-25 Adjustment Group & Factors

Hospital Name	Adjustment Group	Inpatient Supplemental Payment	Outpatient Adjustment Factor
AdventHealth Avista	Private NICU	$ 1,995.50	77.10%
AdventHealth Castle Rock	Private	$ 808.00	19.40%
AdventHealth Littleton	Private NICU	$ 1,995.50	77.10%
AdventHealth Parker	Private NICU	$ 1,995.50	77.10%
AdventHealth Porter	Private	$ 808.00	19.40%
Animas Surgical Hospital	Private Rural/CAH	$ 740.00	120.00%
Arkansas Valley Regional Medical Center	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Aspen Valley Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Banner East Morgan County Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Banner Fort Collins Medical Center	Private	$ 808.00	19.40%
Banner McKee Medical Center	Private	$ 808.00	19.40%
Banner North Colorado Medical Center	Private High Medicaid Utilization	$ 850.00	70.00%

Hospital Name	Adjustment Group	Inpatient Supplemental Payment	Outpatient Adjustment Factor
Banner Sterling Regional MedCenter	Private Rural/CAH	$ 740.00	120.00%
Children's Hospital Anschutz	Private Pediatric Specialty	$ 720.00	5.00%
Children's Hospital Colorado Springs	Private Pediatric Specialty	$ 720.00	5.00%
Community Hospital	Private Independent Metro	$ 555.00	163.75%
Conejos County Hospital	Private Rural/CAH	$ 740.00	120.00%
Craig Hospital	Rehabilitation/Long Term Acute	$ 20.00	16.10%
Delta County Memorial Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Denver Health Medical Center	Non-State Gov Teaching	$ -	0.00%
Estes Park Health	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Family Health West	Private Rural/CAH	$ 740.00	120.00%
Foothills Hospital	Private Independent Metro	$ 555.00	163.75%
Grand River Health	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Gunnison Valley Health	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Haxtun Health	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
HCA HealthONE Aurora Hospital	Private NICU	$ 1,995.50	77.10%
HCA HealthONE Mountain Ridge Hospital	Private High Medicaid Utilization	$ 850.00	70.00%
HCA HealthONE Presbyterian St. Luke's Hospital	Private NICU	$ 1,995.50	77.10%
HCA HealthONE Rose Hospital	Private NICU	$ 1,995.50	77.10%
HCA HealthONE Sky Ridge Hospital	Private NICU	$ 1,995.50	77.10%
HCA HealthONE Swedish Hospital	Private NICU	$ 1,995.50	77.10%
Heart of the Rockies Regional Medical Center	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Intermountain Health Good Samaritan Hospital	Private	$ 808.00	19.40%
Intermountain Health Lutheran Hospital	Private NICU	$ 1,995.50	77.10%
Intermountain Health Platte Valley Hospital	Private High Medicaid Utilization	$ 850.00	70.00%
Intermountain Health Saint Joseph Hospital	Private Heart Institute	$ 1,458.00	15.00%

Hospital Name	Adjustment Group	Inpatient Supplemental Payment	Outpatient Adjustment Factor
Intermountain Health St. Mary's Regional Hospital	Private Sole Community	$ 3,390.00	130.00%
Keefe Memorial Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Kindred Hospital - Aurora	Rehabilitation/Long Term Acute	$ 20.00	16.10%
Kindred Hospital - Denver	Rehabilitation/Long Term Acute	$ 20.00	16.10%
Kit Carson County Memorial Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Lincoln Community Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Longmont United Hospital	Private	$ 808.00	19.40%
Melissa Memorial Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Mercy Hospital	Private Rural/CAH	$ 740.00	120.00%
Middle Park Medical Center	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Montrose Regional Health	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Mt. San Rafael Hospital	Private Rural/CAH	$ 740.00	120.00%
National Jewish Health	Private	$ 808.00	19.40%
Northern Colorado Long Term Acute Hospital	Rehabilitation/Long Term Acute	$ 20.00	16.10%
Northern Colorado Rehabilitation Hospital	Rehabilitation/Long Term Acute	$ 20.00	16.10%
OrthoColorado Hospital	Private	$ 808.00	19.40%
Pagosa Springs Medical Center	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
PAM Rehabilitation Hospital of Greeley	Rehabilitation/Long Term Acute	$ 20.00	16.10%
PAM Rehabilitation Hospital of Westminster	Rehabilitation/Long Term Acute	$ 20.00	16.10%
PAM Specialty Hospital of Denver	Rehabilitation/Long Term Acute	$ 20.00	16.10%
Penrose-St. Francis Hospital	Private NICU	$ 1,995.50	77.10%
Pioneers Medical Center	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Prowers Medical Center	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Rangely District Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Rehabilitation Hospital of Colorado Springs	Rehabilitation/Long Term Acute	$ 20.00	16.10%
Rehabilitation Hospital of Littleton	Rehabilitation/Long Term Acute	$ 20.00	16.10%

Hospital Name	Adjustment Group	Inpatient Supplemental Payment	Outpatient Adjustment Factor
Reunion Rehabilitation Hospital - Denver	Rehabilitation/Long Term Acute	$ 20.00	16.10%
Reunion Rehabilitation Hospital - Inverness	Rehabilitation/Long Term Acute	$ 20.00	16.10%
Rio Grande Hospital	Private Rural/CAH	$ 740.00	120.00%
San Luis Valley Health Regional Medical Center	Private Rural/CAH	$ 740.00	120.00%
Sedgwick County Health Center	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Southeast Colorado Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Southwest Health System	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Spalding Rehabilitation Hospital	Rehabilitation/Long Term Acute	$ 20.00	16.10%
Spanish Peaks Regional Health Center	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
St. Anthony Hospital	Private	$ 808.00	19.40%
St. Anthony North Hospital	Private	$ 808.00	19.40%
St. Anthony Summit Hospital	Private Rural/CAH	$ 740.00	120.00%
St. Elizabeth Hospital	Private Rural/CAH	$ 740.00	120.00%
St. Francis Hospital - Interquest	Private	$ 808.00	19.40%
St. Mary-Corwin Hospital	Private	$ 808.00	19.40%
St. Thomas More Hospital	Private Rural/CAH	$ 740.00	120.00%
St. Vincent Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
The Memorial Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
UCHealth Broomfield Hospital	Private	$ 808.00	19.40%
UCHealth Grandview Hospital	Private	$ 808.00	19.40%
UCHealth Greeley Hospital	Private	$ 808.00	19.40%
UCHealth Highlands Ranch Hospital	Private NICU	$ 1,995.50	77.10%
UCHealth Longs Peak Hospital	Private	$ 808.00	19.40%
UCHealth Medical Center of the Rockies	Private	$ 808.00	19.40%
UCHealth Memorial Hospital	Private Heart Institute	$ 1,458.00	15.00%
UCHealth Parkview Medical Center	Private Safety Net Metro	$ 555.00	163.75%

Hospital Name	Adjustment Group	Inpatient Supplemental Payment	Outpatient Adjustment Factor
UCHealth Pikes Peak Regional Hospital	Private Rural/CAH	$ 740.00	120.00%
UCHealth Poudre Valley Hospital	Private NICU	$ 1,995.50	77.10%
UCHealth University of Colorado Hospital	State Teaching	$ 781.96	49.75%
UCHealth Yampa Valley Medical Center	Private Rural/CAH	$ 740.00	120.00%
Vail Health Hospital	Private Rural/CAH	$ 740.00	120.00%
Valley View Hospital	Private Rural/CAH	$ 740.00	120.00%
Vibra Hospital of Denver	Rehabilitation/Long Term Acute	$ 20.00	16.10%
Vibra Rehabilitation Hospital of Denver	Rehabilitation/Long Term Acute	$ 20.00	16.10%
Weisbrod Memorial County Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Wray Community District Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%
Yuma District Hospital	Non-State Gov Rural/CAH	$ 2,672.30	82.59%

Essential Access Supplemental Payment

A hospital's FFY 2024-25 Essential Access supplemental payment is calculated by dividing $26 million by the total number of Essential Access hospitals. There are 34 Essential Access hospitals for FFY 2024-25, resulting in a payment of $764,706 per hospital.

Disproportionate Share Hospital Payment Adjustment Groups

Several designated hospital groups are included in the FFY 2024-25 DSH supplemental payment calculation. Hospitals that meet the requirements of a designated group receive a percentage of their hospital-specific DSH limit as payment. Provided below are the hospital groups, the requirements for inclusion in each group, and the percentage of the hospital-specific DSH limit paid.

Hospital Group	Requirements	% of Hospital-Specific DSH Limit
State-Owned Government Teaching Hospital	A qualified state-owned government teaching hospital	96.00%

Hospital Group	Requirements	% of Hospital-Specific DSH Limit
High CICP Cost	A qualified hospital with uninsured patient write-off costs greater than 950% of the statewide average	90.00%
Critical Access & Rural	A qualified Critical Access Hospital or Rural Hospital	100.00%
Small Independent Metro	A qualified hospital that is not owned or operated by a healthcare system network, is located within an MSA, and has less than or equal to 50 beds	40.00%
Low MIUR	Medicaid Inpatient Utilization Rate (MIUR) less than or equal to 22.5%	20.00%

Hospital Quality Incentive Payment Measure Groups

A hospital's FFY 2024-25 HQIP supplemental payment is based on their scores for specific measure groups and measures. The groups and measures are listed below.

Maternal Health and Perinatal Care Measure Group

- Exclusive Breastfeeding
- Cesarean Section
- Perinatal Depression and Anxiety
- Maternal Emergencies and Preparedness
- Reproductive Life/Family Planning

Patient Safety Measure Group

- Zero Suicide
- Reduction of Racial and Ethnic Disparities
- Clostridium Difficile
- Sepsis
- Antibiotic Stewardship
- Adverse Event Reporting
- Culture of Safety Survey
- Handoffs and Sign-outs

Patient Experience Measure Group

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

More information on the HQIP measure groups and measures can be found on the Hospital Quality Incentive Payment Program web page.

Contact Kyle Iftodi at Kyle.Iftodi@state.co.us with any questions or concerns.

Hospital Specialty Drug Policy: Prior Authorization Update

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.

Niktimvo™ (axatilimab), Healthcare Common Procedure Coding System (HCPCS) code J9038, and Aucatzyl® (obecabtagene autoleucel), HCPCS code Q2058, have been added to the approved hospital specialty drug list effective April 3, 2025, and July 1, 2025, respectively. The entire list of specialty drugs subject to this policy are listed on Appendix Z: Hospital Specialty Drugs List.

Appendix Z criteria updates have been made for Amvuttra® (vutrisiran) HCPCS code J0225, Besponsa® (inotuzumab ozogamicin) HCPCS code J9229, and Carvykti® (ciltacabtagene autoleucel) HCPCS code Q2056 in accordance with the U.S. Food and Drug Administration (FDA) labeling changes.

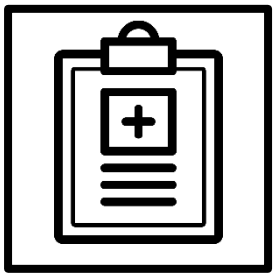
Member-specific prior authorization requests (PARs) must be submitted directly to the Department of Health Care Policy & Financing at HCPF_PharmacyPAD@state.co.us and approved prior to administration of the specialty drug.

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

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.

Hospital Specialty Drug Billing Guidance



Effective January 1, 2024, certain Hospital Specialty Drugs may be administered in the Inpatient setting and be reimbursed outside of the All-Patient Refined Diagnosis Related Group (APR-DRG) methodology when billed on an Outpatient Hospital claim. Reimbursement is based on a percentage of acquisition cost.

The following processes must be completed prior to administration of the Hospital Specialty Drug:

- A member-specific prior authorization is required
  - All Hospital Specialty Drugs requiring prior authorization are listed on Appendix Z
  - Hospital Specialty Drug policy and procedures can be found on the Physician-Administered Drugs web page
  - An approved prior authorization must be on file prior to administration of the Hospital Specialty Drug
    - Retroactive authorization is not usually considered
    - An approved prior authorization on file does not guarantee payment

The following billing processes must be completed after administration:

- Outpatient hospital administration
  - Outpatient claim is billed
  - Amount billed
    - Acquisition cost
      - Cost per National Drug Code (NDC) unit multiplied by the number of NDC units administered to the member
    - Claim will be denied if the amount billed does not equal the number of NDC units billed on the claim multiplied by the invoice dollar amount per NDC unit administered
  - NDC
    - The NDC of the Hospital Specialty Drug administered to the member must be billed on the line
  - Units billed
    - The amount of drug administered to the member must be billed on the claim line in both Healthcare Common Procedure Coding System (HCPCS) and NDC units
  - Invoice attached
    - The claim will be denied if no invoice is attached
  - All Physician-Administered Drugs (PADs), 340B and inpatient (IP)/outpatient (OP) policies apply
- Inpatient hospital administration
  - Inpatient hospital claim is billed
    - IP claim must be in paid status before the next steps can be completed
  - Outpatient hospital claim is billed
    - All requirements from above apply
      - In addition, modifier "SE" must be billed on the claim line
  - Amount billed
    - Acquisition cost
      - Cost per NDC unit multiplied by the number of NDC units administered to the member
    - Claim will be denied if the amount billed does not equal the number of NDC units billed on the claim multiplied by the invoice dollar amount per NDC unit administered
  - NDC
    - The NDC of the Hospital Specialty Drug administered to the member must be billed on the line

- Units billed
  - The amount of drug administered to the member must be billed on the claim line in both HCPCS and NDC units
- Invoice attached
  - The claim will be denied if no invoice is attached
- All PAD and IP/OP policies apply

- 340B exception
  - 340B inventory cannot be used when a Hospital Specialty Drug is administered in an Inpatient setting and billed on an Outpatient claim

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

Nursing Facilities

Hospital Back-Up (HBU) Reimbursement Methodology Update

Effective October 1, 2025, the Hospital Back-up (HBU) program will transition from the Resource Utilization Group (RUG) system to the Patient-Driven Payment Model (PDPM). Reimbursement for HBU services will be calculated in accordance with the PDPM methodology, ensuring alignment with federal Centers for Medicare & Medicaid Services (CMS) standards. The HBU PDPM component recognizes the higher clinical complexity and resource intensity associated with hospital-based care delivery.

- **Coverage:** Applies to all qualified HBU stays reimbursed under PDPM.
- **Rate Structure:** The HBU PDPM component will utilize case-mix adjusted rates consistent with CMS classification criteria for physical therapy, occupational therapy, speech language pathology, nursing, non-therapy ancillaries and Non-Case-Mix components, with appropriate modifiers for hospital-based settings.
- **Compliance:** Facilities must submit all required clinical and utilization data to support classification and payment under the HBU PDPM component.

The HBU PDPM Fee Schedule effective October 1, 2025, is posted to the Provider Rates and Fee Schedule web page under the Hospital Back-Up category.

Physician-Administered Drug (PAD) Providers

Prior Authorization Update

Effective October 1, 2025, Evkeeza® (evinacumab), Healthcare Common Procedure Coding System (HCPCS) J1305 will be added to the list of PADs that require prior authorization (PA).

Providers must ensure that a member-specific prior authorization request (PAR) must be submitted directly to the Department's Utilization Management vendor, Acentra, and approved prior to administration of the PAD.

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

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

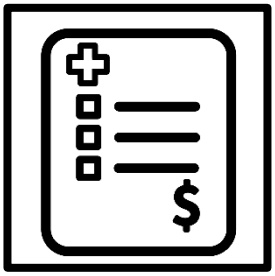
Contact HCPF_PAD@state.co.us with all other PAD questions.

Quarter 4 Rate Update 2025

The Physician Administered Drug (PAD) rates for the fourth quarter of 2025 have been updated. The new rates are effective October 1, 2025, and are posted to the Provider Rates & Fee Schedule web page under the Physician Administered Drug Fee Schedule section.

Pharmacy Providers

Total Annual Prescription Volume (TAPV) Survey



Myers and Stauffer has been contracted by the Department to conduct the TAPV survey of pharmacy providers. The prescription volume information submitted by most pharmacy types will be used to determine their dispensing fee for the 2026 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, 2025, and completed surveys must be returned to Myers and Stauffer by October 31, 2025. 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 ($9.31).

Beginning October 1, 2025, 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 the 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 TAPV	$10.25
110,000+ TAPV	$9.31
Rural Pharmacy	$14.14
Government Pharmacy	$0.00

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

Prescription Drug Acquisition Cost (AAC) Survey

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, 2025, 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 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 that all submitted invoice data will remain strictly confidential.

Pharmacy Coordination of Benefits (COB) for Members with Primary Insurance

More pharmacy commercial insurance data will begin importing into the Pharmacy Benefit Management System (PBMS) later this year. The PBMS will use this information to ensure that Health First Colorado remains the payer of last resort. Pharmacies should ensure that a member's primary insurance is billed prior to billing Medicaid as secondary.

Members should be utilizing providers and pharmacies that are in-network with their primary insurance carrier. This includes using in-network providers for mail order options, maintenance prescriptions and pharmacy locations as outlined in the carrier’s plan documentation.

When a pharmacy attempts to bill Health First Colorado as the primary payer and the member has an active Third-Party Liability (TPL) span, the pharmacy will get a point-of-sale rejection instructing the pharmacy to bill the member’s primary plan. The message is: "Submit Bill To Other Processor Or Primary Payer," and the PBMS will also transmit over the TPL information if available.

If the member believes this is an error and states that they do not have primary insurance, the member may contact the Member Contact Center at 1-800-221-3943, State Relay:711, to

report the issue. The pharmacy or member may also contact the Pharmacy Liaison for assistance at Samantha.Eagan@state.co.us or (303) 866-3588.

Pharmacies needing assistance processing Coordination of Benefits (COB) claims may contact the Prime Therapeutics Help Desk at 1-800-424-5725.

Pharmacy and All Medication Prescribers

Prescriber Tool Update

The Prescriber Tool is a powerful resource available directly within many Electronic Health Record (EHR) system workflows, giving providers seamless access to vital member pharmacy benefit information. This tool has integrated features such as e-prescribing, Real-Time Benefits Inquiry (RTBI) and electronic prior authorizations to deliver transparency and efficiency at the point of care.

Providers can make faster, more informed decisions with instant access to medication coverage details and lower-cost therapeutic alternatives — improving care while managing rising pharmaceutical costs.

Key Benefits Include:

- **EHR Integration**: The Prescriber Tool is accessible in most EHRs within the provider workflow, making it easily accessible during patient visits.
- **Real-Time Pharmacy Benefit Information**: Gain immediate access to member-specific benefits, including cost-effective therapeutic alternatives and coverage details.
- **Faster Prior Authorizations**: Submit and manage prior authorizations electronically and efficiently.
- **System Upgrade Coming**: Beginning in February 2026, the new Pharmacy Benefit Management System will expand access to the tool by integrating with more EHR systems.

Visit the Prescriber Tool Project web page for more information.

Physician Services

Metabolic and Bariatric Surgery Policy Update

Effective September 30, 2025, the Department's Metabolic and Bariatric Surgery policy has been amended to align with current standards of care. The Medical/Surgical billing manual reflects these changes. The full text of the new policy can be found in Department Rule at 10 CCR 2505-10 8.300.3.C.

Contact Chris Lane at Chris.Lane@state.co.us with any questions.

Colorado Medicaid eConsult Update

Health First Colorado providers can access a free, secure statewide electronic consultation platform via ColoradoMedicaideConsult.com. The eConsult platform allows Primary Care Medical Providers (PCMPs) to consult electronically with specialists, often reducing the need for in-person referrals for members.

Now Available: Expanded eConsult Access

- Specialty-to-Specialty Consults (Effective July 1, 2025): The PCMP role has broadened to a general "submitter" role, allowing specialists (Medical Doctors [MDs]/Doctors of Osteopathic Medicine [DOs], Nurse Practitioners [NPs] and Physician Assistants [PAs]) to initiate eConsults as treating practitioners.
- Staff-Initiated eConsults (Launched September 2025): Designated staff can now initiate and submit eConsults with guidance from the referring provider, making the process faster and easier for practices.

Benefits for practices:

- Efficiency: Staff manage submissions from start to finish.
- Workflow: Fits into existing eConsult processes, replacing in-person referrals when appropriate.
- Utilization: Fewer steps for providers means more eConsults submitted.

Reimbursement Updates

The Telemedicine Billing Manual has been updated to reflect these changes. It now includes guidance for:

- Submitting claims for specialty-to-specialty reimbursement
- Updated criteria and reimbursement policies

Refer to the Telemedicine Billing Manual for complete details.

Free Screening, Brief Intervention and Referral to Treatment (SBIRT) Training for Health First Colorado Providers

Free SBIRT training for Health First Colorado providers is provided through partnership with Peer Assistance Services (PAS), Inc. The SBIRT program promotes prevention and early intervention efforts through in-person, online and virtual training; technical assistance; and hands-on SBIRT implementation.

Providers are required to participate in training that provides information about the implementation of evidence-based protocols for screening, brief interventions and referrals to treatment to directly deliver screening and intervention services.

Face-to-face trainings and consultations are available through various entities such as SBIRT Colorado, Colorado Community Managed Care Network and the Emergency Nurses Association.

Elevate SBIRT and motivational interviewing skills with Peer Assistance Services' new self-paced, interactive practice scenarios. Create a free account to access a risk-free practice environment and engage in conversations with a patient about substance use. These simulations use guided prompts to walk through each interaction, improving the delivery and effectiveness of brief interventions.

Register for an upcoming SBIRT training at the PAS training calendar. The shared goal is to promote SBIRT as a standard of care throughout Colorado. Refer to the SBIRT Billing Manual to learn more about best billing practices.

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

Substance Use Disorder Continuum

Invitation: 2025 Annual 1115 Waiver Substance Use Disorder (SUD) Stakeholder Forum

The annual 1115 Expanding the Substance Use Disorder (SUD) Continuum of Care (1115 SUD Waiver) stakeholder forum will be hosted on October 28, 2025. The most recent Annual Report outlining the substance use disorder (SUD) component of Demonstration Year 4 of the 1115 SUD Waiver and update the community about ongoing efforts and anticipated changes will be reviewed during the forum by the Department.

This year's forum will be held virtually Tuesday, October 28, from 9-10:30 a.m. MT. Participants can register now to attend.

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 questions or comments.

Meeting Accommodation and Language Access Notice

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 (1) week prior to the webinar to make arrangements.

Las ayudas y servicios auxiliares para individuos con discapacidades y servicios de idiomas para individuos cuyo idioma materno no sea inglés pueden estar disponibles por solicitud.

Comuníquese con organizador de reuniones hcpf_1115waiver@state.co.us o con el oficial de derechos civiles a hcpf_1115waiver@state.co.us al menos una (1) semana antes de la reunión para hacer los arreglos necesarios.

Transportation Providers

Non-Emergent Medical Transportation (NEMT) Rural Mileage Edit

Effective **September 30, 2025**, a revision to the current 25-mile rule (10 CCR 2505-10 8.014.4.A) will be implemented and edit for Non-Emergent Medical Transportation (NEMT) in rural communities.

Key Changes

- **Increased Mileage Limit**: The daily *roundtrip* mileage limit will increase from 52 miles to 125 miles for members residing in designated rural counties.
    - This change reflects the geographic challenges of large and sparsely populated counties.
    - It is intended to improve access to care for rural members while supporting local NEMT providers.
    - Trips in excess of 125 miles round trip are still covered but can only be provided under certain circumstances and require certain documentation on the claim. Both are details in the Non-Emergent Medical Transportation (NEMT) Billing Manual.
- **Eligibility**:
    - Eligibility for the expanded limit is based on the member's county of residence.
    - A list of qualifying counties is found below and is posted in the NEMT Billing Manual.
    - No new forms or processes are required. Existing trip logs and reporting procedures remain in effect.
- **Claims Review:**
    - NEMT claims billed for procedure codes A0425, S0215 or S0209 will be suspended for review if billed units exceed 125 (for designated rural counties).
    - Claims billed for more than 125 miles for members in these rural counties must have attached the required forms detailed in the NEMT Billing Manual and found on the Provider Forms web page under the Claim Forms and Attachments drop-down menu.

- **Designated Rural Counties**:
  Alamosa, Archuleta, Bent, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Fremont, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Lake, Lincoln, Logan, Mineral, Moffat, Montrose, Morgan, Otero, Ouray, Park, Phillips, Pitkin, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedwick, Washington.

The finalized rule also introduces two (2) billing restrictions:

- **10 CCR 2505-10 8.014.6.13.** NEMT providers may not transport their own family or household members under standard NEMT billing. The provider must use the personal mileage reimbursement process if the individual is an eligible Health First Colorado member. Mileage reimbursement information and the trip mileage form can be found on the Transdev Member Resources web page.
- **10 CCR 2505-10 8.014.3.D.4.** When multiple members are transported on a single NEMT trip, providers may submit a claim for only one (1) Health First Colorado ID to avoid duplicate billing.

These changes aim to ensure program integrity and equitable access while reducing the administrative burden for rural providers and members.

NEMT Coding Changes

Effective July 1, 2025, all NEMT providers must follow these billing and coding changes for claims with dates of services July 1, 2025, or later:

- Healthcare Common Procedure Coding System (HCPCS) A0425 is to be used only for ambulance trip mileage. It is no longer used for non-ambulance trip mileage.
- HCPCS S0215 is to be used only for all NEMT provider trips that are non-ambulance and non-wheelchair van mileage. It will be priced at $3.00 per unit (per mile). **Note:** All NEMT providers must begin using this code for billing mileage for non-ambulance and nonwheelchair trips with dates of service on and after July 1, 2025.
- HCPCS S0209 is to be used only for wheelchair van trip mileage. It will have a rate increase to $3.00 per unit (per mile).

Effective July 1, 2025, HCPCS A0425 is no longer covered for non-ambulance trips. Providers that continue to use HCPCS A0425 for non-ambulance trip mileage will be subject to overpayment recovery which may result in termination for cause from Health First Colorado.

Span Billing for NEMT

Span billing (grouping multiple lines with separate dates of service on one [1] claim) is not allowed for transportation providers.

- Claims must be submitted with one (1) date of service per claim. The From Date of Service (FDOS) needs to be the same as the To Date of Service (TDOS), which is one (1) date of service per claim. The mention of “line” in the manual is advising providers that both the FDOS and the TDOS fields need to be completed with a single date of service. If there are separate codes being billed for the same date of service, an additional line should be added to the claim for the same date of service only.

Billing Status Changes

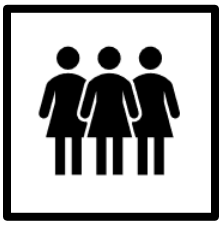
Billing status changes will be delayed and further reviewed due to fraud, waste and abuse concerns of NEMT services billing in addition to the moratorium currently in effect regarding NEMT provider enrollment. The Department will not be allowing any NEMT provider to add billing capabilities.

Do not call the Provider Services Call Center with these questions as they cannot make changes. Contact NEMT@state.co.us with any questions.

Women's Health

Doula and Lactation Support Services Update

The Health First Colorado website contains a provider search tool that offers a resource for Health First Colorado and Child Health Plan *Plus* (CHP+) members to search for and contact providers. Doulas and Lactation providers can now be found using the provider search tool. Members can search for Doula and Lactation providers by location, provider type, specialty or name.



The information in the search results is limited to what individual providers submit to the Department. Providers are encouraged to keep contact information current via the Provider Web Portal.

All providers are required to provide a service location, billing address, and mailing address. If a provider offers services only through home visits or telehealth, their service location can be updated to the address of a hospital, clinic or other associated business.

Refer to the Provider Maintenance Quick Guide for instructions on updating contact information in the Provider Directory.

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

Lactation Support Services Update

The Health First Colorado Breast Pump Supplier List has been updated and is now available on the Lactation Support Services web page.

There may be other suppliers available not listed, including both pharmacies and durable medical equipment (DME) companies. Members can obtain a breast pump from any enrolled supplier, as this list serves as a resource only.

Contact Alaina Kelley at Alaina.Kelley@state.co.us to be added to the list of breast pump suppliers for Health First Colorado.

Provider Training Sessions

October 2025 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:

Provider Enrollment

Provider enrollment training is designed for providers at various stages of the initial enrollment process with Health First Colorado. It provides an overview of the 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.

[Note: This training does not provide guidance on revalidation for already enrolled providers.]

Beginner Billing Training

There are two (2) beginner billing training sessions offered. One (1) is for providers that submit professional claims (CMS 1500), and the other is for providers that submit institutional claims (UB-04). These training sessions are identical except for claim submission specifics.

Click "Which Beginner Billing Training Do I Need?" on the Provider Training web page to find training aligned to provider type.

Beginner billing training provides a high-level overview of member eligibility, claim submission, prior authorizations, Department website navigation, Provider Web Portal use and more.

Staff that 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.

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 2025				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
		1	2	3
6	7 Provider Enrollment Training 9:00 a.m. - 11:30 a.m. MT	8	9	10
13	14 Beginner Billing Training: Institutional Claims (UB-04) 9:00 a.m. - 11:30 a.m. MT	15	16 Beginner Billing Training: Professional Claims (CMS 1500) 9:00 a.m. - 11:30 a.m. MT	17
20	21	22	23	24
27	28	29	30	31

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

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

Upcoming Holidays

Holiday	Closures
Frances Xavier Cabrini Day Monday, October 6	State Offices, AssureCare and the Provider Services Call Center will be closed. Capitation cycles may potentially be delayed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks. Acentra, DentaQuest, Gainwell Technologies and Prime Therapeutics will be open.

Provider Services Call Center

1-833-468-0362