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The Ways of the RAEs

Regional Accountable Entities and Their Role
in Colorado Medicaid's Newest Chapter

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The Way to the RAEs

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Health care is evolving for more than 1 million Coloradans — both in the clinic and behind the scenes.

On July 1, 2018, Health First Colorado, the state's Medicaid program, launched a new phase of its effort to reform Medicaid. Phase Two of the Accountable Care Collaborative (ACC) is part of an ongoing shift in how care is delivered and financed for nearly 1.3 million Medicaid members.

Phase Two of the ACC aims to control costs in the state government's largest agency while helping Medicaid members improve their health through integrating primary care and behavioral health, which includes mental health and substance use disorder services.

This report explains the major changes to the organizational structure of the state's Medicaid program that are part of Phase Two of the ACC. It also poses questions to consider as these developments in Health First Colorado take hold.

The Colorado Department of Health Care Policy and Financing (HCPF), which oversees Health First Colorado, has been developing and revising plans for this second phase of the ACC since 2015.

Phase One of the ACC started in 2011. It entailed ensuring that health services for Health First

Three Things to Know About RAEs:

- Regional Accountable Entities, or RAEs, are new organizations in Health First Colorado, Colorado's Medicaid program. They are responsible for coordinating members' care, ensuring they are connecting with primary and behavioral health care, and developing regional strategies to serve Health First Colorado members.
- While the aim is to eventually improve care, many changes are largely administrative and behind the scenes, and RAEs are attempting to launch their programs without disrupting services for members.
- RAEs have common requirements and responsibilities, but they have latitude in how they craft their regional strategies and relationships with health care providers.

Colorado members were coordinated and that members were connected with primary care. The goal is to avoid long-term chronic conditions and increased costs to the state down the line. So far, the ACC has shown incremental savings each year and is credited with cutting \$161 million in costs by coordinating patient care and connecting members with primary care.¹

Phase Two involves a number of changes aimed at coordinating care and reducing costs. The biggest development was the launch of seven new organizations — Regional Accountable Entities, or

Changes to Colorado's Medicaid Program in Phase Two of the ACC

- Regional Accountable Entities (RAEs) are responsible for building networks of providers, monitoring data and coordinating members' physical and behavioral health care. RAEs replace and consolidate the administrative functions of Regional Care Collaborative Organizations (RCCOs) and Behavioral Health Organizations (BHOs).
- Mandatory enrollment in the ACC for all Medicaid members, with the exception of Health First Colorado members enrolled in Program All-Inclusive Care for the Elderly (PACE).
- Primary care providers can bill Health First Colorado for up to six short-term behavioral health visits to an onsite behavioral health clinician per person per year.
- New pay-for-performance programs — or modifications of existing ones — provide financial incentives to RAEs and providers for progress toward goals such as reducing unnecessary emergency department visits or following up with members who are positively screened for depression.
- A new process for attributing, or assigning, Health First Colorado Members to a primary care provider will affect providers and members. In Phase Two, all members are attributed to a primary care medical provider (PCMP) based on where they or a family member have sought care in the past or to a primary care provider near where they live. They are then assigned to the RAE region in which the PCMP is located. In Phase One, members were connected to a RCCO based on the county in which they lived. This change means that each primary care site only has to work with a single RAE, rather than with multiple RCCOs as in Phase One.
- RAEs build their networks by contracting directly with primary care providers and behavioral health providers. RAEs can use value-based payments — financial incentives like bonus payments — to providers as a way to improve care.
- Financial reporting and transparency are required for RAEs and participating providers. HCPF plans to create a dashboard to share metrics.

RAEs — on July 1, 2018. The RAEs' responsibilities include ensuring Health First Colorado members have access to primary care and behavioral health services, coordinating members' care and monitoring data to ensure members are receiving quality care. They also have a role in paying providers, including managing payments for behavioral health services and using bonus payments to encourage primary care providers to improve care — responsibilities largely carried out by other entities in Phase One.

Although the state Medicaid program is changing, many components are staying the same. For example, fee-for-service claims for physical health care services will continue to be paid by HCPF, not the RAEs.

Five private organizations won a competitive bidding process to take over the coordinating role in the state's seven RAE regions. The companies earn revenue from

HCPF in a system that encourages them to operate efficiently and is aimed at keeping them accountable for quality.

This is not the first time that HCPF has contracted with private organizations to administer Medicaid services. The RAEs replace two Phase One mainstays: the Regional Care Collaborative Organizations (RCCOs) and the Behavioral Health Organizations (BHOs).

Prior to that, Colorado's experiment with Medicaid managed care in the 1990s ended badly after payment disputes spurred lawsuits.²

Currently, most states contract with private companies to manage their Medicaid programs, though there is wide variation in how this looks.³ RAEs are Colorado's unique approach to managing Medicaid.

What to Expect from This Brief

As RAEs start work, community leaders, policymakers and others are asking, “What are these new organizations?” In response, CHI has developed this issue brief, an online interactive map and a series of podcast interviews with the leaders of the RAEs. The series serves as an introduction to these developments as Colorado ushers in a new era of Medicaid and to serve as a foundation for future analysis.

The CHI team aimed to answer three key questions:

- **What are RAEs?** This brief outlines the principles guiding RAEs, their key functions, the regions they serve, their history and the variety of partnerships that define how they are organized.
- **What is the role of RAEs in paying providers?** The ACC gives RAEs a significant role in new payment arrangements that aim to improve the quality of care while lowering costs, including the ability to pay financial incentives aimed at driving providers’ behavior. This brief explains the new payment arrangements.
- **What are the big questions heading into Phase Two?** This brief flags key issues that have emerged, including how Phase Two of the ACC will impact Health First Colorado members’ access to behavioral health services and how changes to attribution will affect members and providers.

What Are RAEs?

RAEs have five primary responsibilities:

1. **Coordinating** the care of Health First Colorado members in their region to ensure that care is delivered efficiently and duplication of services is minimized.
2. **Building** networks of primary care and behavioral health care providers so that Health First Colorado members have access to these services.
3. **Administering** the state’s capitated behavioral health program. Health First Colorado pays the RAE a monthly amount to provide or arrange for behavioral health services for all Health First

How We Got Here

To understand where Colorado’s Medicaid program is going, it’s important to understand where it’s been.

The Accountable Care Collaborative is Colorado’s unique approach to reforming Medicaid. It’s an iterative, ongoing effort that is being rolled out in several phases. The aim is to improve the health of Health First Colorado members and curb costs to the state by promoting “person-centered” care. This approach is focused on the needs of the whole person rather than treating physical and behavioral health separately.

In Phase One, launched in 2011, Health First Colorado members weren’t required to be enrolled in the ACC. In Phase Two, it’s mandatory, which means that members are required to be connected to a primary care practice that is working with a RAE.

The ACC is based on many principles of “accountable care” currently in use in commercial insurance and Medicare. The principles guiding the ACC include:⁴

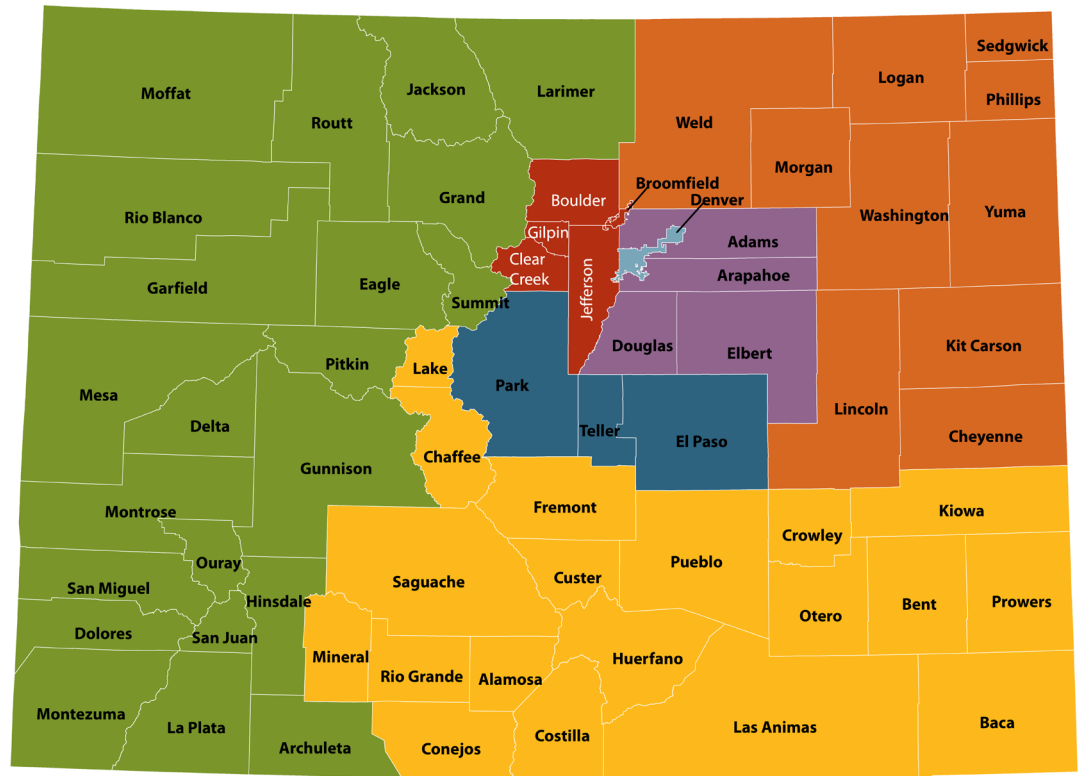
- Increasing access to primary care and preventive care can avoid higher costs down the road.
- Coordinating patient care leads to greater efficiencies and quality.
- Financial incentives are effective in improving the quality of care and reducing costs.
- Data can be harnessed to measure these improvements.
- Regional entities can best meet the needs of their local populations.
- Members should have a choice of where they seek their primary and behavioral health care.
- Integrating behavioral health and primary care must occur not only in the clinic but at the administrative level.
- Providers and regional entities should be held accountable for their performance, and their finances and quality measures should be transparent.

For more information on the ACC, see CHI’s publication *The Route to the RAEs*.
coloradohealthinstitute.org/research/route-raes

Colorado members. (The state government, not RAEs, reimburses physical health providers directly.)

4. Monitoring data and metrics to ensure RAEs and their provider networks meet their goals to provide quality care.

5. Improving health of Medicaid members in a variety of ways, such as developing plans to address the health needs of sub-populations — such as children or adults — in a RAE’s region.



If these duties sound familiar, it’s because

RAEs replace two mainstays of Colorado’s Medicaid program — RCCOs and BHOs. The RAEs combine their duties under one administrative umbrella. (See Figure 1.)

The seven Regional Care Collaborative Organizations (RCCOs) were responsible for building networks of primary care providers in different geographic regions, coordinating the care of Health First Colorado members and monitoring progress using data. They were created in 2011 when Phase One of the ACC launched.

The five Behavioral Health Organizations (BHOs) were created by legislation passed in 1995. Colorado paid

Map 1. Regional Accountable Entity (RAE) Regions in ACC Phase Two.

- **Region 1:** Rocky Mountain Health Plans
- **Region 2:** Northeast Health Partners
- **Region 3:** Colorado Access
- **Region 4:** Health Colorado, Inc.
- **Region 5:** Colorado Access
- **Region 6:** Colorado Community Health Alliance
- **Region 7:** Colorado Community Health Alliance

Figure 1. The Responsibilities of RAEs.



a lump sum to each regional BHO, which arranged for behavioral health care for all Health First Colorado members in its region.

Phase Two of the ACC assumes that by combining the administrative duties of BHOs and RCCOs new efficiencies will be gained, moving the state closer to its vision of integrated physical and behavioral health care. This, in turn, is intended to promote a more holistic, “person-centered” approach to each member’s health.

The RAEs cover seven regions. (See Map 1.) Geographically, these are very similar to regions covered by the RCCOs, with the exception of Elbert County, which moved from RCCO Region Seven to RAE Region Three. HCPF selected one organization in each region through a competitive process to serve as the RAE. There are only five operators because two organizations — Colorado Access and the Colorado Community Health Alliance — were each awarded two regions.

Origin Stories: Who Runs the RAEs?

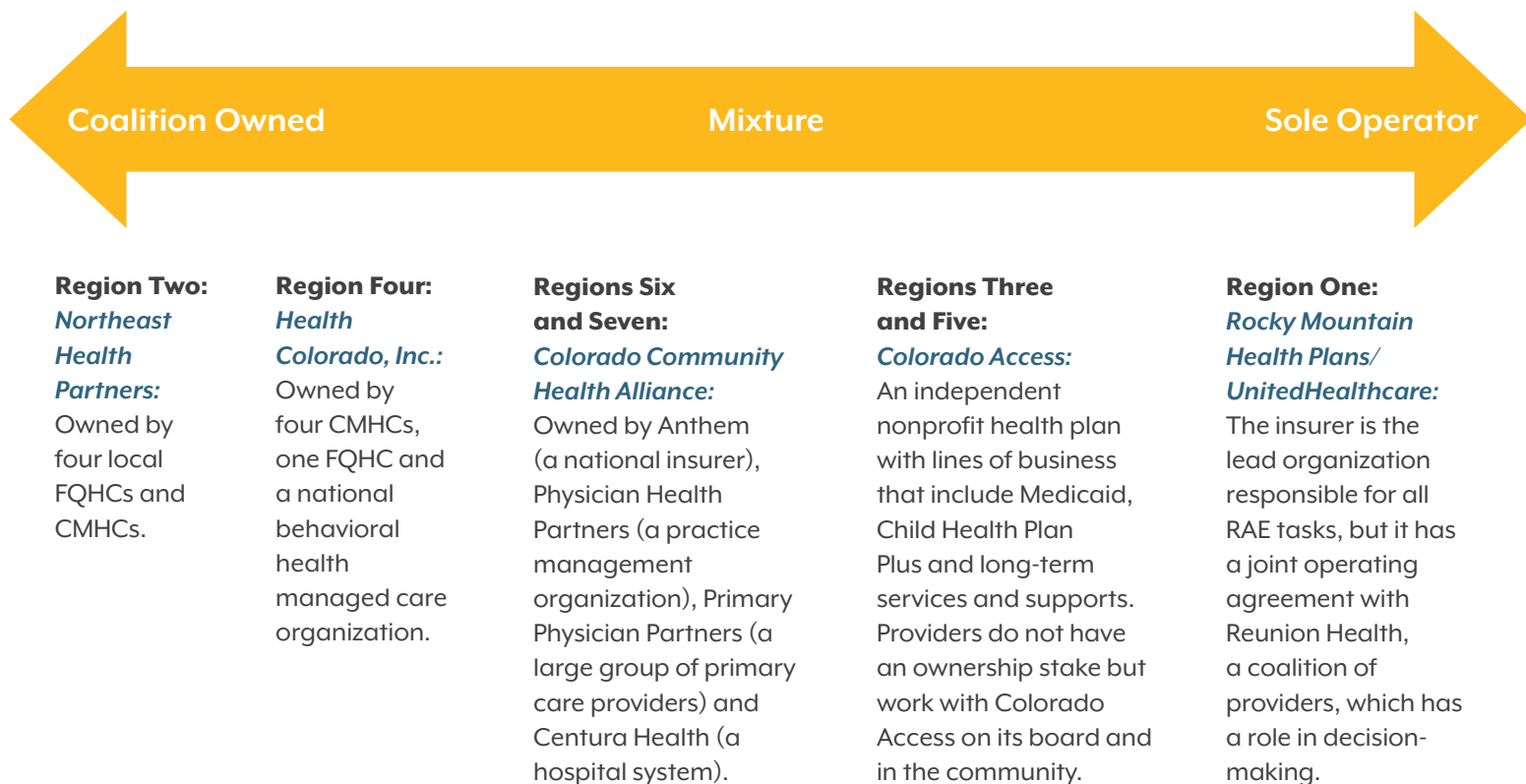
The RAEs are a mix of established and new organizations with varying previous experience working with HCPF.

Three RAEs served as RCCOs in Phase One: Colorado Access, the Colorado Community Health Alliance and Rocky Mountain Health Plans. Colorado Access also served as a BHO.

Two new organizations, Northeast Health Partners and Health Colorado, Inc., were created — at least in part — by local federally qualified health centers (FQHCs) and community mental health centers (CMHCs) to serve as RAEs.

Although BHOs are going away in their current form, many BHOs were partially operated by community mental health centers. Several of these centers also have an ownership stake in the two new RAE organizations.

Figure 2. Continuum of Provider Involvement in RAEs



A National Foothold

National managed care companies have a bigger presence in the RAEs than they did in Phase One of the ACC. A national managed care company plays a role in each RAE except Colorado Access.

- **Beacon Health Options:** A national behavioral health managed care company — previously known as Value Options — has an ownership stake in Region Four (southeast and central Colorado), and it is a subcontractor providing administrative services in Region Two (northeast Colorado).
- **Anthem, Inc:** The firm has a 50 percent ownership stake in the Colorado Community Health Alliance (CCHA) in Regions Six (centered on Boulder and Jefferson counties) and Seven (Colorado Springs and surrounding counties).

- **UnitedHealthcare:** The firm is the parent company of Rocky Mountain Health Plans, which serves as the Region One RAE on Colorado’s western slope.

The Role of Local Providers

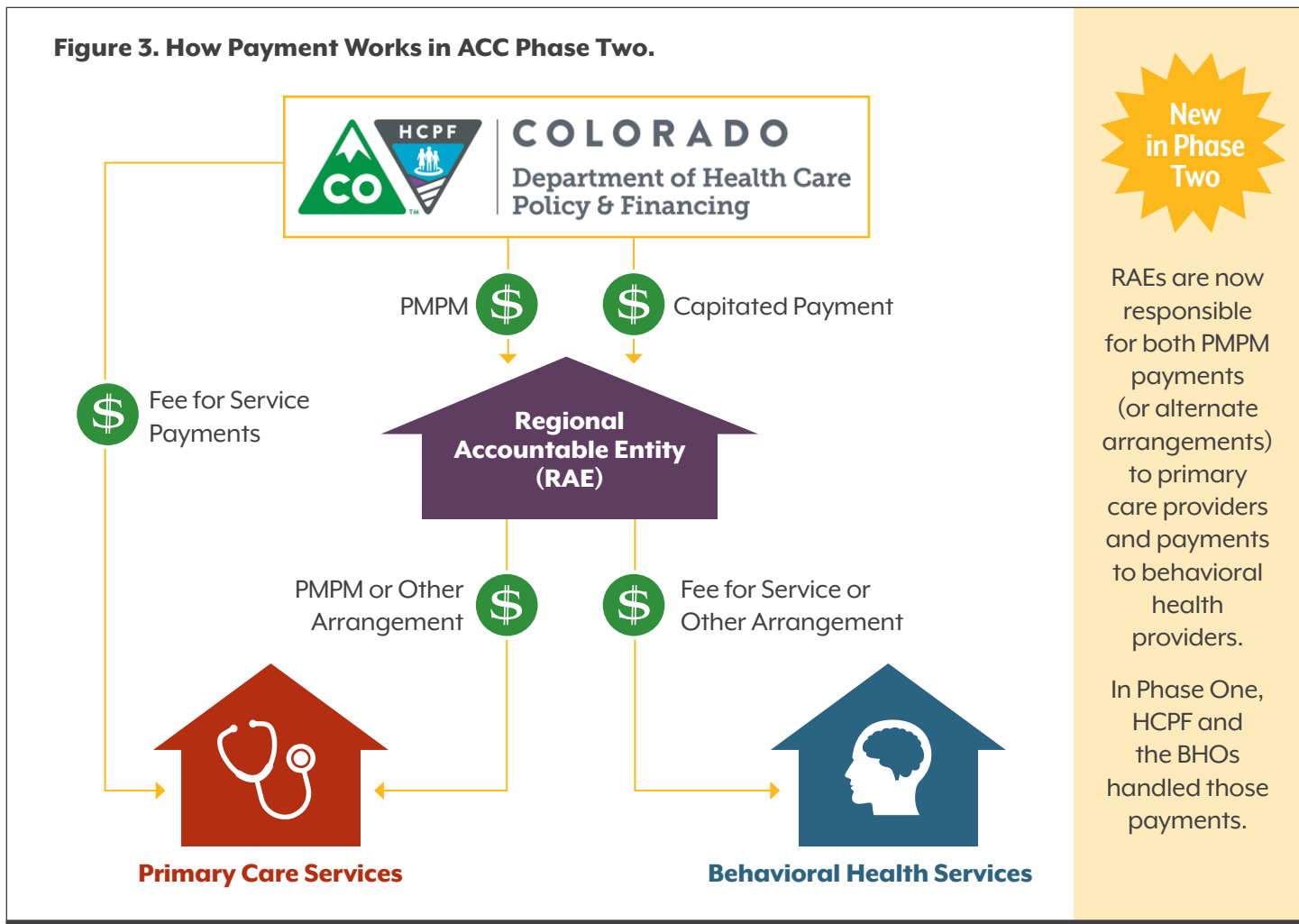
Health care providers have varying degrees of ownership in RAEs. Several are owned by coalitions that include providers. On the opposite end of the spectrum are sole operators, CHI’s term for a single entity that manages a RAE. (See Figure 2.)

The provider-owner arrangement has potential benefits and pitfalls. On one hand, a provider-led RAE may be attuned to patient needs because of providers’ frontline involvement in care. On the other hand, some perceive a potential conflict of interest when providers partially own an entity responsible for paying their own practices. HCPF representatives say the agency

Table 1. Four Key Types of Medicaid Payment in Colorado.

Concept	Definition	How It’s Used in the ACC
Fee-for-Service	Reimbursement from the state to a provider for each service rendered, based on a predetermined fee schedule.	Payments to primary care and specialty care providers for physical health care services.
Capitation	A per capita amount of money paid by the state to a managed care organization to cover health benefits for each member in its geographic region. Capitation rates are adjusted based on the health needs and demographic characteristics of members in that region.	Payment to RAEs for provision of behavioral health services.
Per Member Per Month (PMPM) Payments	Monthly administrative payments from HCPF to RAEs — and then from RAEs to primary care providers — to enable RAEs and providers to offer specific support, like care coordination, to members who need it.	Payments to RAEs for ensuring member access to care coordination. RAEs offer a PMPM or other value-based payment to primary care providers for offering a medical home for members. RAEs may also use the PMPM to pay other types of providers in the “health neighborhood,” such as dentists, specialty care providers or local public health agencies.
Pay-for-Performance	Financial sticks and carrots to encourage improvements in the quality of care provided to Health First Colorado members.	Incentives or other value-based payments to reward RAEs or providers for meeting, exceeding or making progress toward established goals. These programs take many different shapes in Phase Two.

Figure 3. How Payment Works in ACC Phase Two.



New in Phase Two

RAEs are now responsible for both PMPM payments (or alternate arrangements) to primary care providers and payments to behavioral health providers. In Phase One, HCPF and the BHOs handled those payments.

created new financial transparency rules in ACC Phase Two to address this issue.

Sole operators, on the other hand, may have an advantage when it comes to administrative efficiency and coordination, but may be more removed from providers.

RAEs are expected to solicit suggestions from providers and members to inform their strategy and decisions. Each RAE is doing this in different ways. Some have established governance councils made up of health care providers in their network. These councils help guide a RAE’s decision-making. But the composition of the RAEs raises questions: For example, some RAEs have determined that only providers of a certain size can be members of a governance council, leaving questions of how the RAE will engage with smaller clinics and practices. RAEs are also establishing advisory councils to inform behavioral health decisions and engage members.

Additional details about each RAE’s ownership structure is provided in the profiles and interactive map. (See Page 14.)

What is the Role of RAEs in Paying Providers?

Payment is often used as a tool to shift provider behavior and bring about system-wide change. Table 1 highlights the ACC’s four types of payments for primary care and behavioral health care.

RAEs play a larger role in paying providers than their predecessors, the RCCOs.

Figure 3 shows how these four types of payment flow from HCPF to primary care and behavioral health providers in the ACC’s Phase Two. The key takeaway from Figure 3 is that one entity — the RAE — is now responsible for both the PMPM payment (or alternate

The ACC Through a Member's Eyes

While many of the changes in the ACC Phase Two involve payments, contracts and other behind-the-scenes issues, the million-plus Health First Colorado members will likely experience some tangible changes. For one, enrollment in the ACC is now mandatory for all members – with the exception of those enrolled in the Program for All-Inclusive Care for the Elderly (PACE) – though members will still be able to visit any provider they wish as long as the provider is enrolled in the ACC.

Figure 4 illustrates three significant areas of focus for the ACC – care coordination, primary care services and behavioral health services – and how these areas have progressed since before the ACC's launch in 2011. CHI plans to explore how other types of care – such as long-term services and supports, dental services and specialty care – are impacted by the ACC's evolution.

Figure 4. Changes in Phase Two Through a Member's Eyes.

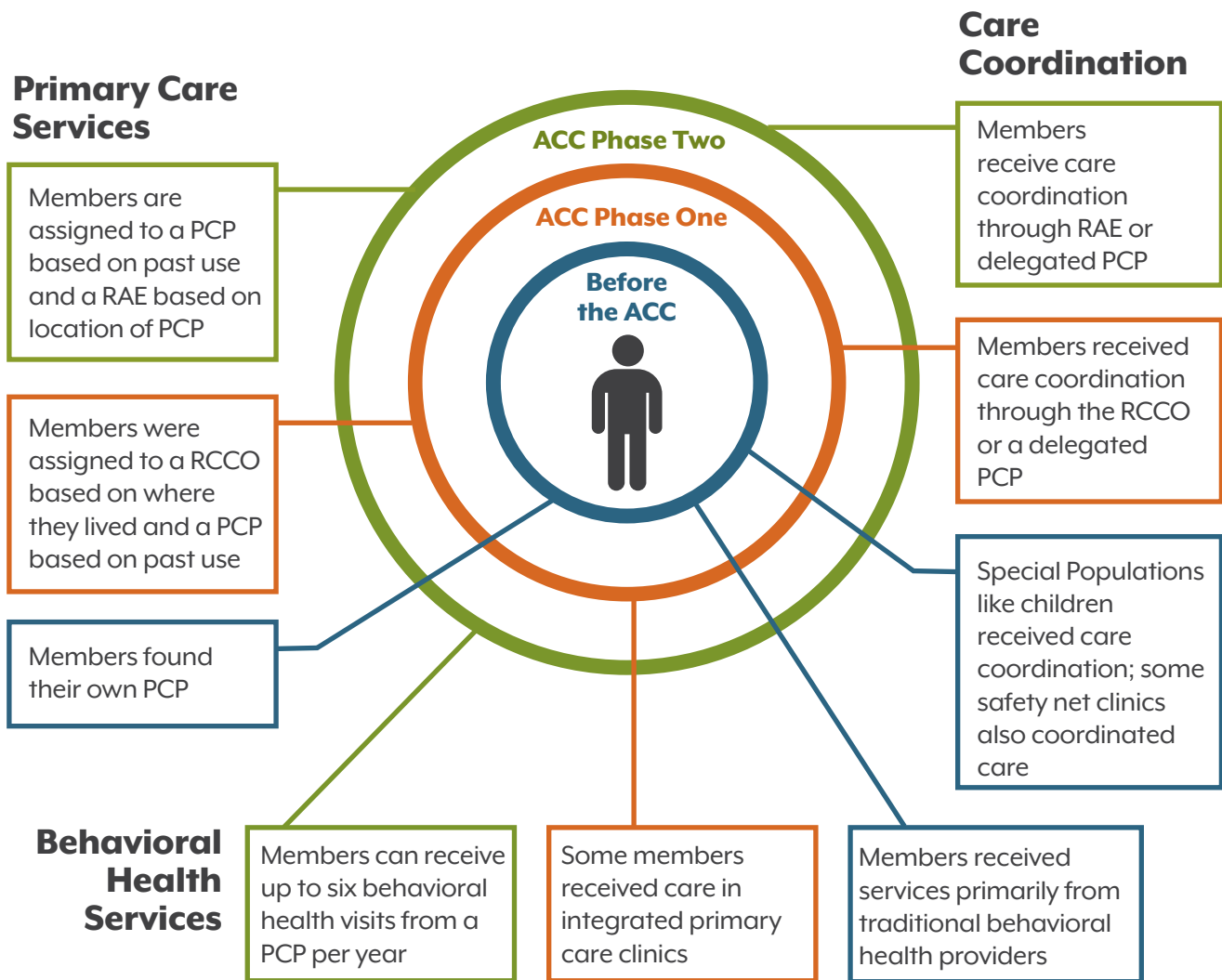


Table 2. Financial Incentives in Phase Two.

Incentive	How It's Structured in Phase Two
Key Performance Indicators (KPIs) and pay-for-performance pool	<p>As in Phase One, HCPF withholds a portion of each RAE's PMPM payment and puts it into a pay-for-performance pool. RAEs can earn payments from the pool by showing improvement on KPIs or achieving other goals to be set by HCPF.</p> <p>The KPIs for the 2018-19 fiscal year include:</p> <ul style="list-style-type: none"> • Potentially avoidable costs • Emergency department visits • Well visits • Members receiving behavioral health services • Prenatal care • Dental visits • Connections and referrals between primary care and specialty care providers
PMPM payments to Primary Care Medical Providers (PCMPs)	<p>In Phase Two, primary care providers contract directly with RAEs — rather than HCPF — for PMPM payments. RAEs have the latitude to develop alternative financial incentive programs with providers. RAEs must offer to pay a portion of their administrative PMPM to primary care providers but are encouraged to negotiate alternative, value-based payment arrangements with the provider.</p>
Alternative Payment Model (APM)	<p>Eligible primary care providers may earn higher fee-for-service payments for demonstrating improvement on selected performance measures. HCPF has also developed an APM specific to federally qualified health centers. The APM began in Phase One and continues in Phase Two. RAEs are expected to support the primary care providers in their networks in implementing the APM.</p>
Behavioral health incentives	<p>HCPF has implemented a variety of “sticks and carrots” to incentivize RAEs to provide high-value service to members. RAEs can earn higher rates when they achieve key performance targets.</p> <p>The behavioral health incentive measures⁵ are:</p> <ul style="list-style-type: none"> • Engagement in outpatient substance use disorder (SUD) treatment • Follow-up within seven days after an inpatient hospital discharge for a mental health condition • Follow-up within seven days after an emergency department visit for a SUD • Follow-up after screening positive for depression • Behavioral health screening or assessment for foster care children

arrangement) to primary care providers and payments to behavioral health providers. In Phase One, HCPF and the BHOs handled those payments.

Some payments have not changed since Phase One. Primary care providers are paid on a fee-for-service basis, and behavioral health services are paid on a capitated rate. Extra incentive payments aim to push the ACC's big idea — that focusing on improving the health and experience of Health First Colorado members saves the state money in the long run.

But Phase Two makes some important changes in the way money flows:

- The RAE passes along incentive payments to primary care providers (although HCPF still pays primary care providers for medical services to Health First Colorado members). The RAE also handles all payments to behavioral health providers.

- In Phase One, HCPF paid incentives to providers based on how the provider's entire RCCO region performed on a set of metrics called the Key Performance Indicators (KPIs). For example, one KPI measured Medicaid members' use of the emergency department. In Phase Two's first year, HCPF increased the number of KPIs from three to seven (see Table 2), with the possibility of expanding the number of indicators in the future. Similar to Phase One, the KPI payment from HCPF to the RAE is based on the overall regional performance of the RAE. The difference in Phase Two is that RAEs — and not HCPF — make the KPI payments to primary care providers.
- Phase Two introduces additional opportunities for RAEs and providers to earn incentive money for improving the quality of care explained in Table 2. Primary care providers contract directly with RAEs in Phase Two, which gives RAEs more latitude than RCCOs had to develop innovative payment approaches with providers. The question remains as to whether these incentives will improve health and save money for the state.

What are the Big Questions Heading into Phase Two?

As Phase Two of the ACC unfolds, CHI is monitoring a few key questions:

How will changes in attribution affect members and providers? HCPF's changes to its attribution approach are intended to make life easier for primary care providers by ensuring that they will only have to contract with a single RAE. The changes are also intended to preserve members' choice of providers while linking them to the primary care provider with whom they've had a prior history as a medical home. Yet the complicated exercise of linking over a million members to thousands of providers raises many questions, especially because attribution determines the volume of PMPM payments that RAEs receive. Will HCPF attribute the expected number of members to each provider? What happens if providers aren't assigned all the patients they are expecting? And how will attribution handle exceptions, like when a chronic care patient's main care provider is a specialist instead of a primary care clinician?

How will changes in the way care is paid for in Medicaid impact cost, quality and access to care? The ACC counts improving Health First Colorado members' access to care and quality of care — as well as saving Medicaid dollars — among its key objectives. There are a few promising areas where this could happen in Phase Two. First, RAEs can develop innovative arrangements with primary care providers that encourage efficiency and quality. Second, Phase Two continues the emphasis on coordinating care — potentially avoiding duplicative services and ensuring patients get the right care at the right time. Finally, Phase Two places an even greater emphasis than Phase One did on tracking progress through data and measurement, then tying improvement to financial incentives. HCPF, RAEs and providers are figuring out ways to make the data they need available in a timely fashion. Understanding the ways in which RAEs and providers are using these tools will be key to evaluating Phase Two's success.

How will success be measured? The many elements of the ACC mean that success can be measured in many ways. Cost savings to the state is one; performance on key metrics is another. Phase One included an evaluation of cost, quality and utilization in the ACC conducted by the University of Colorado Denver.⁶ Are there plans to evaluate Phase Two, and what can be learned about each RAE's strategies, successes and challenges?

Phase Two includes the added dimension of public reporting of data. HCPF aims to increase transparency and focus on improving the health of populations by posting a dashboard of metrics. This dashboard includes KPIs and additional clinical and public health measures, such as suicide rates, developmental screening and medication management of asthma.

How will the six behavioral health visits primary care providers can now bill for and other Phase Two changes affect access to behavioral health services? Phase Two includes several ways to improve access to behavioral health services. For example, primary care provider practices or clinics are now allowed to bill for up to six short-term visits to a Medicaid-enrolled, licensed behavioral health clinician in a primary care setting.

Each RAE also has to develop a statewide network of behavioral health providers. Previously, BHOs reviewed behavioral health providers and allowed those it approved to bill for services. The process is called credentialing. Many smaller or independent providers felt shut out of Health First Colorado because they could not get credentialed. Now RAEs are in charge of credentialing in their regions. Some behavioral health providers may have to contract with multiple RAEs in order to serve patients with primary care providers in different regions. Will the RAEs' new systems increase the number of behavioral health providers in their networks, and will these changes improve access to behavioral health care or oversaturate the market?

How will RAEs manage the integration of physical and behavioral health?

Behavioral health in Health First Colorado is a capitated managed care program. While each RAE either has experience managing behavioral health care or has a managed care organization as a partner, there will still likely be a learning curve for some of them in administering payments, working with providers and providing care coordination services. How will patient care be affected by having one organization manage both primary care and behavioral health care services for the member? How will two very different payment systems — fee-for-service and capitation — work together under the same roof?

How will RAEs collaborate with providers in the health neighborhood?

In Phase Two, RAEs may contract not only with primary care and behavioral health providers, but with other providers in their “health neighborhood,” including dentists, specialty care providers, local public health agencies and hospitals. These relationships hold the potential for RAEs and their partners to implement innovative approaches that address challenges with Health First

Colorado members' access to services. They also may be given lower priority as RAEs work within their budgets to ensure access to primary care and behavioral health first.

Who will be at the table to inform RAEs' strategic direction?

Each RAE is supposed to solicit ideas from stakeholders to inform their strategy. Consumer and provider representation is of particular interest. How will the perspective of Health First Colorado members be considered? And to what extent will the perspectives of providers of all types and sizes be included?

Conclusion

With the launch of Phase Two, the Accountable Care Collaborative is now the primary way Colorado's Medicaid program is aiming to reduce costs and improve care for more than one million Medicaid members.

Phase Two also marks the state's most tangible step yet in its goal of integrating primary care and behavioral health. By putting one entity in charge of arranging both physical and mental health care for Health First Colorado members, the ACC's architects hope that care will become more integrated not just in the clinic, but also behind the scenes.

The overarching question is whether changes in Phase Two will maintain or increase access, reduce costs and improve care. Phase Two places a lot of faith in private organizations that own Regional Accountable Entities to understand local needs and encourage better care for a lower price.

The future of the state's Medicaid program rests in large part on how this vision unfolds.

RAE Profiles

Throughout the spring and summer of 2018, CHI sat down with leaders in the Colorado Department of Health Care Policy and Financing (HCPF) and each RAE organization. The goal was to help communities understand RAEs: What are their strategies, challenges, aspirations and opportunities?

The interviews were recorded and are available in CHI's new podcast series, The Checkup. Highlights of the interviews — edited slightly for clarity and brevity — are included in the following written profiles, as well data and descriptions about each of the regions. An interactive map of each of the RAE regions is also available at coloradohealthinstitute.org/research/ways-raes.

A common theme through all the interviews was excitement about launching the new phase of Health First Colorado. RAE leaders also expressed concerns about data sharing, reaching diverse populations and attribution . Above all, each of the interviewees expressed commitment to serving Health First Colorado members.



COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

A Conversation with Laurel Karabatsos

Deputy Medicaid Director

CHI's Jeff Bontrager sat down with Laurel Karabatsos, Deputy Medicaid Director at HCPF, for a conversation about Phase Two of the ACC and the RAEs. Here are a few excerpts from that conversation.



Laurel Karabatsos

Jeff: Could you talk a little bit about how RAEs fit into the overall vision of the Accountable Care Collaborative and Colorado's Medicaid Program?

Laurel: Seven or eight years ago, when we embarked on this project ... we felt there were many areas that needed solutions because of the rising cost of health care and the fragmentation of the system and the complex needs of our members, but we felt that trying to solve all those issues at one time was not a reasonable solution for Colorado. So we intentionally designed a program that would be iterative by starting with a primary care focus and then moving from there.

With Phase Two, we are moving on and building on that initial vision and now really integrating behavioral health into the structure of our program. That is the key role that the RAEs will have — that they will be one accountable entity responsible for both physical and behavioral health in our program.

Jeff: What were some of the lessons learned from Phase One of the Accountable Care Collaborative?

Laurel: We found that encouraging members to have a focal point of care ... has been successful. They have received more preventive services, and we've had indications that outcomes are improving.

There are many other lessons I think we've learned from that we're building on, such as tying payment to value and incentivizing performance. We're continuing to build on the regional aspect of our program and to try to formalize the lessons that are learned out in the field and local communities. We've learned lessons about the importance of care transitions for our members and tried to build more requirements into our

contracts with the RAEs related to that. And we've also learned that in some areas there's a greater need for transparency and accountability in the program.

Jeff: Is there an example or two of changes that were made around those two areas that you'd point to?

Laurel: We've increased our emphasis on value-based payment. We've also given more authority and flexibility to the regional organizations themselves to make ... payments to providers so that they can actually incentivize activities that result in improved health outcomes and reduce costs.

Another area that we've added more transparency and accountability is in terms of financial reporting.

In the behavioral health program there had been perceived conflicts of interest as providers and managed care organizations work together to deliver care. We've added requirements to increase transparency in terms of providers being accepted into the behavioral health network or the governance structure of the organization.

Jeff: What are some of the biggest challenges?

Laurel: We learned from Phase One that attribution and communication were challenging, and we're continuing to find these two are the biggest challenges in Phase Two. We're developing strategies to address them such as a ... messaging center ... and an entire team of staff working on this issue of attribution.

We've had a very successful behavioral health program over the last 22 years and we're seeking to build upon the success of that, not cause disruption to the system or our safety net providers. We want to make sure that we hear right away if our actions have unintended consequences so that we can correct quickly.



This interview was edited for clarity and brevity. For more of Jeff's conversation with Laurel, listen to CHI's podcast *The Checkup*: coloradohealthinstitute.org/podcast

REGION ONE: ROCKY MOUNTAIN HEALTH PLANS



ROCKY MOUNTAIN HEALTH PLANS®

About the RAE:

Rocky Mountain Health Plans (RMHP) is a Grand Junction-based health maintenance organization (HMO) that is part of United Health Group, a national insurance company. RMHP serves as the RAE contractor for Region One and will perform services in partnership with Reunion Health, a network of 12 federally qualified health centers and community mental health centers pursuant to a Joint Operating Agreement. Providers that comprise Reunion Health share responsibility for community governance, quality improvement, care model design, data sharing and provider recruitment.

More about RMPH's local programs: RMHP



Patrick Gordon

operates the Accountable Health Communities Model, a Centers for Medicare & Medicaid Services program to close the gap between clinical and community services through screening, referral, community navigation and a community advisory structure.



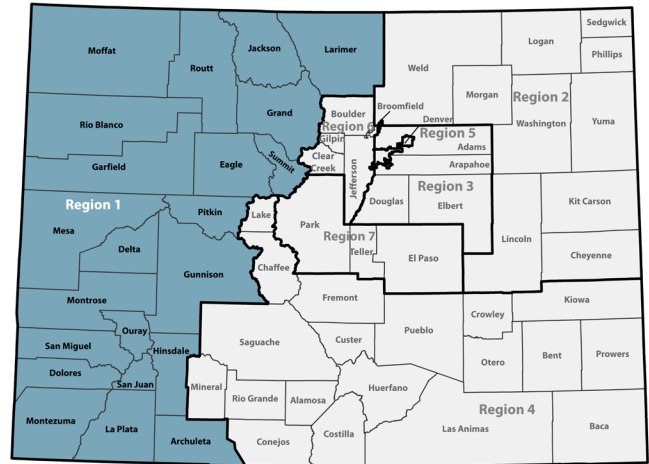
Meg Taylor

Rocky Mountain Health Plans also runs an innovative payment reform program called Rocky Mountain Prime. See box at right for more on Rocky Mountain Prime.

CHI spoke with Patrick Gordon, Vice President, and Meg Taylor, Program Officer, Region One RAE.

CHI: How will the experiences of Medicaid members in your region change with this new model?

Meg: One thing is that members will no longer have to figure out who they need to call to get connected to



RAE AT A GLANCE

Membership, August 2018: **191,024**

Previous ACC affiliation: **RCCO, Region One**

REGION AT A GLANCE:

Total population: **910,852***

Percentage of the population:

- On Medicaid: **19.5%****
- Income at or below poverty line: **13.2%****
- White: **80.9%***
- Hispanic: **15.3%***
- American Indian: **1.3%***
- Asian: **1.7%***
- African American **0.8%***

Source: Colorado Demography Office*; 2017 CHAS**

different health services. We have one number they can call ... We are really committed to no longer handing them a list of providers to remember when they're in, say, mental health distress and hoping that ... they get connected.

CHI: Are there any populations in your region you're particularly concerned about?

Meg: There is a lot of work we can do, especially with Medicaid expansion, around populations of individuals involved in criminal justice. Oftentimes, members in

Region Highlight: Rocky Mountain Health Plans (RMHP) Prime

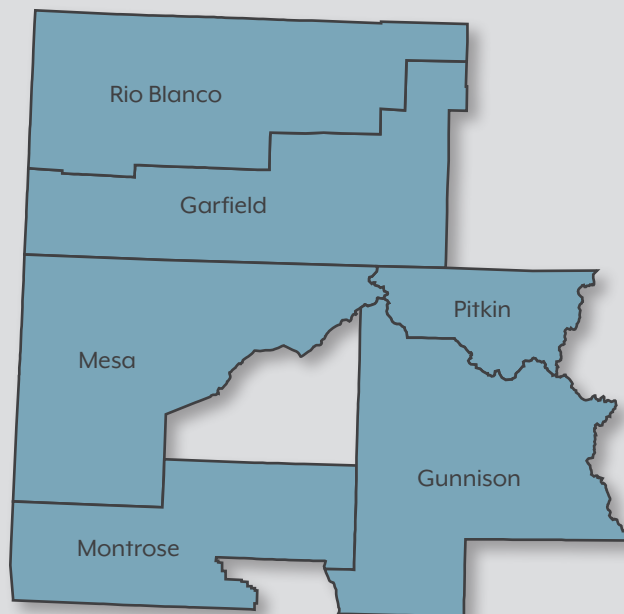
In 2014, as part of the ACC, Rocky Mountain Health Plans launched a program called RMHP Prime. The areas served by Prime encompass six counties within Rocky Mountain Health Plans' RAE region: Garfield, Gunnison, Mesa, Montrose, Pitkin, and Rio Blanco. The program's roots were in a law passed in 2012 (HB12-1281) that directed HCPF to establish a pilot program for innovative payment reform in the Medicaid program.

RMHP receives a payment from the state to cover the physical health needs of those enrolled in Prime. RMHP in turn makes capitated payments to primary care providers, who serve as medical homes for their patients. RMHP also is responsible for paying for other services such as hospital and specialty care, though those payments are based on a fee-for-service approach. Prime does not cover behavioral health or substance use disorder services, though RMHP works with mental health centers to enhance the integration of physical and behavioral health services. In 2018, RMHP was selected to be the Regional Accountable Entity (RAE) for Region One, which includes the six Prime counties. All Prime members are also enrolled in the RAE. Effective July 1, RMHP pays for behavioral health and substance use disorder services that are covered under HCPF's capitated behavioral health initiative.

The Prime contract provides RMHP with additional flexibility in creating a provider network and developing a shared savings strategy. In order to participate and share in potential savings, providers and community agencies must meet total cost and quality targets established by the state of Colorado.

HCPF and RMHP negotiate a fee to cover all services for its Prime enrollees. The state pays the monthly capitated amounts to RMHP, which then pays

Region 1 Areas Served by RMHP Prime



participating primary care providers a capitated amount to cover their Prime enrollees. The amount varies by provider, adjusted to account for the health status of members. This risk adjustment process is designed to reduce the incentive for providers to accept only the healthiest enrollees.

If the cost of providing care comes in under budget and quality standards are met, the savings are shared by HCPF, RMHP and providers. This payment system creates substantial incentives for RMHP and providers to control costs.

HCPF's ongoing evaluation of the Prime pilot program shows that it is meeting or exceeding care quality standards. In addition, the program's emphasis on better coordinated care has led to greater access to important behavioral health services.⁷

prison became eligible for Medicaid while they were there, and it's really on us as a RAE to go into these correctional facilities and help our members learn about their Medicaid benefit.

CHI: What do you mean when you talk about "integration"?

Patrick: We very often get focused on clinical

integration. So, how do people access different types of services? How do we bring them closer to where they're most frequently accessing services and reduce the need for referrals?

For that to really work, however, requires a host of other supports, including financial integration ... and data integration, meaning that we're sharing data efficiently. Then there's leadership. You've got to have a

process in which multiple voices from multiple sectors are empowered — and not just in an advisory capacity, but in an actual governance capacity.

The idea of one phone number for people to call ... is a simple concept, but it actually entails a lot of work behind the scenes to bring it off.

CHI: Of all the different approaches you're planning to use to meet the health needs of Health First Colorado members, is there anything particularly promising or innovative?

Patrick: Within our RAE, we have formal criteria by which we assess the comprehensiveness of each primary care partner in the region — their readiness for additional investment and their need for supportive resources.

But the really innovative stuff is looking well outside the

realm of health care itself, like housing.

CHI: If you fast forward three, four years from now, looking back how will you know if this was successful?

Patrick: Right now, there's a tremendous amount of work to integrate behavioral and physical health delivery systems and financing models, to create better transparency, and to move from siloed data and budgets to whole data and budgets. Three to five years from now, if we're successful, those edges [between physical and behavioral health delivery systems] won't seem so sharp.



This interview was edited for clarity and brevity. For more of our conversation with Patrick and Meg, listen to CHI's podcast [The Checkup: coloradohealthinstitute.org/podcast](https://coloradohealthinstitute.org/podcast)

REGION TWO: NORTHEAST HEALTH PARTNERS



About the RAE: Northeast Health Partners (NHP) is a new organization jointly owned by four health care providers in northeast Colorado — two federally qualified health centers (Sunrise Community Health and Salud Family Health Centers) and two community mental health centers (Centennial Mental Health Center and North Range Behavioral Health). Each center was closely involved in the prior RCCO and BHO programs, which were run by Colorado Access. The new arrangement puts NHP as the lead agency and primary contact with HCPF, while the centers provide health services to Medicaid members. NHP subcontracts with Beacon Health Options for administrative services. Beacon is a national managed behavioral health care organization that provides many types of services to state Medicaid programs. For NHP, Beacon provides quality

oversight, data system management and reporting, provider network development, information technology, financial management and more.

More about Northeast Health Partners' local programs:

NHP is planning several wellness campaigns like Text4Health, Text4baby, and Text2quit. It is also creating a psychiatric consultation program that primary care providers can use, telehealth programs, and a care management tool to promote communication between interdisciplinary teams.

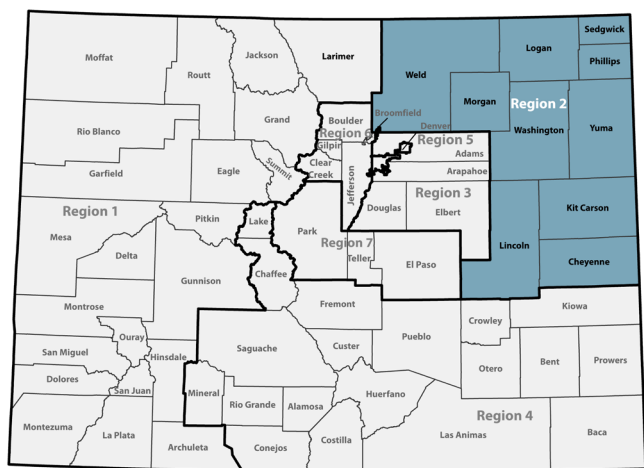


Kari Snelson

CHI spoke with Kari Snelson, Executive Director.

CHI: What drives you personally to do this work?

Kari: The root of all things is that I am a social worker, and I worked in rural frontier areas for about 20 years and saw the gaps in care. We were part of a RCCO at



RAE AT A GLANCE

Membership, August 2018: **91,604**

Previous ACC affiliation: **None**

REGION AT A GLANCE

Total population: **381,141***

Percentage of the population:

- On Medicaid: **24%****
- Income at or below poverty line: **13.1%****
- White: **67%***
- Hispanic: **29.4%***
- American Indian: **0.8%***
- Asian: **1.4%***
- African American: **1.4%***

Source: Colorado Demography Office*; 2017 CHAS**

that time, and it's not enough to give people referrals. I've seen it personally and professionally. ... I have such a passion for making sure people get the right care and that there really is no wrong door.

CHI: Tell us a little about your region in Northeast Colorado.

Kari: The region covers 23,000 square miles, and six of the communities are frontier... as well as the urban region of Greeley. Our community has always had to make sure that we're trying to be very resourceful

in treating people. We've had to build our own resources in the community. We've had to make things accessible in a unique way.

The region has a large refugee population ... and a large volume of migrant workers. We really want to make sure that they're able to access care where they're living and working.

CHI: What are some different approaches you're taking to addressing members' health needs?

Kari: Building health neighborhoods is one of the core components of the RAE — so identifying not just the health resources, not just behavioral health resources, but the community resources I need. If I'm having housing issues or utility issues or I need food, how do I access all those resources? We're addressing this by building a health neighborhood within the different communities.

CHI: What organizations might you partner with to address those issues?

Kari: Public health is a significant one. We're working with them on the Healthy Communities, onboarding members, and EPSDT programming. The Department of Human Services is a key partner in every community. There's also the North Colorado Health Alliance; they are a care coordination program, but so much more.

CHI: Are all these new partnerships?

Kari: These partnerships are long-standing. I can look at the history, and some of these partnerships go back decades. What makes doing work in this community so much easier is that these people are actually community members. They attend each other's events. They've been to weddings and funerals. ... They really are committed to developing their community and they truly care.



This interview was edited for clarity and brevity. For more of our conversation with Kari, listen to CHI's podcast [The Checkup: coloradohealthinstitute.org/podcast](http://coloradohealthinstitute.org/podcast)

REGIONS THREE AND FIVE: COLORADO ACCESS



About the RAE: Colorado Access is a nonprofit health plan founded in 1994. The company served as the RCCO for Regions Two, Three and Five since 2011 and the BHO for Denver since 2004 and for the northeast corner of the state since 2014. Colorado Access was originally founded by Children’s Hospital Colorado; the Colorado Community Managed Care Network, a Front Range network of federally qualified health centers; and University Health Systems Inc. Although these organizations do not have an ownership stake in Colorado Access, they remain important stakeholders and are represented on its board. Colorado Access is unique among RAEs in that it holds its own HMO license and does not have a national insurer or managed care company as a contractor or part owner.

More about Colorado Access’s local programs:

The Aspire program helps newly enrolled Health First Colorado members understand their Medicaid benefits and key opportunities available to them.

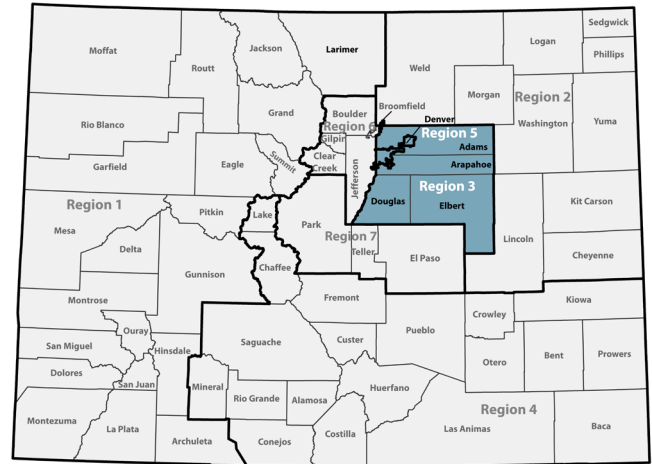


Gretchen McGinnis

New members are linked with care coordinators who answer questions about Medicaid benefits, connect them with a primary care medical home and dental provider, promote annual wellness and dental exams, and coach them on improving their own mental wellness.

The Vulnerable Populations program focuses on members who have been recently released from prison and on refugee families. It often supports a collaborative approach with community and clinical entities that specialize in serving these populations, and services are frequently delivered in a community setting.

CHI spoke with Gretchen McGinnis, Senior Vice President of Health Care Systems.



RAE AT A GLANCE

Membership, August 2018:

Region 3: **269,169**

Region 5: **217,116**

Previous ACC affiliation: **RCCO, Regions Two, Three and Five, and BHO**

REGIONS AT A GLANCE

Total population: **2,181,714***

Percentage of the population:

- On Medicaid: **19.5%****
- Income at or below poverty line: **13.2%****
- White: **59.8%***
- Hispanic: **27.2%***
- American Indian: **0.9%***
- Asian: **5.0%***
- African American: **7.2%***

Source: Colorado Demography Office*; 2017 CHAS**

CHI: How do you explain what a RAE is and what it does?

Gretchen: As the RAE, our job is to be a sort of a one-stop shop. We’re here to help you understand what kind of care you need and help you get that care in the most efficient and high-quality way.

So, how do we as an organization that’s responsible for the care for Health First Colorado members in this particular geographic region take that 30,000-foot-

view and say, “What are the Health First Colorado members in Denver and the east metro area struggling with?” We know we have really high suicide rates. We have really high substance abuse rates. What can we be doing to help the whole system address those things? How can we make sure each individual patient gets what they need...? Then, how do we look at what can we add and coordinate and develop in the area so that the health of the entire population improves?

CHI: What’s unique about your region?

Gretchen: Region Five is the City and County of Denver... Region Three has both urban and very rural parts.

But the regional boundary ... is invisible, frankly, for people who are living their lives. So, having two contiguous regions allows us to really interact with the health care systems that exist in a less artificial capacity.

CHI: Colorado Access was the only organization that had experience as both a behavioral health organization and a physical health provider. What does that experience bring to the table?

One is in terms of practical implementation. We have payment models and structures ... dedicated to

behavioral health coordination. So, there was less for us to build.

We expect to have about 38-40 percent of Health First Colorado membership in our RAE region going forward. We often think of ourselves as the canary in the coal mine when there are challenges with eligibility files, enrollment, or just changes in how health care is being delivered.

CHI: How will you know if these efforts are successful?

Gretchen: We’ll be meeting hopefully all, but at least the majority, of the key performance metrics at the state level — things like wellness visits for all ages, reduced emergency costs. ... There are actual dollars tied to these goals.

But in a couple years, one of my goals is to really see the conversations ... take on a different tone. What are we trying to achieve as a region, what are our goals?



This interview was edited for clarity and brevity. For more of our conversation with Gretchen, listen to CHI’s podcast [The Checkup: coloradohealthinstitute.org/podcast](http://coloradohealthinstitute.org/podcast)

REGION FOUR: HEALTH COLORADO, INC.



About the RAE: Health Colorado, Inc. is a new organization headquartered in Pueblo. It replaces the RCCO, Integrated Community Health Partners (IChP), and the BHO, Colorado Health Partnership. Six of the nine organizations that comprised IChP founded Health Colorado, and each have an equal stake in the RAE’s ownership. Four of the six organizations are community mental health centers: Health Solutions, San Luis Valley Behavioral Health Group, Solvista Health and Southeast Health Group. The other two owners are Valley-Wide Health Systems, a federally

qualified health center operating throughout southern Colorado, and Beacon Health Options, Inc., a national managed behavioral health care company. Similar to the arrangement in Region Two, Beacon will provide all administrative services for Health Colorado as a subcontractor. Examples of these services include financial management, information technology support and the development of the RAE’s health care provider network. The primary difference between Beacon’s roles in Regions Two and Four is that the company has an ownership stake in Health Colorado.

More about Health Colorado’s local programs:

Health Colorado operates mobile clinics to reach Medicaid members in remote areas. It’s also using a digital therapy program to increase access to behavioral health care.

CHI spoke with Alonzo Payne, Chief Executive Officer:

CHI: How do you describe the role of the RAEs?

Alonzo: It's really an effort by the state to ensure that our Medicaid population is receiving the appropriate behavioral health, substance abuse treatment, and coordination with primary care providers and specialists that are necessary so we can help reduce the cost curve.



Alonzo Payne

I really see it as an avenue where we can provide that sort of health care for our members. In Region Four, I think it's beyond important just because of the makeup of our communities. They are the poorest counties in the state, so it's very, very relevant.

CHI: People in Medicaid have often cited challenges in getting access to services like behavioral health care. What are you doing in your RAE to ensure they can actually get in to see these providers?

Alonzo: We've made every effort to go out and contract with all the community mental health centers that serve our area, and we work with some of the individual providers. We're working with some of the hospitals to ensure we have access, if necessary. And I think we're making sure that we develop healthy neighborhoods, and that we have connections with all of the providers whether they be primary care, specialists, or behavioral health.

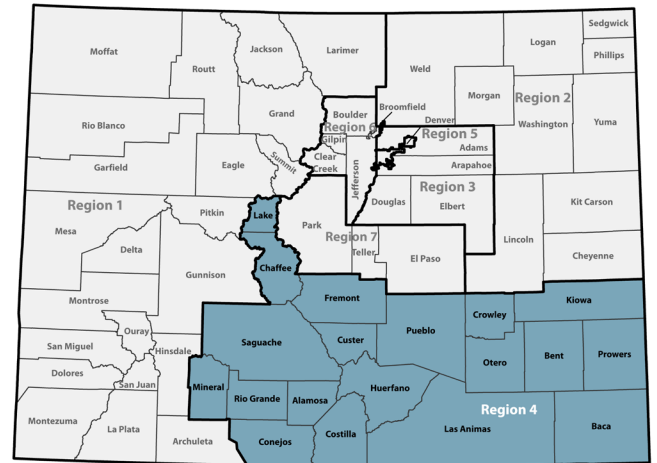
CHI: Has it been challenging to create a larger network of providers in your region?

Alonzo: We still have some issues with access to specialty care because it's just a difficult thing.

CHI: What should people know about Region Four?

Alonzo: Everybody in the state needs to recognize that it doesn't begin and end on the I-25 corridor. There are areas such as Antonito, such as (the town of) Center that have ... a lot of Medicaid members in relation to the population. And it's important that they receive the same level of health care that you would be able to receive in a metro area.

CHI: Are there some specific approaches you can describe about how you're planning to meet the needs of Health First Colorado members?



RAE AT A GLANCE

Membership, August 2018: **132,745**

Previous ACC affiliation: **None**

REGION FOUR AT A GLANCE

Total population: **356,594***

Percentage of the population:

- On Medicaid: **31.2%****
- Income at or below poverty line: **21%****
- White: **58.3%***
- Hispanic: **37.7%***
- American Indian: **1.0%***
- Asian: **1.0%***
- African American: **1.9%***

Source: Colorado Demography Office*; 2017 CHAS**

Alonzo: We want to put our members first. We aren't a multistate corporation that is concerned solely about the bottom line; we are locally owned. So, we really try to approach what's in the best interest of the member.

We are going to have advocacy groups made up of members and providers so we can get some feedback as to what we are doing right, what are we doing wrong.



This interview was edited for clarity and brevity. For more of our conversation with Alonzo, listen to CHI's podcast **The Checkup:** coloradohealthinstitute.org/podcast

REGIONS SIX AND SEVEN: COLORADO COMMUNITY HEALTH ALLIANCE



About the RAE: Based in Denver, Colorado Community Health Alliance (CCHA) is a partnership between Anthem, Inc., an accredited NCQA Managed Behavioral Healthcare Organization that manages Medicaid behavioral health programs in 18 states; Centura Health, the largest health system in Colorado; Physician Health Partners, a local primary care management services organization; and Primary Physician Partners, an independent practice



Nielson

association with approximately 150 primary care physicians.

In the first phase of the ACC, CCHA served as the RCCO for Region Six encompassing Boulder, Broomfield, Clear Creek, Gilpin and Jefferson counties.

It coordinated physical health benefits for more than 130,000 Health First Colorado members. In ACC Phase Two, CCHA became the RAE for Region Six as well as Region Seven, which includes El Paso, Park and Teller counties. In this role, CCHA will manage both physical and behavioral health benefits for approximately 330,000 members.

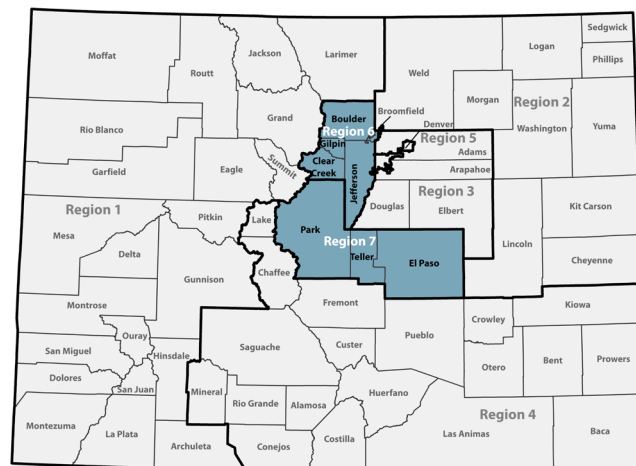


Fox

Regional Approaches: CCHA plans to use a technology platform that will help providers analyze population health for members and make connections to social determinants of health like housing and transportation.

CHI spoke with Ken Nielson, Interim Executive Director, and Patrick Fox, MD, Medical Director:

CHI: What are some of the strategies CCHA will be using to fulfill its goals, which include improving



RAE AT A GLANCE

Membership, August 2018

Region 6: **151,914**

Region 7: **174,302**

Previous ACC affiliation: **RCCO, Region Six**

REGIONS AT A GLANCE

Total population: **1,706,858***

Percentage of the population:

- On Medicaid: **18%****
- Income at or below poverty line: **14.6%****
- White: **76.1%***
- Hispanic: **15.5%***
- American Indian: **0.9%***
- Asian: **4.1%***
- African American: **3.3%***

Source: Colorado Demography Office*; 2017 CHAS**

population health, reducing costs, and focusing on patients' and providers' satisfaction?

Patrick: CCHA is bringing an innovative technology platform that includes advanced data analytics so that we can analyze population health as well as health for the member across many different domains. This data is crucial so that we can get a sense as to not just where that member is accessing care and services or

where they have needs that fall clearly within the scope of what the RAE is responsible for, but also those other unmet needs.

By assigning a care coordinator — that’s a person who will form a real relationship with that member to say, “Hey, when we analyze the data about your episodes of care, we see that there may be an issue with your ability to access housing. We’ll work with you to help you to access housing resources in your area.” We will do this by coordinating with and drawing on available county and state resources.

CHI: What have been some of the challenges so far?

Ken: Number one would be attribution — the method for how members get assigned to a medical home. If there was a history of a contact between a member and a primary care physician, then that’s an easy attribution to make. Where it becomes more challenging is if the member is new to Medicaid and they have no claims history, and so attribution can just happen by proximity to the provider.

And so we need to educate the member about who they’re connected to at that point. Because they’ve never seen that provider and vice versa.

CHI: What changes will affect physical or behavioral health providers as the ACC moves to this next phase?

Patrick: Oftentimes providers need specific resources to best meet the needs of the patient that they’re seeing. They don’t always know what resources are available in the community to address those social determinants of health, which are those aspects of an

individual’s overall well-being that are not classically thought of as health, such as access to food, access to stable and safe shelter, access to appropriate clothing, access to transportation, to employment opportunities and a positive social network.

We want to work with those providers. We have practice transformation coaches that are available to go into those practices and to share with the provider the data we have collected with respect to health outcomes for members they treat. If we identify outcomes that fall below expectation, we can discuss with the provider whether they are asking members whether they have food in their house, whether they have access to transportation or why they’re not attending scheduled appointments.

The state is currently exploring the viability of Colorado jails creating a unified health information portal that will connect to the health information exchanges. If this is accomplished, CCHA is keenly interested in examining the data for our members who may be involved with the criminal justice system, as this information has been historically difficult to aggregate. If the data shows that a high proportion of our members are justice-involved, we can more comprehensively assess member needs and develop specific strategies to, when appropriate, divert and deflect our members from the criminal justice system.



This interview was edited for clarity and brevity. For more of our conversation with Ken and Patrick, listen to CHI’s podcast [The Checkup: coloradohealthinstitute.org/podcast](https://coloradohealthinstitute.org/podcast)

Endnotes

- ¹ Colorado Department of Health Care Policy and Financing (2017). “FY2018-19 Joint Budget Committee Hearing (Dec. 13, 2017).” P. 46. Retrieved from <https://www.colorado.gov/pacific/sites/default/files/2017%20Health%20Care%20Policy%20and%20Financing%2C%20EDO%20Hearing%20Responses.pdf> October 2018.
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- ⁵ Colorado Department of Health Care Policy and Financing. “Performance Measurement, Accountable Care Collaborative Phase II June 2018. Retrieved from https://www.colorado.gov/pacific/sites/default/files/Performance%20Measurement%20fact%20sheet%20June%202018_1.pdf October 2018.
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