CAHP
Colorado Association of Health Plans

FACT SHEET

Medicaid and the Regional Accountable Entities (RAEs)

FICTION VS. FACT

Given recent public statements, CAHP would like to separate fact from fiction on several issues being discussed by legislators.

FICTION	FACT
Value-based payments in primary care and maternity care will transform Medicaid	RAEs are already engaged in efforts to create a variety of different payment models, including value-based contracts, to improve physical and behavioral health outcomes for members and increase provider accountability.
RAEs make $500 million in profit per month	The RAEs are subject to an 85 percent medical loss ratio (MLR) similar to commercial plans. This means 85 percent of the dollars they earn must be spent on direct care services or be returned to the state. The vast majority of funding that goes to RAEs is used to reimburse providers for services provided to members.
RAEs underpay behavioral health providers	The behavioral health capitation rates are not built on the Medicaid Fee-for-Service rates. Reflecting federal and state regulations, the rate-setting process is based on historical utilization and cost data trended to the future contract period.[1] Rates between RAEs and providers are considered to be proprietary by the Federal Trade Commission given that each provider contracts with the RAEs directly and can negotiate or accept the rates offered which may include supplemental value-based payments. Disclosing rates could be considered price fixing.[2] RAEs must submit plans to HCPF to outline how they are expanding their networks including reimbursement rates to providers.
RAEs don't follow mental health parity rules	RAEs are subject to extensive oversight including annual Mental Health Parity audits by an external contractor. Under federal regulation, HCPF is charged with determining the RAE's Parity compliance. The 2021 independent review of parity in the Medicaid program stated: *"An assessment and comparative analysis of MH/SUD benefit limitations compared to M/S benefit limitations found the written policies and procedures to be parity compliant in all Non-Quantitative Treatment Limitations (NQTLs) except for one.[3]"*
HCPF doesn't manage the RAEs	HCPF provides extensive oversight of the RAEs and holds them accountable for numerous physical and behavioral health performance metrics that help determine whether the RAE receives incentive payments. For 2020 – 2021, these performance metrics included: potentially avoidable costs, ER visits, well visits, behavioral health visits, and prenatal visits.[4] Per contract requirements, RAEs participate in more than 40 meetings with HCPF (recurring weekly, bi-weekly, monthly, and quarterly). Each region also has a Performance Improvement Advisory Committee (PIAC) made up of stakeholders who provide input on RAE performance. There is also a state-wide PIAC that makes general program recommendations. RAEs submit hundreds of written report deliverables to HCPF on annual, bi-annual, and quarterly basis, in addition to ad-hoc HCPF requests for information and data.
RAEs don't coordinate care	Care coordination is a key component of the RAE model. RAEs help members understand and manage their benefits, find providers, and connect to social service resources such as transportation, housing, and food assistance. RAEs are also required to report on the types and volume of these efforts.

1 C.R.S. 25.5.-5-408 Capitation payments
2 Federal Trade Commission Protecting America's Consumers: Price Fixing
3 2021 Parity Comparison Analysis Report
4 Department of Healthcare Policy and Financing Performance Measurement Accountable Care Fact Sheet 2021

FICTION	FACT
RAEs don't reimburse for providers-in-training	Medicaid allows unlicensed providers to provide care under the supervision of a licensed individual, but an unlicensed provider cannot be validated, credentialed, or bill Medicaid. Federal law explicitly prohibits Medicaid dollars from being used to pay additional reimbursement to behavioral health providers for supervising unlicensed providers.[5]
RAEs are delaying credentialing for behavioral health providers	After providers are validated with HCPF, the credentialing process with the RAE can begin. HCPF reports that most credentialing applications are completed in 20-30 days. Newly executed RAE contracts require a 90-day credentialing and contracting timeline for 90% of all applicants. RAEs are required to re-credential all individual behavioral health practitioners at least every three years.[6]
RAEs increase prior authorizations to reduce care and improve their profits	Federal and state regulations require the RAEs to develop utilization management criteria, reflecting the composition of their provider networks and needs of their members.[7] Just as doctors use scientific evidence to determine the safest and most effective treatments, the RAEs rely on the same data and evidence to ensure the care provided is medically necessary and consistent with best practices. The RAEs are prohibited from interfering with appropriate medical care decisions rendered by their contracted network providers.
RAEs have closed provider networks	RAEs are required to generate one quarterly Network Adequacy report for each applicable line of business and this data is publicly available. Based on the most recent quarterly network adequacy reports to HCPF (2021), all RAE regions saw increases in the number of behavioral providers from the previous quarter totaling 32,503 behavioral health providers. Of those providers, 26,075 are accepting new Medicaid members.[8]
RAE board members self-refer business	Each RAE is contractually obligated to have a Governance Policy on their website that addresses Conflict of Interest. Such policies prohibit self-dealing as board members are not responsible for contracting decisions.
RAEs look for ways to claw back money from providers	HCPF and RAEs are required to prevent, identify, and combat fraud, waste, and abuse of Medicaid funding, in addition to ensuring accurate processing of claims and other health insurance eligibility, which can sometimes result in the recoupment of provider funds. Based on federal rules, each state must contract with a contingency-fee-based vendor to review provider claims and reduce improper Health First Colorado payments through the efficient detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments.[9] In many instances, CMS or a state's Medicaid authority determine the lookback period for recoupments. Providers are required by Section 1902(a)(27) of the Social Security Act and 10 CCR 2505-10, Section 8.130 to: [10] • Retain records necessary to disclose the nature and extent of services provided to recipients. • Maintain records which fully substantiate or verify claims submitted for payment. • Submit records to federal and state government upon request.

5 HCPF Uniform Service Coding Standards Manual, April 2021.
6 HCPF: Health First Colorado Managed Care Contracts
7 HCPF: Health First Colorado Managed Care Contracts
8 HCPF: Network Adequacy Plan and Quarterly Reports
9 Section 6411(a) of the Affordable Care Act
10 Sec. 1902. [42 U.S.C. 1396a]