COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2018–2019 Accountable Care Collaborative Regional Accountable Entity Site Review Aggregate Report

June 2019

This report was produced by Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy and Financing.

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Overview

Background

The Colorado Department of Health Care Policy and Financing (Department) implemented the Accountable Care Collaborative (ACC) program in 2011 as a central part of its plan for Health First Colorado (HFC)—Colorado's Medicaid program—reform. The ACC was designed to improve the member and family experience, improve access to care, transform incentives and the healthcare delivery system into a system that rewards accountability for health outcomes, and use available finances more wisely. A key component of the ACC program was partnership with seven Regional Care Collaborative Organizations (RCCOs), each of which was accountable for the program in a designated region of the State. Effective July 1, 2018, pursuant to Request for Proposals 2017000265, the Department executed contracts with Regional Accountable Entities (RAEs) for the Accountable Care Collaborative (ACC) program. The RAEs are responsible for integrating the administration of physical healthcare (previously administered through the RCCOs) and behavioral healthcare (previously administered by behavioral health organizations [BHOs]) and manage networks of fee-for-service primary care providers and capitated behavioral health providers to ensure access to care for Medicaid members.

RAEs qualify as both primary care case management (PCCM) entities and prepaid inpatient health plans (PIHPs), and as such are required to undergo periodic evaluation to determine compliance with federal Medicaid managed care regulations. The Department elected to complete evaluation of the RAEs' compliance with managed care regulations by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG). In addition, the Department requested that HSAG conduct on-site focus topic group interviews with key RAE staff members to explore individual RAE experiences related to *Transitioning and Integrating the Capitated Behavioral Health Benefit Into the RAE.*

Methodology

Between January and April 2018, HSAG performed a site review of each RAE to assess compliance with Medicaid managed care regulations released May 2016 and with State contract requirements. During the site review, HSAG also used a qualitative interview process to gather information from staff regarding the select focus topic. The Department requested a review of four managed care standards to evaluate compliance with managed care regulations. The standards chosen were Standard III—Coordination and Continuity of Care; Standard IV—Member Rights and Protections; Standard V—Member Information; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. HSAG developed a review strategy and monitoring tools consisting of these four standards for reviewing the performance areas chosen. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable* and assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met.*

To facilitate the focus topic interviews, HSAG used a semi-structured qualitative interview methodology to explore with RAE staff members information pertaining to the Department's interests related to the focus topic selected. The qualitative interview process encourages interviewees to describe experiences, processes, and perceptions through open-ended discussions and is useful in analyzing systemwide issues and associated outcomes. Focus topic discussions were not scored. HSAG analyzed information obtained during the on-site interviews to identify common experiences or concerns across RAE regions, then developed statewide recommendations for continued successful implementation of Colorado's ACC program.

This report documents the aggregate results of RAE site-reviews to provide a statewide perspective of RAE operations and progress toward achieving ACC program goals. Section 2—Statewide Summary of Results—includes a comparison of RAE performance based on aggregated scores of compliance with federal and State managed care requirements. Section 2 also includes a bulleted synopsis of focus topic interviews with each RAE. Section 3—Statewide Trends Related to Discussion Themes—includes HSAG's trend analysis of common characteristics across RAE regions as derived from the focus topic interviews. Section 4 documents HSAG's conclusions and overall observations and recommendations related to the focus topic discussion. Appendix A includes the focus topic interview guide as reference.

Summary of Compliance With Managed Care Regulations

For the 2018–2019 RAE reviews, the Department identified four standards for evaluation of compliance with Medicaid managed care regulations and State contract requirements—Coordination and Continuity of Care, Member Rights and Protections, Member Information, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services. Compliance review scores for individual standards are included in each region's RAE compliance review report.

Table 2-1 presents comparative RAE scores aggregated for all standards reviewed in FY 2018–2019.

Table 2-1—Summary of FY 2018–2019 Scores for All Standards

RAE	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Region 1	46	45	41	4	0	1	91%
Region 2	45	40	39	1	0	5	98%
Region 3	46	43	41	2	0	3	95%
Region 4	45	40	37	3	0	5	93%
Region 5	46	43	40	3	0	3	93%
Region 6	45	40	36	4	0	5	90%
Region 7	45	40	36	4	0	5	90%
Total	**318**	**291**	**270**	**21**	**0**	**27**	**93%**

Table 2-2 presents comparative RAE scores for individual standards reviewed in FY 2018–2019.

Table 2-2—Summary of FY 2018–2019 Scores for Individual Standards

RAE	Coordination and Continuity of Care	Member Rights and Protections	Member Information	EPSDT Services
Region 1	100%	86%	83%	100%
Region 2	91%	100%	100%	100%
Region 3	100%	100%	94%	88%
Region 4	82%	100%	100%	88%
Region 5	91%	100%	94%	88%
Region 6	100%	100%	86%	75%
Region 7	100%	100%	86%	75%
Total	**95%**	**98%**	**92%**	**88%**

Summary of Focus Topic Discussion by Region

Since the inception of the ACC, HSAG has conducted annual on-site reviews using a qualitative interview methodology to solicit information from RAE staff regarding specific ACC goals and objectives. Each year, the Department identifies high priority focus topics for discussion during the on-site reviews. Results of focus topic discussions are not scored. HSAG uses the Department-approved *Focus Topic Interview Guide* to provide a semi-structured format to solicit input from RAE staff. HSAG analyzes information gathered during the on-site focus topic discussion to identify common themes and statewide trends and to make observations and recommendations.

Focus Topic: Integration of Behavioral Health Into the RAE—Members	
Region 1—Rocky Mountain Health Plans (RMHP)	• Prior to RAE implementation, RMHP was the RCCO in Region 1. All community mental health centers (CMHCs) and Federally Qualified Health Centers (FQHCs) in the region created an organization—Reunion Health—to work with RMHP to deliver integrated behavioral health (BH) services to members. • RMHP's ongoing working relationship with Reunion Health provided the foundation for identifying many members engaged in BH care at the time of RAE implementation. • Most RAE members received BH services through the four CMHCs in the region. • All previously authorized services for members in treatment were continued by RMHP to prevent any disruption in care. • RMHP identified members receiving BH services through independent provider network (IPN) practitioners through any claims received; RMHP also committed to continuing payment for services pending completion of contracting with a provider. • RMHP worked with providers behind the scenes to avoid member confusion and promote transparency for members involved in BH care at the time of transition to the RAE. • All providers were allowed to continue to serve members in treatment, thereby ensuring continuity of care. • RMHP care coordination (CC) staff met with care coordinators from all BHOs and the four regional CMHCs to identify members who were high risk or required complex CC services. • RMHP contacted all providers serving members identified as high risk and met with each high-risk member to explain the RAE and CC processes. • Members with less intensive CC needs remained the responsibility of the CMHCs' care managers. • RMHP's Essette care coordination system enables sharing of collaborative CC between RMHP and the CMHCs. • RMHP developed transition-of-care agreements and workflows with acute care facilities providing BH services to members—i.e., facilities in the Denver metropolitan area and the new West Springs Hospital in Grand Junction. • Implementation of BH services in the RAE has enabled RMHP to progressively build a BH claims database and incorporate data into RMHP's stratification methodology to identify high-risk and complex needs members for CC.

Focus Topic: Integration of Behavioral Health Into the RAE—Members	
Region 2—Northeast Health Partners (NHP)	• Prior to RAE implementation, Colorado Access (COA) held the contract for both the RCCO and the BHO in Region 2. Beacon Health Options (Beacon) the administrative services organization (ASO) for NHP, was not engaged in Region 2 prior to RAE implementation. NHP's shareholders include the two regional CMHCs (previously affiliated with COA) and two FQHCs (previously affiliated with COA). North Colorado Health Alliance (NCHA)—previously affiliated with COA—was retained as a delegated care coordination (CC) entity in Region 2. • Whereas NHP was not the previous BHO and Beacon had no pre-existing data—e.g., utilization management (UM) records or daily census reports—to identify members involved in active BH treatment at the time of transition to the RAE, NHP depended on the previous Region 2 BHO to identify members engaged in services. NHP reported a number of issues in obtaining adequate information from the BHO to smoothly transition members engaged in higher levels of care. • NHP pursued several workaround approaches to compensate for lack of useful information from the previous BHO, including working with partner CMHCs who could identify at-risk members through crisis intervention programs or through case manager discharge planners. NCHA's integrated CC program could also identify members engaged in BH services. • NHP targeted communications to providers for members engaged in services to convey that the BHO would remain responsible for payment of previously authorized inpatient and outpatient BH services and to inform of continued authorization processes through Beacon. • The two partner CMHCs and two large counseling centers provide ongoing mental health services to 75 percent of Region 2 members. NHP targeted these providers for early contracting with the RAE. • By working with providers behind the scenes, NHP was able to ensure that members continued care with their current providers and that transitioning to the RAE was essentially transparent for members. • To identify members at risk for needing BH services, NHP worked with NCHA and with the Departments of Human Services (DHSs) in the region to identify members needing BH care. CMHCs and NHP care coordinators outreached to individual at-risk members to explain transition to the RAE, ensure members that BH benefits would not change, and offer CC services. • NHP care coordinators communicated with a variety of community partners, including school-based BH practitioners in 26 locations and Women, Infants, and Children (WIC) programs, to identify high-risk BH members. NCHA's pre-established relationships with numerous community agencies and providers enabled identification of members involved in community-based specialized intervention programs. Care coordinators outreached to these populations to ensure continuity of services and to engage members in CC. • When a member engaged in CC or authorized services was attributed to another RAE, NHP's UM or CC staff contacted the RAE care coordinators in the other regions to transfer the member.

Focus Topic: Integration of Behavioral Health Into the RAE—Members	
	• NHP has embedded BH care coordinators in several large primary care medical provider (PCMP) practices. NCHA—providing CC to 80 percent of members in Region 2—maintains a diversity of expertise within its integrated CC teams. NCHA care coordinators have continued to coordinate care for members with complex needs attributed to Region 1 but residing in Region 2, in order to maintain continuity of services with other providers in Region 2. • Prior to RAE implementation, NHP invested in mass communication efforts with members through mailers, town forums, and disseminating information through high-touch points in the region to inform members of the new RAE. • Beacon conducted extensive training of call center staff to answer inquiries regarding transition to the RAE. • Staff members reported that, while members were confused, early efforts to communicate with members regarding RAE transition alleviated member anxieties concerning RAE implementation. • NHP anticipated a high number of problems associated with the PCMP attribution methodology. NHP encouraged providers to closely monitor their Medicaid patient listings compared with the attribution list to identify inconsistencies. NHP worked with the Office of Behavioral Health (OBH) to identify members most likely to be receiving BH services in Region 2 but attributed to PCMPs in another region. • The geographic assignment methodology primarily impacted members of select populations, including: members residing in Region 2, but seeking primary care from PCMPs in Larimer County (Region 1); foster care children in custody of DHSs in Region 2 counties who were placed with families in other parts of the State; members who lived in other regions in the State but worked in Region 2 counties, where they would most likely select a provider close to work; aging members with long term services and supports (LTSS) services or residing in nursing homes; and special needs members receiving services through Children's Hospital providers assigned to Region 3 rather than PCMPs in Region 2. • NHP worked with the Department to resolve macro-level attribution issues. NHP care coordinators contacted individual members to assist with reattribution, when needed. • For several months following RAE contract implementation, member transition and attribution issues presented a significant challenge and workload for CC and member call center staff.

Focus Topic: Integration of Behavioral Health Into the RAE—Members	
Regions 3 and 5—Colorado Access	*Note: Due to the geographic proximity of Region 3 and Region 5 in the metropolitan area, Colorado Access' programs and processes apply to both regions. Unless otherwise noted, focus topic outcomes apply to both Region 3 and Region 5.* • Prior to RAE implementation, Colorado Access (COA) was the RCCO and the ASO for the BHO in Region 3. COA was the RCCO and the BHO contractor for Region 5. • Using its BHO claims database, COA was able to use a data-driven methodology to identify members receiving BH services and high-risk members requiring continuity- of-care services. In Region 3, Behavioral Healthcare, Inc. (BHI) also prepared a list of high-risk members requiring continuity of care. • COA messaged all high-risk members to introduce COA as the new RAE organization through which they would receive BH services and assured members that nothing would change. • In Region 5, members in authorized placement remained involved with the COA BH care managers through transition to the RAE. In Region 3, BHI and RCCO care managers met weekly to arrange a warm handoff from BHI to COA of members engaged in active care coordination (CC). • COA identified BH providers serving Region 3 and Region 5 members and prioritized those providers for contracting with the RAE. For members receiving services from a BH provider not yet contracted with the RAE, COA applied continuity-of-care rules to ensure continued care with a non-contracted provider. • Due to RAE overlap with the previous RCCO and BHO, COA reported that most members receiving BH services were transitioned into the RAE without disruption to ongoing care. • COA anticipated some shift in member population between RAE regions—particularly for members residing in the border areas of the regions—due to the Department's new attribution methodology. However, on RAE implementation both regions experienced significant shifts in the member population, with members transitioning both in and out of each region. • In Region 5, attribution resulted in significant shifts (thousands of members) in member assignments between the Denver Health managed care organization (MCO) and the RAE. The Department's reattribution efforts to correct problems between Denver Health's MCO and the RAE caused some members to receive enrollment packets from both Denver Health and the Department, further adding to member confusion. The Department extended the 90-day MCO opt-out period for members. • Department letters to members communicating the member's assigned PCMP caused much concern and confusion for members, and calls to COA customer services increased significantly. COA trained its customer services and CC staff regarding the attribution methodology, designed member messaging scripts, and instructed staff to escalate concerns to management when necessary. • COA identified two specialized populations most impacted by RAE attribution: foster care children in custody of counties' DHS Child Welfare Services (CHS) and

Focus Topic: Integration of Behavioral Health Into the RAE—Members	
	geriatric members—dual-eligible Medicare and Medicaid beneficiaries—aligned with a Medicare provider not previously contracted with Medicaid. • COA increased the number of BH care managers, including some care managers from BHI, to accommodate integration of BH into the RAE. COA's organization of CC into CC specialty teams includes a BH transition-of-care team—aligned with specific BH facilities—and a BH ongoing care management team. • COA's care management documentation system was redesigned to incorporate the full spectrum of an individual member's behavioral, physical, and social support needs and an integrated whole-person care plan. • COA coordinated care with other RAEs for members actively receiving authorized services and transitioning between RAEs.
Region 4—Health Colorado, Inc. (HCI)	• Prior to RAE implementation, Beacon was both an organizational partner and provider of ASO services in both the BHO and the RCCO in Region 4. Beacon remains the ASO partner in the RAE. • Beacon could identify all members engaged in inpatient or higher levels of authorized BH care at the time of transition to the RAE. All members remained engaged in treatment with established services, and the BHO remained responsible for payment for inpatient services through member discharge or for intensive-level outpatient services through the date of RAE implementation. UM staff issued authorizations for continuing care through the RAE. • Health Colorado, Inc. (HCI) UM staff needed only to communicate new RAE authorization procedures to BH providers. Members engaged in lower levels of BH services—not requiring authorization—were able to continue with existing providers, and provider billing procedures remained consistent. Single-case agreement (SCA) processes of the BHO were also transitioned to the RAE. • Members experienced no disruption in services, and transition from the BHO to the RAE was transparent for members engaged in treatment. • Prior to RAE implementation, HCI invested in mass communication efforts with members through mailers, town forums, and disseminating information through CMHCs. Approximately 80 percent of members in Region 4 access BH services through the CMHCs. • Beacon conducted extensive training of call center staff to answer inquiries regarding transition to the RAE and implemented a phone texting campaign to ensure that members were aware of their RAE benefits. • Using data from the Department and HCI's BH claims database, HCI identified high-risk members per the HCI stratification model; care coordinators conducted outreach calls with individual at-risk members to reassure them of continued benefits through the RAE. • Staff members reported that, while members were confused, early efforts to communicate with members regarding RAE transition alleviated member anxieties concerning RAE implementation.

Focus Topic: Integration of Behavioral Health Into the RAE—Members	
	• In response to integration of behavioral and physical healthcare (PH) services in the RAE, several RAE care coordination (CC) entities expanded and reorganized their CC teams into integrated BH/PH CC teams with diverse expertise. In addition, care managers from CMHCs and nurse care coordinators in PCMPs operate as one integrated team. • HCI anticipated a high number of problems associated with the PCMP attribution methodology. NHP encouraged providers to closely monitor their Medicaid patient listings compared to the attribution list to identify inconsistencies. HCI noted that primary misattribution issues were related to providers within Region 4 and not across RAE boundaries. While HCI described several types of macro issues experienced with the attribution methodology, most issues were related to the geographic assignment methodology—i.e., attempting to assign members to PCMPs in close proximity to their residences. • HCI worked with the Department to resolve macro-level attribution issues. Care coordinators worked with individual members to assist in reattribution to their chosen providers. • For several months following RAE contract implementation, member transition and attribution issues presented a significant challenge and workload for CC and member call center staff.
Region 6—Colorado Community Health Alliance (CCHA)	• Prior to RAE implementation, CCHA was the RCCO in Region 6. Through the RCCO, CC staff had developed relationships with the two CMHCs in the region and had a working relationship with the BH care managers at each CMHC. • CCHA worked directly with the CMHCs to identify members with complex BH needs. The BHO also created a list of high-risk members. In addition, CCHA care coordinators could identify members with BH needs engaged in CCHA CC. CCHA practice transformation coaches worked with PCMPs to identify lists of members with high-risk physical health needs. • CCHA outreached to all individual members on high-risk lists to explain the RAE, ensure members that benefits would not change, and offer CC services to ensure continuity of care. • CCHA's UM manager met with UM staff from other BHOs to identify members with authorizations in place for existing services. UM staff contacted providers of authorized services to inform of continuation of previously authorized services and explain how future authorizations would be processed through the RAE. • CCHA extended the transition payments to out-of-network BH providers from 90 days to 120 days to allow for provider contracting with the RAE. • Staff members stated that most members engaged in BH services at the time of RAE implementation experienced no disruption in continuity of care or services. • The major threat to disruption of care was associated with RAE member attribution, which confused both members and providers.

Focus Topic: Integration of Behavioral Health Into the RAE—Members	
	• CCHA trained Member Support Services call center staff regarding messaging to explain the RAE, inform members of benefits, answer questions, and, if necessary, assist members with reattribution. • Member Support Services staff received many calls from members engaged in outpatient BH services with a BH provider that did not coincide with the region to which the member was attributed. While most providers continued ongoing services to members in treatment, some BH providers discontinued provision of services to members attributed to a region in which the provider was not contracted. • Initial HFC macro-level attribution issues included: PCMPs in the region were not listed in the HFC enrollment broker files; and, for members reattributed through the enrollment broker, the reattribution assignment was subsequently "lost" in the system. Most importantly, PCMP panel size limits were not considered in the initial Department attribution methodology. Once the panel size limits were implemented (took several months) members initially dropped (HFC reattributed) from PCMPs with which they had a long-term relationship were unable to regain access to their established PCMP due to panels being filled in the interim with geographically attributed members. This was a problem of significant magnitude for Kaiser members. For Kaiser members unable to be reattributed to Kaiser, CCHA assisted members with successful transition to new PCMPs. • Through the RCCO, CCHA already had in place CC programs and staff—including BH and social work professionals—for RAE implementation. Prior to RAE implementation, CCHA worked with CMHC BH coordinators to conduct a warm handoff of members to CCHA care coordinators, resulting in seamless CC for members. • Some members engaged in active CC with the CCHA RCCO were attributed to other regions upon RAE implementation. CCHA met with staff from other RAE regions—primarily Region 3 or Region 5—to transition those members. Some members with highly complex needs remained involved with CCHA care coordinators until they could be smoothly transitioned or reattributed to new PCMPs in Region 6. • Providers delegated to perform CC in the RCCO were "grandfathered" into the RAE as accountable care network (ACN) providers, which preserved continuity of CC processes for members. Staff reported that 45 percent of Region 6 members are attributed to ACN providers. • For several months following RAE contract implementation, member transition and attribution issues presented a significant challenge and workload for CC and member support services staff.

Focus Topic: Integration of Behavioral Health Into the RAE—Members	
Region 7—Colorado Community Health Alliance (CCHA)	• Prior to RAE implementation, CCHA had no previous relationship with either the BHO or RCCO in Region 7. During the RAE start-up period, CCHA hired the chief operating officer of the Region 7 RCCO to lead the Region 7 RAE, thereby preserving continuity of relationships with the RCCO and with many community partner agencies and providers. • CCHA worked with the Region 7 RCCO to identify a list of members with high-risk physical health needs. • CCHA depended on the BHO in Region 7 to provide a list of high-risk BH members or members engaged in services at the time of RAE implementation. CCHA had no previous BH claims data to identify members receiving BH services at the time of transition to the RAE. • CCHA was unable to obtain from the BHO or CMHC a list of members engaged in BH services at the time of RAE implementation. • CCHA operationalized the Colorado Overutilization Program (COUP) lists from the Department to outreach members potentially in need of continuity of care services. CCHA identified BH inpatient providers and quickly developed relationships with those providers to continue payment for previously authorized services and to identify members for care coordination (CC) services. • While CCHA attempted to use all available resources to identify and contact members during transition to the RAE, CCHA staff members stated that they were unable to verify whether or not continuity of care for BH for some members was disrupted during the transition process. In addition to member identification issues, provision of previously established co-located BH services in numerous PCMP locations was initially discontinued. Despite provider confusion regarding reimbursement for co-located BH services, BH providers continued ongoing services being provided to individual members. • CCHA developed member assessment processes and messaging for Member Support Services staff and care coordinators interacting with members and providers to explain RAE transition. • Prior to the RAE implementation, CCHA hired all new CC staff—including nurses, social workers, BH specialists, and peer support specialists—to implement CCHA's CC model in Region 7. • CCHA worked with the Region 7 RCCO to conduct a warm handoff to CCHA care coordinators of all members engaged in RCCO CC. In addition, Member Support Services staff outreached all members on the RCCO's high-risk list and referred members to CCHA CC when indicated. • CCHA built off of the RCCO's pre-established relationships with criminal justice facilities to maintain the CC processes implemented in those facilities. CCHA has a specialized criminal-justice involved (CJI) CC team and recently hired a Region 7 medical director to further its relationship with the Department of Corrections (DOC). • CCHA designated Peak Vista Medical Community Health Centers and Matthews-VU Medical Group as RAE ACN providers—i.e., delegated CC entities. Staff members estimated that 55 percent of Region 7 members are attributed to ACN providers. CCHA worked with ACN providers to define CC workflows for BH

Focus Topic: Integration of Behavioral Health Into the RAE—Members	
	members. CCHA also met individually with all PCMPs to introduce CCHA's CC model. • CCHA maintained the RCCO's previously established relationships with Rocky Mountain Rural Health and Aspen Mine Center to provide navigation services for RAE members in Park and Teller counties. CCHA re-established an MOU with The Resource Exchange—community centered board—to collaboratively coordinate services for members with intellectual and developmental disabilities. • Additional issues encountered in transitioning members to the RAE resulted from HFC's attribution methodology, which confused both members and providers. • Initially, the Department's letters to Medicaid members informing them of the RAE and PCMP assignment confused members. CCHA used its website, stakeholder communications, and information provided to members through various member high-touch points in the region to explain the meaning of the Department's letter. • Region 7 experienced few cross-regional issues related to PCMP attribution. Significant intra-regional attribution issues related to failure of the Department's enrollment and attribution systems to initially incorporate PCMP panel size limits into its initial attribution methodology. Of Region 7's RCCO population, 40 percent had been previously unattributed. When these members were attributed to a PCMP on RAE implementation, a high number of members were assigned to PCMPs with established Medicaid panel limits and which lacked the capacity to absorb newly attributed members. CCHA worked with the Department for reattribution of members due to HFC attribution system issues. • CCHA identified additional attribution issues associated with special member populations, as follows: members engaged with BH services with a BH provider located in a region that did not coincide with the region to which the member had been attributed; foster care children in custody of Region 7 DHSs were assigned to PCMPs in Region 7, yet were placed in foster homes outside the region; many inmates of the criminal justice system were released to the DOC headquarters office address in El Paso county and assigned to PCMPs in Region 7, yet resided in locations over a broad statewide geographic area; pediatric members were assigned to adult-only PCMPs; nursing home residents utilizing the PCMP associated with the facility were geographically assigned to PCMPs aligned with their home residence; rural Park and Teller county residents were assigned to PCMPs in Colorado Springs, far from their homes, when more accessible PCMP locations were available. • CCHA trained Member Support Services staff to assist all misattributed members with reattribution. CCHA's practice transformation coaches trained providers to use the eligibility portal to verify whether members were correctly attributed, assist members with reattribution when necessary, and/or refer a list to Member Support Services staff for outreach. • For several months following RAE contract implementation, member transition and attribution issues presented a significant challenge and workload for CC and Member Support Services staff.

Focus Topic: Integration of Behavioral Health Into the RAE—Providers	
Region 1—Rocky Mountain Health Plans (RMHP)	• RMHP did not hold the previous BHO contract for Region 1. RMHP initiated BH provider contracting with the regional CMHCs, which were providing services to most Medicaid members in the region. RMHP's relationship with Reunion Health facilitated fast-tracking of contracting with the CMHCs. • Contracting with CMHCs required negotiating payment rates for the broad array of services and programs provided by the CMHCs. In addition, due to scarcity of residential and acute BH facilities in the Region, RMHP needed to contract with facilities on the "front-range"—i.e., Larimer County and specialty facilities in the Denver area. • RMHP had a long-term existing network of approximately 350 BH IPN providers to serve its other lines of business, which served as the base for independent provider contracting with the RAE. RMHP met with each individual provider to discuss the RAE model, offer a contract, and assist with provider applications. • RMHP committed to paying all BH providers for services rendered to Medicaid members pending completion of credentialing and contracting. RMHP fast-tracked credentialing of RAE IPN applicants and extended a temporary letter of agreement to each practice pending completion of contracting. • When providers were enrolled with the State as Medicaid providers, RMHP added a Medicaid amendment to the existing independent provider contract. RMHP Provider Relations staff assisted approximately 100 IPN providers to become enrolled with the State as Medicaid providers. • RMHP stated that 80 to 90 percent of BH providers in RMHP's commercial and CHP+ IPN were transitioned into the RAE BH provider network. • RMHP had numerous integrated PCMP practices. Soon after initiation of the RAE contract, RMHP contacted all PCMPs with employed or co-located BH providers to explain the RAE reimbursement for short-term BH services delivered in the PCMP office and instructed practices on where and how to bill for BH services. • Many rural areas of Region 1 have no IPN BH provider and no CMHC. RMHP is engaged in an active development process with Heart-Centered Counseling to make available tele-behavioral health services to every member in the region. This initiative requires establishing a communication hub in various communities, and the health information exchange will provide the infrastructure for communications.

Focus Topic: Integration of Behavioral Health Into the RAE—Providers	
Region 2—Northeast Health Partners (NHP)	• As the RAE contractor, NHP was a new organization in Region 2. Prior to RAE implementation, COA held the contract for both the RCCO and the BHO in Region 2. Beacon Health Options (Beacon)—the ASO for NHP—also was not engaged in Region 2 prior to RAE implementation. • NHP initially used COA's BHO list of contracted providers, NHP's partner CMHCs, and NCHA's community agency partners to identify and target providers for contracting. • Initial contracting efforts focused on the CMHCs and two large counseling centers, which collectively provide BH services to 75 percent of members in the region. • IPN providers, who require support from the CMHCs for member care, maintain close working relationships with the CMHC. All previously contracted BHO providers transitioned their contracts to the RAE. In addition, Beacon contracted an additional 200 IPN providers in Region 2 and Region 4 combined. • Region 2 experiences a general workforce shortage in rural areas, a shortage of BH providers available for recruitment to the RAE, and a lack of substance use disorder (SUD) providers throughout the region. • DHSs provided Beacon a list of preferred providers for RAE contracting. Region 2 also has 26 school-based BH providers and specialized services and programs in rural areas, where BH services are limited. Beacon continues to recruit BH providers, including providers for higher levels of care, to expand capacity within rural areas of the region. • Providers had to absorb the impact of RAE infrastructure issues associated with RAE implementation—i.e., billing and payment structure changes, authorizations, communications among providers, and new ACC rules and expectations. • NHP conducted early education of IPN providers to inform them of BH integration into the RAE, new authorization processes, monitoring requirements, and other administrative changes. IPN providers had been relatively isolated from the ACC program and the previous RCCO and were dismayed with changes in the Medicaid program. • Similarly, NHP held weekly webinars with PCMPs to provide information on the RAE contracting process, new per member per month (PMPM) reimbursement, and attribution. PCMPs were initially "shocked" by the changing PMPM and attribution methodology. NHP ensured providers that they could continue to serve and be paid for services to members regardless of attribution and encouraged providers to monitor their attribution lists. • NHP conducted a "cultural change" webinar to help PCMPs understand communications with BH providers. Staff stated that PCMPs and BH providers do not yet understand each other's processes in the integrated delivery system model. • CMHCs have embedded BH providers in all FQHCs in Region 2, which have not been impacted by the implementation of fee-for-service (FFS) reimbursement for six routine BH visits. In other PCMP practices, reimbursement for six routine BH visits has presented the following issues: billing for the six FFS visit codes is an administrative burden for providers who have not previously used those codes for

Focus Topic: Integration of Behavioral Health Into the RAE—Providers	
	Medicaid members and members who must be transitioned from the six PCMP sessions to a CMHC for continuing care must adjust to a totally different therapeutic environment and may be vulnerable to gaps in service when transitioned. • Due to the vast distance, limited services, and sparse population in the rural areas, NHP is supportive of implementing telehealth services wherever possible to enhance delivery of healthcare. Several telehealth initiatives are already underway in Region 2 through Heart-Centered Counseling, Banner Health, HealthONE, and Children's Hospital. Despite these programs, only 38 percent of Region 2 providers are aware of telehealth services. Provision of in-home telehealth services is precluded by lack of an adequate Internet infrastructure in the rural areas, where schools and hospitals offer the best access points for telehealth.
Regions 3 and 5—Colorado Access	*Note: Due to the geographic proximity of Region 3 and Region 5 in the metropolitan area, Colorado Access' programs and processes apply to both regions. Unless otherwise noted, focus topic outcomes apply to both Region 3 and Region 5.* • COA was the previous BHO contractor for Region 5, the previous BHO's ASO for Region 3, and the previous RCCO contractor for both regions. As such, COA had pre-established contracts with a large network of BH providers across both regions—all CMHCs and 5,000 IPN providers. COA was able to transition all existing provider credentialing and contracts to the RAE rather than re-contracting with BH providers. • The SUD provider network did not align with the RAEs as these providers were aligned with the managed service organization (MSO). COA worked with the regional MSO to identify SUD providers and outreached to each residential and inpatient SUD provider to inform of BH network changes within the RAE. • To facilitate transition of BH providers into the RAE, COA held large provider training sessions and provider forums to familiarize providers with the new concepts and terminology of the ACC and to work through concerns as identified. • COA noted that solo or part-time IPN providers were particularly isolated and disconnected from the system. COA includes all BH providers in quarterly RAE provider forums to encourage networking among diverse providers. • Within Region 3, CMHCs experienced a significant change in the BH provider environment and relationships associated with Colorado Access. While CMHCs in Region 3 were previously owners in the BHO and had specific catchment areas and established members, CMHCs were not offered ownership in the RAE organizations. In addition, COA places higher emphasis on IPN providers than did the previous BHO for Region 3. COA has explored mechanisms to positively promote integration of CMHCs and IPN providers to comprise the network, while minimizing CMHCs' perceptions that competition exists with IPN providers and may threaten the financial viability of the CMHCs. • Within Region 5, Denver Health specialty providers may provide services to either RAE (FFS) members or MCO (capitated) members, requiring Denver Health providers to be particularly diligent in confirming whether a Medicaid member is attributed to the MCO or to the RAE, in order to bill correctly. Major shifts in

Focus Topic: Integration of Behavioral Health Into the RAE—Providers	
	member attribution between the RAE and MCO further aggravated this situation. COA and Denver Health conducted pre- and post-RAE implementation provider training to ensure that providers checked eligibility of each member. Providers' confusion regarding billing for FFS or capitated services results in Denver Health receiving inaccurate monthly capitation payments. • COA had 49 integrated BH/PCMP practices in Region 3 and 29 integrated practices in Region 5. While COA facilitates transition of any BH provider interested in working within an integrated PCMP practice, COA had previously worked with Mental Health Center of Denver (MHCD) to co-locate or offer for hire BH therapists to align with select PCMP practices. COA has encouraged Region 3 CMHCs to work with MHCD on strategies to do the same. • COA stated that the Department's FFS reimbursement for up to six BH visits is too low to sustain the financial viability of integrated practices. COA has developed an enhanced payment model to support PCMP practices with employed BH practitioners. While 12 PCMPs are currently participating in the enhanced payment model, COA intends to expand access to enhanced payment methodologies to additional integrated practices. • COA's tele-behavioral health program offers peer-to-peer consultation for providers and virtual therapy to members in primary care offices. COA hires BH clinicians to provide these services free of charge to PCMPs. Not all provider offices are able to hire a BH practitioner or expand office services to accommodate an on-site BH therapist; therefore, telehealth enables more widespread delivery of BH services throughout the RAE network. COA had 27 PCMPs participating in this service. • COA also plans to expand the offering of telehealth services to all BH providers and will involve CMHCs in expansion strategies.
Region 4—Health Colorado (HCI)	• Prior to RAE implementation, Beacon provided ASO services to both the BHO and the RCCO in Region 4 and remains the ASO partner in the RAE. • Through Beacon, HCI had pre-established contracts with BH providers across the region—all CMHCs and 600 BH IPN providers. HCI amended existing BH provider contracts to apply to the RAE, thereby expediting the BH contracting process. HCI contracted with an additional 200 IPN providers in Region 2 and Region 4 combined. • Despite the available network of IPN providers, staff reported that 80 percent of BH services in Region 4 are delivered through the CMHCs. • RAE operational administrative processes (administered by Beacon)—UM, billing, and provider relations—were unchanged from the BHO processes in Region 4 as those were also administered by Beacon. • For existing BH providers in Region 4, the Region 4 RAE contracting process was transparent and seamless; however, BH providers were required to contract with other RAEs in order to provide services to members attributed to other regions. • HCI held weekly webinars with PCMPs to provide information on the RAE contracting process, new PMPM reimbursement, and attribution. PCMPs were initially "shocked" by the changing PMPM and attribution methodology. HCI

Focus Topic: Integration of Behavioral Health Into the RAE—Providers	
	ensured providers that they could continue to serve members and be paid for services to members regardless of attribution and encouraged providers to monitor their attribution lists. • While provider contracting was largely transparent upon implementation of the RAE, providers necessarily absorbed the impact of infrastructure issues associated with the new, integrated RAE model. • HCI conducted a "cultural change" webinar to help PCMPs understand communications with BH providers. Staff stated that PCMPs and BH providers do not yet understand each other's processes in the integrated delivery system model. • HCI reported that various methods to promote provision of BH services in PCMP practices are complex in rural areas, where many practices are experiencing financial losses. The Department's reimbursement of PCMPs for six routine BH visits is an administrative burden for providers. In addition, practices with co-located physical health and behavioral health practitioners are confused about what to bill and where to bill specific services in a mixed capitation and FFS model. • Members who must be transitioned from six BH sessions at the PCMP for continuing treatment with a BH provider—i.e., CMHC—must adjust to a totally different therapeutic environment, which may be a deterrent to the member's continuity of care. • Due to the vast distance, limited services, and sparse population in the rural areas, HCI is supportive of implementing telehealth services wherever possible to enhance delivery of healthcare. Staff reported implementing telehealth in some rural offices; however, many geographic areas in Region 4 lack adequate Internet infrastructure to support uninterrupted service. Widespread telehealth services will not be possible until the telecommunications infrastructure is improved.
Region 6—Colorado Community Health Alliance (CCHA)	• Prior to RAE implementation, CCHA was the RCCO in Region 6. Through the RCCO, CC staff had developed relationships with the two CMHCs in the region. • All PCMPs with a pre-established RCCO contract were successfully transitioned to the RAE. • CCHA initiated BH provider contracting with the two Region 6 CMHCs to preserve continuity of care for members and continuity of BH support services available within the region. • The regional BHO communicated with all contracted providers to encourage them to contract with CCHA. CCHA identified BH providers treating Region 6 members at the time of RAE implementation and requested those providers to join the network. • In an effort to expand the BH IPN, Anthem (CCHA's partner organization), messaged its commercially contracted BH providers to encourage them to join the CCHA network. These communications stimulated a flood of interest from IPN providers previously unable to contract with the BHO network in Region 6. ◆ The DHS in each county in Region 6 identified to the RAE core service providers, which were targeted for contracting by CCHA.

Focus Topic: Integration of Behavioral Health Into the RAE—Providers	
	◆ CCHA has contracted with 2,000 BH IPN providers in Region 6 and Region 7 combined. ◆ CCHA conducts ongoing analysis of potential gaps in the network and has added many psychologists to address such gaps. Staff stated that the Region 6 network has adequate outpatient SUD providers, including numerous medication-assisted treatment (MAT) practices. Respite care and residential treatment facilities for specialized BH needs remain in short supply. ◆ RAE contracting requirements were of greatest concern to independent practice BH providers, who had no previous relationship with CCHA. In addition, BH providers were required to contract with multiple RAEs in order to treat members attributed to another region. Due to the geographic proximity of RAE regions in the metropolitan area, Region 6 had many providers with cross-regional members. ◆ Prior to RAE implementation, CCHA held town hall meetings with BH providers and held weekly "open mic" sessions to answer questions about the credentialing and authorization processes, attribution issues, and the "six BH visit" FFS benefit for PCMPs. Questions about attribution dominated these discussions. During RAE implementation, Provider Relations staff maintained one-on-one communications with BH providers to address unique concerns of individual providers. ◆ Region 6 has 48 PCMPs—including three FQHCs and several pediatric practices—that have integrated BH practitioners into their practices. Prior to RAE implementation, the CMHCs provided co-located BH practitioners to PCMPs. Since RAE implementation, CCHA has facilitated integration of private BH practitioners into PCMPs, thereby expanding the number of integrated practices. ◆ Introduction of FFS reimbursement for six PCMP-based BH visits confused providers with co-located BH practitioners regarding appropriate billing of FFS and capitated BH visits. CCHA worked with integrated providers to clarify billing procedures. Staff reported that billing issues for co-located BH practitioners have been resolved but suggested that new codes for lower-acuity PCMP-delivered BH services should be considered by the Department. ◆ CCHA is exploring the potential for expansion of tele-behavioral health services in the region. CMHCs and two hospital systems use tele-behavioral health services for select populations. CCHA is testing a phone texting online behavioral health therapy application—Ieso Digital Health— offering a secure, typed message exchange between a member and a licensed BH clinician. CCHA was initiating discussions with Heart-Centered Counseling and other BH entities to explore telehealth options for rural and mountain areas.

Focus Topic: Integration of Behavioral Health Into the RAE—Providers	
Region 7—Colorado Community Health Alliance (CCHA)	• As the RAE contractor, CCHA was new to Region 7, with no previous relationship with either the BHO or RCCO in Region 7. During the start-up period, CCHA hired the chief operating officer of the Region 7 RCCO to lead the Region 7 RAE, thereby preserving continuity of relationships with the RCCO and with many community providers. • CCHA contacted all RCCO network PCMPs to discuss terms of the CCHA provider contract, which included new payment methodologies perceived as a significant overall decrease in PMPM payments. Provider confusion associated with changes in payment methodologies and attribution methodologies initially slowed the PCMP contracting process. CCHA ultimately contracted with most of the RCCO PCMP network. • CCHA had no data sources to identify providers currently billing for BH services to enable CCHA to contact existing Medicaid BH providers for contracting; however, the CMHC in the region had a previous working relationship with the RCCO and provided services to most BH members in Region 7. • Initial contracting with the CMHC was complicated by several issues: the CMHC had been an owner in the BHO and would not be an owner in the RAE; transitioning from the BHO to the RAE contract required changes in reimbursement rates for the CMHC; the Department's initiation of FFS payments for six PCMP BH visits was perceived to be financially disadvantageous for the CMHC's co-located BH providers. CCHA worked with the CMHC regarding payment methodologies and successfully executed the CMHC contract. • CCHA staff reported that 53 PCMP locations are currently billing for the six primary-care BH visits and that all such practices have co-located BH providers. Providers remain confused about how to blend billing for the FFS and capitated BH visits. • El Paso DHS identified to CCHA its list of numerous core BH providers, which CCHA outreached for RAE contracting. RAE contracts represented a significant change for these providers, who considered CCHA payment rates unacceptable. In addition, DHS Child Welfare Services heavily utilized family preservation program providers, whose terminology and specialized services for members were unconventional and required translation into Medicaid billing codes. All of these concerns were resolved through one-on-one meetings with providers to address individual provider issues and clarify payment mechanisms. • To expand the BH IPN in Region 7, CCHA's organizational partner—Anthem—contacted all of its contracted independent BH providers prior to RAE implementation to inform them of the opportunity to participate in the Region 7 network. These communications stimulated an outpouring of interest from independent BH providers, who began calling CCHA's call center in large numbers. • Anthem's IPN providers had been totally isolated from Medicaid processes, including billing, credentialing, and member eligibility processes; many were not previously enrolled Medicaid providers with the State. Provider relations staff

Focus Topic: Integration of Behavioral Health Into the RAE—Providers	
	conducted extensive one-on-one, telephonic, and e-mail communications to educate and assist providers through the RAE contracting process. • CCHA has contracted with 2,000 IPN providers in Region 6 and Region 7 combined. • CCHA is not concerned with the overall adequacy of the expanded provider network in Region 7; however, CCHA continues to work on filling gaps in the rural areas. CCHA assesses network adequacy ongoing. BH members requiring inpatient residential care must seek services outside the region. • CCHA has considered how to most effectively and proactively communicate each new Medicaid process to BH providers ongoing. CCHA's provider newsletter dedicates more than 50 percent of its content to BH provider topics; staff members stated that BH resources on the provider website are the most accessed component of the website. CCHA meets on-site with the larger BH provider practices every two weeks and holds regular town hall meetings and "open mic" sessions with providers. CCHA is exploring expanding its practice transformation coaching services to support BH practices. • The CMHC has historically offered members the option to visit a CMHC office near their home to access a therapist through tele-behavioral health services. CCHA is exploring the potential for expansion of tele-behavioral health services in the region through Ieso Digital Health, an online phone texting behavioral therapy application. Using a secure, typed, written exchange between the member and a licensed BH clinician, the application replaces the need for face-to-face therapy, eliminating travel concerns, restricted hours for appointments, and member inhibitions associated with a personal visit to a BH provider office in a small town.

Focus Topic: Integration of Behavioral Health Into the RAE—Challenges and Opportunities	
Region 1—Rocky Mountain Health Plans (RMHP)	• RMHP described difficulty in contracting with specialty BH providers on the front range due to the different financing structure and higher charges associated with these providers, many of which had previously been contracted primarily with commercial insurers. Providers which had not previously had a Medicaid contract found Medicaid payment rates a challenge. • Staff members stated that many members appreciate the benefits of being able to access routine BH therapies within a PCMP. PCMPs have positively received the opportunity for reimbursement of BH services delivered in the primary care setting. • Historically, Region 1 has had only one BH acute care facility, requiring many members to travel to Denver for acute care services. Mind Springs Health has recently opened a second acute care facility—West Springs Hospital— in the region, doubling the number of acute care beds on the Western Slope and expanding programs and services for members. RMHP financially partnered with Mind Springs to develop the facility. The new facility has improved the energy and relationships among providers as well as having allowed members to remain in the community to obtain needed mental healthcare. • Integrated PCMP practices still require BH referral arrangements for some members. Due to the integrated RAE model, RMHP's practice transformation program (PTP) has been able to work with providers to identify and build referral relationships with other BH services; and RMHP has implemented a performance measure related to care compacts with BH providers. The PTP offers practice coaching related to how to integrate BH providers into a primary care practice and offers tiered incentive payments based on the level of BH integration in the PCMP. • Changing the formal structure for delivering BH services from the BHOs to the RAEs has enhanced relationships throughout the region. Staff members described that more discussion occurs about mental health in general within communities and among providers. RMHP and integrated practice providers meet with community leaders to obtain community perspectives on mental health. All regional CMHCs are working to improve two-way communications with referring providers. • RAE integrated CC teams, care coordinators, and BH providers are working more collaboratively, resulting in a smoother and more coordinated process for members with high BH needs. • Reunion Health has implemented a mechanism to develop regionwide goals for mental health that will impact program-level development. • RMHP identified initiatives for special populations related to services that have been facilitated by integration of BH services and capitated payments into the RAE, including: engaging pending DOC parolees prior to release from prison to establish a post-release BH appointment, working collaboratively with county DHS agencies to expand access to and reimbursement for home-based services for foster children and families, working with substance use and medication-assisted treatment (MAT) providers to financially sustain those practices and integrate therapies into primary care practices, and committing financial and other resources to development of supportive housing for chronically homeless youth.

Focus Topic: Integration of Behavioral Health Into the RAE—Challenges and Opportunities	
	• The BH capitated payment to the RAE offers flexibility for the RAE to finance needed care in the region and to incent providers to meet value-based objectives of the RAE. RMHP has been working with the Department to explore payment options for expanding BH covered benefits (e.g., autism) and advocating for practice-specific, tier-based payments.
Region 2—Northeast Health Partners (NHP)	◆ PCMPs throughout Region 2 have pre-established relationships with specialists, primarily through Banner Health. Following RAE contract implementation, Banner Health threatened to withdraw from Medicaid due to unusually divisive political dynamics between hospital systems in Weld and Larimer counties. Such a move would have disrupted established referral patterns among PCMPs and specialists within the region. NHP appreciated assistance from Department leadership to resolve this issue. ◆ PCMPs and specialists have been reluctant to engage in formal care compacts with providers with whom they have longstanding informal working relationships. ◆ Providers have varying perspectives regarding the RAE integration model, including lack of understanding why this shift in BH has taken place in Colorado and/or why it is important to population health. The Department's policy-level rationale for the RAE model has not been well understood by providers, nor are members able to implicitly perceive what may be better due to these changes. ◆ Integration of behavioral and physical healthcare services through the RAE has improved CC for members and improved communication among behavioral and physical health providers. NHP noted that the Department could further facilitate improved communications between BH and PCMP providers by issuing a letter to providers to reinforce the legality of BH providers sharing member information with other RAE providers involved in members' care. ◆ Despite limited availability of traditional healthcare providers—e.g., individual practitioners, facilities—throughout the region, Region 2 has many resources available for members through the broader Health Neighborhood. The region has a unique history of building alliances of healthcare providers, agencies, and community organizations to meet the needs of populations in local communities. These pre-established alliances have enabled NHP to "come alongside" and be a participant in collaborative efforts to improve healthcare for members. NHP considers innovative and community-based initiatives of the Health Neighborhood to be essential for reforming healthcare and providing services to members in rurally-oriented RAE regions. ◆ NHP perceives the need for improved financial margins for the RAE to sustain initiatives of the Health Neighborhood and to implement region-specific objectives. ◆ Since implementation of the "six-BH-visits" FFS benefit, only two PCMPs in the region have been stimulated to initiate provision of office-based BH therapies. NHP has determined that this benefit has not expanded availability of BH services to members, and that other restrictions associated with the benefit could potentially be harmful to the provision of effective integrated BH services.

Focus Topic: Integration of Behavioral Health Into the RAE—Challenges and Opportunities	
	◆ NHP is concerned about the fatigue factor of CC and case management staff who have carried much of the burden of implementation of the RAE. In addition, the RAE system does not recognize through reimbursement mechanisms the complexity of CC efforts and commitment made to meeting Medicaid members' multiple needs. ◆ NHP expressed concern about the increasing consistency in direct and indirect messaging from the Department which appeared to place paramount emphasis on cost-savings and measuring "widgets" of processes rather than improving member-focused care and services. To that end, NHP suggests that the Department reassess its measurement and payment strategies to reflect the depth of expectations in the RAE contract, while recognizing varying cultures and resources in each region. • NHP believes that the collaborative partnerships between the Department and the RAE as well as among the RAEs have been maintained or enhanced to overcome the challenges of transition to the new RAE model. NHP noted that stabilization of staff in both the Department and RAEs will further improve collaborative processes.
Regions 3 and 5—Colorado Access	• The requirement for BH providers to contract with multiple RAEs to provide services to members attributed to other RAE regions exposed BH providers to varying reimbursement rates among the RAEs. While COA's existing contracts with BH providers enabled COA to easily transition providers to the RAE, some providers desired to renegotiate COA rates—perceived as comparatively low—through a new contracting process. COA explained to all providers that COA could not legally discuss rates being paid by other payors. • The necessity for BH providers to contract with multiple RAEs requires providers to comply with the varying rules and processes of each RAE—e.g., authorizations, grievances, billing—resulting in burdensome administrative processes for BH providers (previously associated with a single BHO). • Due to attribution of members to the RAE associated with the assigned PCMP, some members have shifted their BH care to providers in other regions. • Stakeholder organizations' services—e.g., DHSs, community organizations, county alliances, and SUD providers—do not align with RAE regional boundaries, requiring numerous meetings between the RAE and individual organizations to identify concerns and solutions. • Shifts in member populations due to RAE attribution methodology had a profound effect on members, providers, and the RAE. COA stated that significant attribution issues continue and that collaborative efforts to resolve issues also continue between RAEs across the State, the Department, and between COA and Denver Health. • As a result of RAE implementation, COA has strengthened its provider support teams to initiate strategies to improve the provider experience and to work "behind the scenes" to allow members to transparently transition into the RAE. • Staff stated that efforts across RAEs and with the Department to standardize and streamline messaging and programming for providers has been a positive development of RAE implementation. In addition, networking among care coordinators and program managers across RAE regions has increased sharing of best practices.

Focus Topic: Integration of Behavioral Health Into the RAE—Challenges and Opportunities	
	• COA consolidated the customer service experience into one point of contact for members receiving either PH or BH services, promoting consistency in messaging to members. • Criminal justice programs overlap across regions and provide opportunities for increased collaboration. • COA foresees great potential for expanding tele-behavioral health services to extend the services of certified addiction counselors into integrated primary care practices. In addition, integrating telehealth services into the corrections program to interface with CJI members could significantly improve outcomes for these members.
Region 4—Health Colorado (HCI)	• HCI anticipates that members with BH needs will receive improved access to PH services through the integrated RAE model and that integrated whole-person care will result in positive outcomes for members. • BH providers have begun investing in working collaboratively with other providers, the RAE, and the Department to improve the delivery system. The sense of partnership among all entities is enhancing enthusiasm for improving care. • Integration of behavioral and physical healthcare services through the RAE has improved CC for members and improved communication among behavioral and physical healthcare providers. HCI noted that the Department could further facilitate improved communications between BH and PCMP providers by issuing a letter to providers to reinforce the legality of BH providers sharing member information with other RAE providers involved in members' care. • Community-based innovative models of service, more prevalent in rural areas where services are limited, are developing throughout the region. HCI considers such programs to be essential in reforming and improving healthcare. However, such programs are not financially supported through the traditional reimbursement systems of the RAE. • Providers have varying perspectives regarding the RAE integration model, including lack of understanding why this shift in BH has taken place in Colorado and/or why it is important to population health. The Department's policy-level rationale for the RAE model has not been well understood by providers, nor are members able to implicitly perceive what may be better due to these changes. • The dual FFS and capitated reimbursement mechanisms within the RAE present ongoing challenges for providers and RAE administrative processes. Staff members stated that it is unknown whether or not over time the RAE can efficiently and effectively manage services and processes within the current reimbursement model. • HCI is concerned about the fatigue factor of CC and case management staff who have carried much of the burden of implementation of the RAE. In addition, the RAE system does not recognize through reimbursement mechanisms the complexity of CC efforts and commitment made to meeting Medicaid members' multiple needs. • HCI expressed concern about the increasing consistency in direct and indirect messaging from the Department, which appears to place paramount emphasis on cost-savings and measuring "widgets" of processes rather than improving member-focused care and services. HCI suggested the Department improve alignment of key

Focus Topic: Integration of Behavioral Health Into the RAE—Challenges and Opportunities	
	performance indicators (KPIs) with member-oriented program expectations and deliver timely and actionable data reporting to RAEs to allow RAEs and providers to impact future incentive funds. • HCI expressed the need for improved financial margins for the RAEs to support community-based initiatives of the Health Neighborhood as well as to fund region-specific objectives.
Region 6—Colorado Community Health Alliance (CCHA)	• The implementation of the integrated RAE model removed some competition among BH providers in the region. CMHCs have remained committed to collaborating with the RAE and other providers to pursue improved care for members. • CCHA believes that the new RAE model has had a positive effect on members as BH integration is much better for whole-person care. The development of integrated care teams, systems, and care plans for members represents best practice and better healthcare. • Whereas the RCCO was the facilitator of collaborative activities in the community related to physical health services, the RAE model has positioned the RAEs as "Medicaid program" facilitators of community relationships for both physical and behavioral health services. • While changes in the delivery system initially created upset among providers and delivery system partners and stakeholders, those same changes simultaneously forced increased awareness and knowledge of the Medicaid system and increased transparency among all entities. Better understanding exists among all participants as does more accountability to the RAE than was present in the previous system. • The Department's enrollment and attribution systems did not initially incorporate PCMP-specified limits on Medicaid member panel size, creating significant stress related to appropriate member attribution to PCMPs; particularly impacted were numerous Kaiser members unable to regain attribution to Kaiser when Kaiser's member panel limits were re-instituted in the Department's attribution methodology. CCHA explored Kaiser's willingness to expand its cap on Medicaid panel size, yet some members had to be transitioned to a new PCMP. • The bifurcated FFS and capitated payment system for the RAEs is challenging for providers, especially integrated practice providers. In addition, the payment system creates data source challenges for some RAE processes, including performance measures that are dependent on access to both FFS and capitated data. • CCHA continues to decipher laws pertaining to access to SUD data to support collaborative processes.

Focus Topic: Integration of Behavioral Health Into the RAE—Challenges and Opportunities	
Region 7—Colorado Community Health Alliance (CCHA)	• RAE implementation processes for transitioning members and providers into the RAE were complicated by the initial lack of a working relationship between the regional BHO and CCHA, requiring CCHA to employ alternative workaround mechanisms to identify BH providers and members receiving BH services for ensuring continuity of care. • Previous BHO contracts and payments to BHO providers varied from CCHA reimbursement terms, delaying contracting with some BH providers and requiring CCHA to commit extensive and nimble resources to successfully transition BH into the RAE. • Member choice issues have been exceedingly improved by expansion of the BH IPN in the region. Previous member and provider perspectives regarding many barriers to care in the BHO have been alleviated. • Overall utilization of BH services and the BH penetration rate will most likely increase. • Integrated practice locations of primary and behavioral health co-located providers will likely continue to increase as co-located BH practitioners are no longer required to be placed through the BHO. • CCHA believes that the new RAE model has had a positive effect on members, as BH integration is much better for whole-person care. The development of integrated care teams, systems, and care plans for members represents best practice and better healthcare. • ACN providers have developed information exchange workflows with the CMHC. • Whereas the RCCO was the facilitator of collaborative activities in the community related to physical health services, the RAE model has positioned the RAEs as "Medicaid program" facilitators of community relationships for both physical and behavioral health services. • Region 7 providers and community organizations have a long history of working together on local healthcare initiatives and concerns. CCHA has been able to transition many of those relationships to the RAE and can build on them. Expanded availability of BH providers in the region has and will most likely continue to offer opportunities for closer working relationships among all entities. • The Department's enrollment and attribution systems did not initially incorporate PCMP-specified limits on the size of Medicaid member panel size, creating significant stress related to appropriate member attribution to PCMPs. The attribution methodology also impacted various special member populations. • The bifurcated FFS and capitated payment system for the RAEs is challenging for providers, especially integrated practice providers. In addition, the payment system creates data source challenges for some RAE processes, including performance measures that are dependent on access to both FFS and capitated data. • CCHA continues to decipher laws pertaining to access to SUD data to support collaborative processes.

3. Statewide Trends Related to Discussion Themes

Focus Topic: Transitioning and Integrating Behavioral Health Into the RAE

Trends Related to Discussion Themes

Variations in regional characteristics and historical development among RAEs necessitated that the HSAG facilitator allow for flexibility in the focus and depth of discussion regarding each region's experiences regarding *Transitioning and Integrating BH Into the RAE*; therefore, consistency in discussion topics varied across the regions. Nevertheless, HSAG noted the following common themes across the RAEs regarding transition and integration of BH members and providers.

Members

- Each RAE contractor's association with the previous RCCO or BHO in the region impacted the ease of identifying members for transition into the RAE:
  - The RAEs in Regions 1, 3, 4, 5, and 6 were the previous RCCO contractors in their respective regions.
  - The RAEs in Regions 3, 4, and 5 were the previous BHO or BHO ASOs in their respective regions. Regions 1, 2, and 6 had alignments or close working relationships with the CMHCs in their respective regions.
- *All* RAEs reported that most BH members received services through the CMHCs.
- RAEs reported using the following sources to identify members in treatment at the time of RAE implementation:
  - Regions 3, 4, and 5 used BHO data and BHO UM authorizations for intensive-level BH services; Region 6 used authorization information identified by previous BHO UM managers; Regions 2 and 7 were unable to obtain useful data from the previous BHO.
  - Regions 1, 2, and 6 worked with CMHCs to identify members in treatment or high-risk BH members.
  - Regions 1, 3, 4, and 5 used IPN claims data to identify members in outpatient treatment.
  - Region 7 quickly identified inpatient providers and developed relationships with those providers to continue payment for previously authorized services and to identify members for care coordination (CC) services.
  - Regions 1, 2, and 6 also identified, through RCCO care coordinators, members with complex needs who were engaged in BH services.
- To ensure continuity of services—
  - *All* RAEs continued payment for previously authorized BHO services.
  - *All* RAEs continued payment for members in ongoing outpatient services pending completion of provider contracting.

  - *All* RAEs contacted and worked behind the scenes with treating providers to ensure that providers understood continuation of payments and that members experienced transparency in transition of care to the RAE.
- *All* RAEs except Region 7 were confident that most members in BH treatment at the time of RAE implementation were successfully and transparently transitioned into the RAE. Region 7 staff reported confidence that BH members "known to the RAE" at the time of RAE implementation received continuity of care.
- *All* RAEs engaged CC staff to create lists of high-risk BH members involved in CC services with the previous RCCO, previous BHO, or CMHCs. Region 2 did not receive a useful list of high-risk BH members from the previous BHO. Region 7 was unable to obtain lists of high-risk members from the BHO or regional CMHC.
  - Region 2 also worked with county DHSs and community partners—e.g., WIC programs and school-based BH practitioners in 26 locations—to identify at-risk BH members.
  - Region 7 operationalized the Department's Colorado Overutilization Program (COUP) lists to identify members potentially in need of continuity of care services.
  - *All* RAEs outreached individual high-risk members through member services call centers and care coordinators to explain the RAE as the new organization for providing BH services and to assure members that benefits would not change; Regions 1, 2, 6, and 7 also offered CC services to high-risk members.
- Regions 1, 3, 6, and 7 either developed workflows for or arranged warm handoff transition of BH members to RAE care coordinators: Region 1 from acute care facilities, Region 7 from the ACN providers, Region 6 from CMHCs, and Region 3 from the BHO. Region 7 also arranged warm handoff from the RCCO to the RAE of members engaged in RCCO CC at the time of RAE implementation.
- Prior to RAE implementation, Regions 2 and 4 also employed mass communication strategies to inform members of the transition to the RAE and reassure members of continued benefits.
- *All* RAEs reported making adjustments to CC processes and teams to accommodate the integration of BH members into the RAE.
- *All* RAEs except Region 1 described significant shifts in the RAE member populations both in and out of the region due to the new RAE PCMP attribution methodology. Although RAEs described a variety of specific attribution issues, most issues were related to the Department's geographic assignment methodology or the Department's enrollment and attribution systems' inability to initially incorporate PCMP designated panel size limits in the attribution methodology. Some issues that impacted large numbers of members included:
  - Regions 3, 5, 6, and 7 described that the Department's initial letter to members describing the RAEs and PCMP assignment confused members and generated many member inquiries.
  - Region 2 described members residing in Weld County who were engaged with a PCMP in neighboring Larimer County being attributed to Region 1.
  - Region 5 described large shifts in attribution between the Denver Health MCO and the RAE.

  - Region 6 described that members previously engaged in care with Kaiser were unable to regain attribution to Kaiser after Kaiser's panel size limits had been met with members geographically attributed to Kaiser on RAE implementation.
  - Region 7 described that assignment of previously unattributed members—40 percent of the region—to PCMPs on RAE implementation resulted in large numbers of members being attributed to practices with panel size limits and which lacked the capacity to absorb new members.
- *All* RAEs worked with the Department to resolve system-driven macro attribution issues.
- Regions 1, 2, 4, 6, and 7 engaged PCMPs in monitoring practice-specific attribution lists and identifying misattributed members.
- Regions 2, 3, 5, 6, and 7 described special member populations impacted by attribution issues including:
  - Foster care children in custody of county DHSs but placed in homes in other areas of the State. (Regions 2, 3, 5, and 7)
  - Geriatric members receiving LTSS services. (Regions 2, 3, 5, and 7)
  - Members receiving BH services in a region not coinciding with their attributed PCMP. (Regions 3, 6, and 7)
- *All* RAEs mobilized customer services, provider relations, and CC staff to assist individual members with reattribution when necessary. *All* RAEs except Region 1 described expending significant resources to resolve attribution issues.
- RAE CC staff across *all* regions work cooperatively to successfully transition individual members engaged in CC to care coordinators in the member's attributed region.

Providers

- Provider contracting varied according to each RAE's association with the previous BHO in the region. In Regions 3, 4, and 5, the RAE was the previous BHO contractor or was the ASO for the previous BHO. In Regions 1, 2, 6, and 7, the RAE was not the previous BHO.
- Regions 3, 4, and 5 amended previous BHO provider contracts to transition to the RAE, thereby expediting the BH provider contracting process. Provider contracting in these regions was seamless.
  - Regions 3 and 5 transitioned all CMHC and 5,000 IPN provider contracts to the RAEs.
  - Region 4 transitioned all CMHC and 600 IPN provider contracts to the RAE.
- Regions 1, 2, 6, and 7 initiated BH provider contracting with the CMHCs, which provided BH services to most members in each region.
- For BH IPN contracting:
  - Region 1 used its RMHP BH provider network for other lines of business—350 providers— as the base for RAE contracting and executed contracts with an estimated 80 to 90 percent of those providers.
  - Region 2 used the provider list from the previous BHO and contracted with all previous BHO providers.

  - Regions 2 and 4 contracted with an additional 200 IPN providers (across both regions).
  - Region 6 BHO messaged its contracted providers to encourage them to contract with the RAE.
  - Region 7 was unable to directly contact previous BHO providers for contracting with the RAE due to lack of data sources to identify providers.
  - Regions 6 and 7 used Anthem's commercially contracted BH provider network to message providers, encouraging them to contract with the RAE. These communications stimulated a flood of interest from IPN providers in both regions. Regions 6 and 7 contracted with 2,000 IPN providers (across both regions).
- *All* RAEs continued payments to all providers for BH services rendered to members pending completion of contracting and to ensure continued services to members during RAE implementation.
- *All* Regions reported contracting with an adequate BH provider network (to the degree that providers are available) to serve the needs of Medicaid members.
  - Rurally-oriented regions—Regions 1, 2, and 4—experience a general BH provider workforce shortage.
  - Many Region 1 members must seek residential and acute care BH services on the Front Range.
  - Region 2 lacks SUD providers.
  - Region 6 described that respite care and specialized residential treatment facilities are in short supply.
  - Region 7 members must seek inpatient residential care services outside the region.
- *All* RAEs described that BH providers were "dismayed" with the necessity to contract with each RAE region associated with their patients' attributed PCMPs. Contracting with multiple RAEs has exposed BH providers to varying infrastructure processes and rules associated with each RAE.
- Regions 1, 3, 5, 6, and 7 described isolated complications encountered during BH provider contracting. Examples include:
  - Region 1 described difficulty negotiating contracts with specialty BH providers on the front range, many of which had previously been associated with commercial insurers and found Medicaid payment rates inadequate.
  - Similarly, Regions 1, 3, 5, and 7 stated that numerous BH providers, especially new IPN providers, found the individual RAE's payment rates unacceptable.
  - Regions 1, 6, and 7 identified many new IPN providers not yet enrolled by the State as Medicaid providers.
  - Regions 3 and 7 identified that relationships with CMHCs—which had been owners in the previous BHOs and were not owners in the RAE—were politically sensitive and caused concerns among those CMHCs regarding future financial viability.
  - Region 7 discovered that contracting with the RAE represented significant change in reimbursement for core BH providers utilized by DHS.
  - Regions 2, 3, 5, 6, and 7 reported that most IPN providers had been totally isolated from previous BHO and Medicaid processes. All such regions committed extensive resources to both mass and individual provider communications to explain contracting, authorizations, monitoring requirements, and other administrative processes of the RAE.

- *All* regions reported successful transition of PCMP contracts into the RAE. Regions 2, 4, 6, and 7 conducted webinars and/or discussions with individual providers to inform of changes in the RAE per member per month (PMPM) reimbursement and PCMP attribution methodology. All such regions described significant concerns among PCMPs regarding both of these changes, with attribution concerns being paramount.
- *All* RAEs, except Regions 2 and 4, have numerous BH/PCMP integrated practice locations. Regions 2 and 4 FQHCs have integrated practices. Upon implementation of the RAE, *all* RAEs educated integrated practice providers about the Department's FFS payments for six PCMP BH visits.
- RAEs reported varying degrees of success and challenges associated with implementation of the "six routine BH visits" benefit by PCMPs:
  - Region 1 stated that reimbursement for BH delivered within the PCMP setting has been positively received by providers and members.
  - Regions 3 and 5 determined that reimbursement for this benefit is too low to sustain the financial viability of integrated practices. COA has developed an enhanced payment model to support PCMP practices with employed BH practitioners.
  - Region 7 reported that the CMHC perceived that initiation of the FFS BH benefit financially disadvantaged the CMHC. Provision of previously established co-located BH services in numerous PCMP locations was initially diminished. However, currently 53 PCMP sites in the region with co-located BH practitioners are billing for the six FFS BH visits.
  - Regions 4, 6, and 7 reported that integrated practice providers remain confused about appropriate billing mechanisms for this benefit in the mixed capitated and FFS payment environment of the RAEs.
  - Regions 2 and 4 reported that the new benefit has not encouraged expansion of BH services into additional PCMP practices due to the administrative burden of implementing new billing practices and the necessity for transferring a member to a new therapeutic environment for continuing treatment needed beyond the allowable six visits.
- *All* RAEs support the expansion of tele-behavioral health to expand access to or enhance provision of BH services in the region. Opportunities to do so varied among the individual regions:
  - Region 1 is working with Heart-Centered Counseling to establish communication hubs throughout the region for delivery of tele-behavioral health services. This strategy supports members in rural areas where BH providers are scarce or nonexistent.
  - Regions 2 and 4 stated that widespread provision of telehealth services in vast rural areas where BH providers are scarce or nonexistent is limited by lack of sufficient Internet infrastructure in those areas. Region 2 was exploring the possibility of schools and hospitals being the best potential member contact sites for telehealth services.
  - Regions 3 and 5 provide COA's tele-behavioral health program free of charge to PCMPs. COA's program offers peer-to-peer consultations for providers and virtual therapy to members through COA-employed BH clinicians. The services support PCMPs who are unable to incorporate BH practitioners into their practices. COA intends to extend tele-behavioral health to BH providers to support medication management and will involve the CMHCs in strategies to do so.

  - Regions 6 and 7 are exploring implementation of a phone texting interactive messaging system for online therapy with licensed BH clinicians. This application supports members who have travel concerns, difficulty with restricted appointment times, or inhibitions associated with face-to-face BH visits. CCHA was also initiating discussions with Heart-Centered Counseling regarding additional options for expanding tele-behavioral health to rural or mountain areas.

Challenges and Opportunities

- *All* RAEs committed significant resources over the past year to successfully implement the RAE integrated model with members and providers.
- *Most* RAEs benefited from previously established associations with the RCCOs, BHOs, and community partners in their regions to facilitate transition to the RAE. However, RAE implementation in Regions 2 and 7 was complicated by lack of adequate information provided by the previous BHO.
- *All* RAEs described that issues with the RAE PCMP attribution methodology during and following RAE implementation had a profound impact on members, providers, and the RAEs.
  - Regions 3, 5, 6, and 7—more densely-populated regions associated with urban areas—experienced more cross-regional attribution issues than did the vast geographic rural regions.
  - The attribution methodology confused and concerned both members and providers.
  - The Department worked with *all* RAEs to resolve a variety of macro-level attribution methodology issues.
  - *All* RAEs noted that the attribution methodology also impacted members of select populations—e.g., children in foster care, geriatric members, members of Kaiser.
  - *All* RAEs expended significant staff resources to monitor and correct attribution of individual members.
  - Some members shifted their choice of PCMP or BH providers to other regions.
  - RAEs reported that attribution issues have been largely diminished since initial implementation but still continue.
- *Several* RAEs experienced delays in BH contracting due to provider concerns regarding reimbursement rates.
- *All* RAEs except Region 2 identified that integration of BH into the RAE has and will lead to improved access to services for Medicaid members:
  - Regions 6 and 7 cited significant expansion of the IPN as contributing to improved member choice in BH providers.
  - Regions 1, 6, and 7 cited integrated care as an improved model for whole-person care and CC for members.
  - Region 7 predicted a continued increase in the number of integrated PH/BH practices.
  - Regions 1, 3, 5, 6, and 7 are pursuing mechanisms to expand tele-behavioral health services.
  - Region 1 has a newly-opened acute care mental health facility on the Western Slope, doubling the number of inpatient BH beds available in the region.

  - Region 4 cited integration of BH into the RAE as improving BH member access to physical health providers.
- Regions 3, 5, 6, and 7 reported that integrating BH into the RAEs has removed pre-existing barriers between CMHCs and the IPN providers.
- Regions 1, 4, 6, and 7 reported improved dynamics and enhanced relationships in the region regarding mental health in general through: increased awareness of the Medicaid system (Regions 6 and 7); community collaborative initiatives (Regions 1, 6, and 7); enhanced provider-to- provider communications; and sense of partnership among providers (Regions 1, 4, and 7).
- Regions 1, 2, 4, 6, and 7 reported that the Health Neighborhood is strong and is a significant contributor to health reform. These RAEs reported that implementation of the RAE model has enhanced the RAE's participation in Health Neighborhood initiatives and positioned the RAE as the "Medicaid program" facilitator in communities.
- Region 1 noted that the BH capitated payment offers increased flexibility for the RAE to finance regional initiatives related to specialized population needs.
  - Regions 2 and 4 expressed concern about the flexibility of RAE funding and need for improved financial margins in the RAE to support community initiatives.
- *All* RAEs stated that networking and cooperative relationships among all RAEs have improved, especially for purposes of CC.
- Regions 1, 3, 5, 6, and 7 have strengthened provider relations, CC, and member services teams and services.
- *Most* RAEs noted difficulties associated with the bifurcated FFS and capitated payment structure for the RAEs:
  - Regions 2, 3, 4, 5, 6, and 7 noted confusion for integrated PH/BH practices.
  - Regions 4, 6, and 7 noted additional concerns associated with RAE administrative processes.
- Regions 2 and 4 expressed concerns regarding the potential future fatigue factor of CC staff due to complexities of the work and commitments required of coordinators, lack of recognition for complex CC efforts in the RAEs' reimbursement methodology, and heavy workload assumed by care coordinators in transitioning members into the RAE.
- Regions 2 and 4 also expressed dismay that the Department's shift in emphasis to cost-related issues and monitoring "processes" for the RAEs seems inconsistent with region-specific perspectives on health improvement.

4. Conclusions and Overall Recommendations

Development and implementation of the RAE integrated care model in the State's ACC program represented a major strategic shift in the Department's approach to delivering Medicaid services to members across the State. By combining previous BHO responsibilities for administering capitated BH services and previous RCCO responsibilities for coordinating PH services into one entity, the RAE structure is intended to further the integration of services for improved whole-person care, while testing a reimbursement model of combined capitated and FFS payment mechanisms. RAE regions' geographic boundaries were aligned with the previous RCCO geographic boundaries. Members were assigned to a RAE region based on a new attribution methodology which assigned members to a PCMP location; each PCMP location was aligned with a specific region. Upon RAE implementation, BH providers and members using BH services were transitioned to the RAE. All of these underlying characteristics of the RAE model played a role in HSAG conclusions regarding implementation of the RAEs.

HSAG provides the following observations and recommendations related to implementation of the RAE integrated care model.

Conclusions

- Whereas PCMP contracts and RCCO members were already aligned with each RAE, BH providers and BH members had to be formally transitioned into each RAE. RAE organizations previously associated with the BHO in the region were able to readily transition provider contracts and members into the RAE. RAEs not previously associated with the BHO depended on data from the BHO and/or other sources to identify members and providers associated with the BHO and developed a variety of workaround mechanisms to successfully identify BH providers and members for transition to the RAE.
- Despite complications experienced by some RAEs in identifying members engaged in BH services, all regions successfully transitioned most BH members into the RAE without disruption of services or continuity of care.
- Despite complications experienced by some RAEs in BH provider contracting, all regions successfully transitioned most BHO providers into the RAE. In addition, many regions significantly expanded the contracted BH IPN, thereby increasing member choice of BH providers.
- All RAEs agreed that the major challenges encountered during implementation of the RAE were associated with implementation of the Department's new member attribution methodology. While the Department's change in member attribution methodology was designed to eliminate the need for PCMPs to contract with multiple regions, BH providers—previously contracted with a single BHO— were required to contract with multiple regions. This resulted in BH provider confusion and a "heavy lift" for BH providers. In addition, an unintended consequence of the Department's implementation of the new attribution methodology was assignment of members to inappropriate PCMPs or to PCMPs in locations aligned with other regions and/or not consistent with the member's current or desired service providers. Hence, the efforts of the Department to solve a previous

problem for PCMPs created new problems for other providers, service organizations, and individual members.

- All RAEs demonstrated significant commitment to and expended considerable resources—particularly management, provider relations, CC, and member services staff—to assist members and providers with transition and enable successful implementation of the RAE.
- CC remains a key component of the RAE integrated model, and care coordinators continue to perform at an exemplary level for members with complex needs. All RAEs have made adjustments to CC processes to accommodate the integration of BH in the RAE. The occurrence of BH needs in any member's case significantly increases complexity of the CC activities.
- RAEs outlined many more positive than negative outcomes associated with implementation of the RAE, including: strengthening of RAE staff and processes, strengthening of provider relationships, collaboration with community partners, collaboration with the Department, collaboration among the RAEs, and increased visibility of the Medicaid program in communities.
- In addition, RAEs foresee much potential in the RAE integrated care model to expand access to BH services; improve whole-member care; and stimulate enthusiasm and innovation among providers and community partners, to improve mental healthcare and the healthcare delivery system overall.
- Yet to be determined is whether or not RAEs and providers can successfully manage provision of services and funding of RAE objectives within the bifurcated RAE reimbursement structure—i.e., combining traditional FFS and capitation payment structures.
- RAEs continue to cite the importance of region-specific initiatives and collaborative Health Neighborhood activities in reforming and improving healthcare in each region. Some RAEs are concerned about the sufficiency of RAE financial margins to sustain and support these activities.
- The Department's monitoring and measurement activities do not seem to represent the depth of RAE activities or recognize the unique cultures, available resources, and member populations within individual regions.
- HSAG finds that the energies applied by the RAEs and Department during the initial year of RAE implementation have achieved successful transition of members and providers into the RAEs as well as expanded the BH IPN network to provide increased choice for members seeking BH services. Within each RAE and statewide, RAEs have established a solid foundation for moving forward with provision of integrated care to serve the "whole-person" needs of members and address other objectives of the ACC.

Overall Recommendations

- To build on the foundation of the provider networks established by the RAEs, HSAG recommends that:
  - RAEs continue efforts to establish working relationships between CMHCs and BH IPN providers; between BH IPN providers and PCMPs—e.g., improved communication mechanisms and increasing co-located practice sites; and between PCMPs and CMHCs—e.g., smooth transition of members following six PCMP BH visits.
  - RAEs continue to explore with community partners alternatives for providing services that are in short-supply or poorly distributed in the region.
  - The Department begin to examine statewide and regional shortages or maldistribution of BH resources—e.g., BH residential facilities, respite care, or specialized service providers—and determine strategies and potential funding solutions to stimulate expansion of select BH services for members.
- While it is assumed that expanded access to BH IPN providers improves member choice and access to BH providers and alleviates barriers to care experienced in the CMHC-focused BHOs, HSAG recommends that each RAE confirm these assumptions by carefully monitoring the shift of members from CMHCs to the IPN or co-located BH practitioners; BH penetration rates; and trends in overall utilization of BH services by members.
- Considering the importance and increasing complexity of CC activities and the RAEs' commitments to costs, expanded staff, and reorganization of CC processes to accommodate the RAE integrated care model, HSAG recommends that the Department consider additional mechanisms or reimbursements to RAEs to recognize complex CC efforts.
- Community-based and Health Neighborhood collaborative initiatives in all regions are a unique characteristic of the ACC model and play an increasingly significant role in the provision of needed services to Medicaid members. These types of initiatives and services are not recognized within traditional FFS and capitated payment methodologies. The Department and RAEs should work together to determine appropriate funding support to sustain these activities within the ACC program.
- BH providers contracted with multiple RAEs are exposed to varying infrastructure processes and rules associated with participation in each RAE. These variations are an administrative burden for BH providers, many of which are small independent practices. HSAG suggests that all RAEs work collaboratively to explore the feasibility of consolidating and/or developing consistency in BH infrastructure requirements—e.g., authorizations, grievance processing, billing—to ease the burden on BH providers.
- HSAG recommends that all RAEs continue pursuing mechanisms to expand tele-behavioral health services within individual regions and consider further applying tele-behavioral health to support co-located BH practitioners in PCMP offices and/or specialized populations and service needs—e.g., CJI members and SUD services.
- The RAEs have identified several issues that have complicated implementation of the "six BH visits" FFS benefit in PCMPs. Issues seem to include continued confusion about: appropriate

billing—FFS or capitated BH—in integrated practices with a co-located BH therapist, whether defined codes for the FFS benefit are appropriate or need to be modified, whether the "six BH visits" benefit limit is appropriate for members needing continued routine therapy, and whether the FFS payment rate is sufficient to support co-located BH therapists in a PCMP. While the theory of simplifying and expanding access to routine BH services seems worthy, administration of the benefit has confused providers and has generated concern about continuity of BH services for some members. HSAG recommends that the Department, all RAEs, and provider representatives organize a forum dedicated to evaluating whether the FFS BH benefit is currently designed to accomplish the goal for which it was intended, identifying all provider issues and concerns, clarifying billing issues related to the current benefit, and proposing remedies as indicated.

- While most RAEs have implemented practice support programs and resources for PCMPs, HSAG suggests that each RAE consider extending similar practice support teams—e.g., practice transformation activities—to support BH practices.
- Most RAEs reported that some macro systemic issues associated with attribution of members following RAE implementation have been resolved by the Department, yet attribution issues continue related to geographic assignment of members to PCMPs, including:
  - Potentially inappropriate assignment of members to PCMPs located in the geographic boundaries of regions—e.g., between Region 3 and Region 6, between Region 1 and Region 2, and between Region 6 and Region 7.
  - General confusion of members and providers.
  - PCMP panel size limits not incorporated into attribution decisions.
  - Expenditure of significant Department and RAE staff resources to reattribute individual members.
  - Negative impact on some specialized member populations.
  - Specific issues associated with shifting member populations between the MCO and RAE in Region 5.

  HSAG suggests that RAEs and the Department work together to carefully examine possible alternatives for resolving such issues, which might include: (1) consider whether or not attribution could be a shared responsibility between the Department—using data-related sources (i.e., claims)—and the RAE—assuming responsibilities for members' geographic assignment to PCMPs and taking into consideration needs of special populations, location of members' other service providers, PCMP panel size limits, and PCMP locations in border areas of regions; (2) consider providing RAEs with direct access and input into the enrollment broker files to increase the efficiency of reattributing members to select PCMPs; (3) conduct thorough assessment of potential consequences associated with any proposed changes in operational attribution processes. In addition, attribution issues continue to be a challenge for the ACC program overall. The Department may want to re-evaluate the member attribution strategy for its contribution in achieving the overall goals and objectives of the program and consider alternatives to that strategy.
- RAEs noted several concerns with the Department's monitoring and measurement processes, including: misalignment of measures with the priority objectives of each RAE region or with the depth of RAE contract responsibilities; lack of timely access to data to impact incentives; and

difficulties with integrating data from both FFS and capitated sources to address performance measures. HSAG suggests that RAEs and the Department work together to carefully examine the most meaningful mechanisms to measure and incent RAEs and providers to address high-priority RAE issues, including possible consideration of unique RAE-specific measures. In doing so, RAE contract managers may be able to redirect some efforts toward providing oversight and assistance to each RAE to achieve region-specific objectives and measures.

- Considering complexities associated with administering a bifurcated FFS and capitated payment system, HSAG recommends that, going forward, the Department examine the current payment model to determine if the innovative goals of the ACC program are supported by the model. RAEs noted a variety of reimbursement or financing concerns that may be associated with the current reimbursement model, including: BH providers questioning adequacy of reimbursement rates; PCMPs questioning reduction in PMPM payments; confusion of integrated practice providers and MCO specialists regarding appropriate billing in a mixed FFS and capitated environment; adequacy of reimbursement for the "six-BH visits" benefit for PCMPs; potential RAE administrative difficulties associated with managing integrated services and programs within a mixed reimbursement environment; and concerns with adequacy of RAE profit margins for flexible funding of region-specific and community-based initiatives and objectives not readily reimbursable under traditional payment strategies.

  HSAG recommends that the Department continue to evaluate the best payment alternatives for the RAEs. HSAG suggests possible consideration of global payment or similar capitated payment methodologies which might offer increased flexibility for RAEs to implement region-specific objectives and programs as well as alleviate data, cost, and provider confusion issues associated with the current bifurcated payment system.

Appendix A. 2018–2019 RAE Focus Topic Interview Guide

Focus Topic: Transitioning and Integrating Behavioral Health Into the RAE

Members:

- How did you identify members assigned to BHOs for re-assignment to RAE?
- When did you begin to transition BH members? What was the process?
- Who (what organizations) did you work with to integrate and transition the BHO members?
- What types of communications or member outreach did you employ to transition BH members?
- Have any members expressed frustration with transition process?
- Continuity of care:
  - How did you identify BH members who were receiving services at the time of transition to the RAEs?
  - Do you feel the transition from the BHO to RAE was transparent to members who were already engaged in care?
  - What types of disruption in continuity of care—if any—did members experience?
  - Do you feel confident that continuity of care has been maintained?
- Transitioning care coordination for members with complex BH needs:
  - What was the process of transitioning care coordination for BH members?
  - Has there been a difference in care coordination for members with BH needs?
  - What are the care coordination successes or challenges related to integrating BH services into the RAEs?
- How is the process of delivering BH services in primary care provider offices working?
  - How did you implement with members?
  - With providers?
- Overall successes/challenges with BH integration for members to date:
  - What have been some of the major areas of success in transitioning BH members into the RAE?
  - What have been some of the major challenges?
  - What is status of addressing those issues?
  - Are there differences in successes or failures related to specific member populations?
  - What do you see as continuing challenges moving forward?
- Do you have suggestions for the Department or other partners that could assist the RAEs in transitioning members or integrating care?

Providers:

- How did you build or alter your provider network to accommodate the BH needs of members?
- How did you transition BHO providers into the RAE (individual practices, CMHCs, inpatient/residential providers, other treatment facilities)? What was the process?
- What types of communication did you have with BH providers to facilitate transition?
- How has integrating behavioral health into the RAE impacted efforts of BH and PH providers to work collaboratively?
- How has integrating behavioral health and physical health services impacted member care?
  - Has care been more integrated for individual members?
  - What are continuing barriers in achieving integrated BH/PH care for members?
- What have been some of the major successes/challenges in transitioning BH providers from BHOs to RAE?
  - How have BH providers responded to this new organizational model? (Expressions of satisfaction or dissatisfaction?)
  - How has integration of providers into RAE influenced operations, programs, and/or relationships?
  - How are you addressing any continuing issues with BH providers?
  - What are greatest areas of potential success moving forward?
- What has been or could be most helpful from the Department or other entities to facilitate or influence the RAE's relationships with BH providers?