COLORADO
Department of Health Care Policy & Financing

# Accountable Care Collaborative (ACC)
# Program Improvement Advisory Committee (PIAC)
# Meeting Minutes

Aug. 20, 2025
9:30 a.m. to 12 p.m.

## 1. Welcome, Introductions and Minutes Approval

Ian Engle welcomed members to the Program Improvement Advisory Committee (PIAC) meeting.

The following members were in attendance: David Keller, Ian Engle, Wendy Nading, Ty Smith, Daphne McCabe, Catania Jones, Tom Keller, Mark Levine, Donald Moore.

A quorum was present.

Tom Keller announced that he is now with Rocky Mountain Health Plan and is stepping down from PIAC.

Ian Engle presented the June meeting minutes for approval. David Keller abstained from voting. The June meeting minutes were approved.

## 2. Housekeeping

Matt Pfeifer, HCPF, reported that several applications for PIAC voting membership have been received. Applications will be sent to voting members soon. Members will be given 7-10 days to review.

## 3. Updates from the Executive Director

HCPF director Kim Bimestefer provided updates on federal and state circumstances that could impact HCPF and the ACC. Additional information can be found at https://hcpf.colorado.gov/impact

**Fiscal & Federal Challenges**

**Budget Constraints:**

TABOR restricts state revenues, which grow only about 3–4% while medical inflation runs 7–8%.

Colorado faces a $1B+ deficit, requiring further cuts despite previous efforts to balance the budget.

**Federal Context:**

Pandemic-era federal funds ($26B to Colorado) have been spent.

Federal attitudes toward Medicaid are shifting: limiting continuous coverage for children (0–3) and corrections reentry, undocumented individuals, and social determinants of health initiatives (food and housing).

**Provider Tax Reductions:**

Federal formula changes reduce Colorado's hospital/provider tax contribution from 6% to 3.5% of net patient revenue, threatening funding for the Medicaid expansion population which makes up about 425,000 Coloradans.

**Eligibility & Work Requirements:**

Medicaid enrollees in the expansion population will have to renew eligibility **every 6 months** (compared to every 12 months currently).

New **80-hour/month work, school, or volunteer requirement** introduces major risks of coverage loss.

Few models exist (Alabama, Georgia's attempts were unsuccessful).

**Risks & Impacts**

Renewal and paperwork backlogs could replicate Public Health Emergency (**PHE) unwind** problems (members falling off, delayed processing).

Work requirement tracking systems (jobs, school, volunteer hours) are not yet in place.

There is a risk that a large number of Coloradans lose coverage which leads to worse health outcomes, financial strain, and provider instability.

**Medicaid Sustainability Framework**

**Control Cost Trends** – Identify and address cost drivers.

**Maximize Federal Funding** – New submissions, including Denver Health and State Directed Payments.

**Rural Health Transformation Program** - is a federal grant program created by H.R. 1 (the federal funding bill). Colorado expected to receive about$100–200M.

**Invest in Coloradans** – Schools and workforce development.

**Policy Discipline** – Delay or hold unaffordable new programs.

**ACC Phase III** – Improve care delivery (value-based payments, prescriber tools, rural ACO-like models).

**Stakeholder Comments & Questions**

Wendy Nading (Public Health): Asked about exemptions from eligibility and work requirements.

*Response:* Exemptions apply only to work requirements, not renewals every 6 months. Rules for exemptions (e.g., parents, substance use disorders) are still being defined.

Ty Smith (Advocate): Raised concerns about impacts to member quality of life, loss of social determinants supports (food, housing), and long-term strain on rural communities and taxpayers.

*Response:* Kim acknowledged these concerns, emphasizing food and housing as health, and committed to advocating for their protection.

Donald Moore (Provider): Shared staff anxiety about funding cuts and provider morale. Workforce fears loss of sustainability and capacity.

*Response:* Kim stressed prioritization, teamwork, and mutual support during challenges.

Janelle (Advocate): Asked about member communication to reduce fear and potential disenrollment.

*Response:* Kim highlighted the upcoming member message campaign and urged stakeholders to distribute materials widely. Clarified that commercial coverage is unaffordable for most who lose Medicaid, so the focus should be on helping members stay enrolled.

**Next Steps**

**Communications Push:** Distribute simplified **member messages** to help Medicaid enrollees understand renewal/work requirements.

**System Readiness:** Continue building automation and tracking systems for new eligibility/work mandates by October 2025.

**Advocacy & Outreach:**

Engage trusted community voices (providers, advocates, Latino community leaders) to spread awareness.

Coordinate with counties to reduce renewal backlogs.

**Sustainability Planning:** Advance Medicaid Sustainability Framework initiatives and ACC Phase III rollout.

# 4. BHASO Go-Live Updates

Alyssa Hetschel, BASO Division Director at BHA, presented alongside Kayla Martin (Administrative Manager) and Joey Pachta (Service Manager). They introduced the BHASO model and the Colorado LIFTS (Linking Individuals and Families To Services) Network.

**BHASO & LIFTS Model**

Designed to create a coordinated, person-centered behavioral health system.

Built on six pillars: access, whole-person care, accountability, workforce support, affordability, consumer guidance.

Replaces Colorado's prior fragmented crisis, substance use, and mental health networks with a streamlined four-region structure.

The LIFTS Network provides crisis, substance use, and mental health services, with BHASOs adding care coordination.

**Projections & Performance (Kayla Martin)**

First-year estimates:

More than 110,000 individuals will need publicly funded behavioral health services.

About 43,000 individuals are projected to need substance use disorder services.

Highest demand is in Region 4 (about 40,000 individuals).

Demographics: The greatest needs are among minors and adults aged 19–44.

Performance Metrics (Year 1): access and continuity of care benchmarks set, with the potential for future value-based payment models.

**Oversight & Funding (Alyssa Hetschel)**

BHA provides about $203M annually to BHASOs (state + federal braided funding).

Additional $47M in federal grants for mental health, substance use, opioid response, and children's wraparound care.

Oversight areas: access, quality, compliance, regulation monitoring, service validation, financial stewardship.

Entry points for consumers: BHASO Care Navigation Line, ownPath.co website, provider referrals.

**Expected Impacts (Kayla Martin)**

Fewer barriers to finding care via simplified navigation.

Unified network ensures consistency and accountability.

Stronger care coordination across Medicaid, uninsured, and underinsured populations.

**Stakeholder Discussion**

Wendy Nading (Public Health): Asked about referrals to RAEs.

*Response:* Medicaid members are referred to their RAE care navigation line, for both physical and behavioral health needs.

Ty Smith (Advocate): Raised concerns about forced treatment and crisis services, advocating for peer warmline options instead of defaulting to crisis interventions.

*Response:* Alyssa committed to exploring peer warmline integration into BHASO operations and encouraged Ty to join regional advisory councils.

David Keller, MD: Asked about breaking down metrics by age groups.

*Response:* BHA confirmed interest and noted capability through existing data systems (e.g., CCAR records), with emphasis on early childhood access (ages 0–5).

Ian Engle (NW CO Center for Independence): Suggested leveraging existing community-based networks (Aging councils, FQHCs, ADRCs) for outreach instead of third-party contractors.

*Response:* Alyssa confirmed BHASOs are contractually required to conduct outreach with trusted local organizations and will provide branding toolkits and materials for consistent statewide messaging.

## 5. ACC Phase III Go-Live Update

Dave Ducharme, ACC Division Director, provided an update on the implementation of ACC Phase III. The presentation covered identified and actualized risks, system performance, provider and member impacts, and future operational and data strategies.

**Issue Submission and Tracking**

A web form was launched for reporting issues related to Phase III. Only 33 issues have been reported, mostly related to system errors, attribution, and behavioral health access. The average resolution time was approximately two days.

**System and Contract Transitions**

Multiple concurrent changes took place on July 1, including new contractors for the data warehouse and the provider call center. Minor day-one access issues were resolved promptly. No significant systemic failures occurred.

**Simultaneous Program Implementation**

ACC Phase III went live alongside the BHASO program without conflict. The programs serve different populations and operate distinct but overlapping networks.

**Provider Impact**

Realignment from 7 to 4 regions led to close monitoring of network adequacy, particularly where HCI did not retain a contract. Regions 1 and 2 successfully covered the former Region 4. There were isolated contracting issues, but no systemic gaps. Concerns about the removal of geographic attribution and impacts to primary care provider payments are being monitored, with no major disruptions so far.

**Member Impact**

Transitions for complex members were well-managed, with only one notable access issue that was resolved. The issue involved about 1,100 Home and Community Based Services (HCBS) waiver members in Denver who were reassigned to Denver Health MCO, disrupting their specialty care. They were reverted to their prior RAE and Fee for Service payment process for physical health services after quick identification.

**Communication Delays**

Enrollment letters meant for July 1 were delayed to July 18, creating communication gaps. Outreach from the RAEs and follow-up letters were used to address member confusion, especially for those impacted by reassignment reversals.

**Ongoing Monitoring and Goals**

Phase III goals include improved operations, data collection, analytics, provider performance, and Medicaid sustainability. New datasets and dashboards are in development. Enhanced oversight and stability remain priorities.

**Stakeholder Comments and Questions**

David Keller asked about what's happening with provider access to performance data now that the Data Analytics Portal (DAP) is gone.

*Response* (David Ducharme):
The DAP was part of the prior IBM contract and saw low usage (25–45 logins per quarter statewide). With the transition to Conduent, HCPF is building a new, more useful analytics portal. A beta version is expected in November or December, and full rollout to providers in January. It will be easier to understand and more actionable.

Ty Smith reported that he had heard that telehealth rates vary by RAE. He expressed concern that this could cause a problem with providers selecting patients based on reimbursement rates/region.

*Response* (David Ducharme):
Yes, we've heard of behavioral health providers advising members to switch RAEs due to better reimbursement. While we hadn't specifically heard about telehealth rate differences, it's a related issue and we'll look into it. This kind of rate-driven member steering is not acceptable.

*Response* (Matt Pfeifer):
Rate differences between RAEs are intentional in managed care. RAEs are allowed flexibility to respond to regional cost structures and access needs. Still, we recognize equity concerns—especially when providers contracted statewide choose which RAEs to work with based on rates.

# 6. Subcommittee Updates

**BHIS subcommittee**

Lexis Mitchell reported that BHIS reconvened on August 6 after a recess in July. The committee received a presentation on the Behavioral Health Incentive Program (BHIP), which outlined national standards and how they align with care coordination contract requirements.

A concern was raised that social determinants of health screenings are currently limited to members 18 and older. HCPF is evaluating options to expand this screening to younger populations.

The meeting also included overviews of ACC Phase III attribution changes and the HCPF Integrated Care webpage. Members asked about new policy changes allowing psychotherapy for children without a psychiatric diagnosis and requested a policy transmittal review be added to the September 3 agenda.

**P&CE subcommittee**

Mark Levine provided an update on behalf of the P&CE Subcommittee. He shared that the group did not meet in July but reconvened in August to receive a presentation from the Colorado Health Institute regarding House Bill 23-1300. While the bill originally aimed to expand continuous Medicaid coverage, it also mandates a study on how Medicaid can better address health-related social needs—a focus that now includes broader social determinants of health.

Although the subcommittee has not yet made any formal recommendations, Mark noted that they plan to develop future guidance in several key areas:

The role of physicians in certifying long-term services and supports (LTSS)

Accountability in LTSS delivery

Improving disability-competent care

**PMME subcommittee**

Daphne McCabe reported that the PMME subcommittee met on July 24. The meeting featured an ACC Ppase III change management update from Andi Bradley (HCPF), highlighting efforts to track issues and ensure a smooth implementation. Discussion focused on monitoring recurring provider concerns, communication between HCPF, RAEs, and community partners, and the impact of staffing shortages.

Joe Donlin (HCPF) provided the subcommittee with a legislative update, summarizing recent bills affecting Medicaid, behavioral health, and care coordination. Members asked about eligibility changes, funding distribution, and requested a written summary of the session.

Matt Lanphier presented an attribution update during the subcommittee meeting, explaining how members are assigned to RAEs under ACC Phase III. Topics included continuity of care, outreach for member understanding, and coordination for high-need members.

Daphne noted the group's appreciation for improved communication with HCPF and encouraged committee members to volunteer as beta testers for the upcoming data portal redesign.

# 7. Open Comment

Matt Pfeifer encouraged attendees to check the HCPF updates page to stay abreast of changes to Medicaid. https://hcpf.colorado.gov/impact

# 8. Adjournment

David Keller moved to adjourn the meeting at 11:59 AM. He stated that he will be teaching medical students next month and will get to the meeting as quickly as he can. Ian confirmed he will facilitate the meeting. The next PIAC meeting will be on September 17 at 9:30 AM.

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