Regional Medicaid Structures in Other States

Briefing for the Colorado Commission on Medicaid · November 2026

Why the Commission asked

Docket line 19 first proposed reducing the number of RAEs and BHASOs, to two or to one with regions, or else standardizing them. On November 10th, the Commission adopted it 8–1 in narrower form: examine performance standards for every RAE and BHASO and publish results by entity, and examine the regional structure, how it works in other states, and how the entities work with providers, with a view to standardization. The clause about reducing the number of entities at the next procurement was dropped.

In discussion, members raised two concerns for the report: rural economies of scale, and the relationship between a regional entity and its local providers. Earlier in the fall, HCPF cautioned that relying on a single statewide contractor would be risky. This briefing shows how other states organize regionally, what the evidence says, and what Colorado could learn, to support the examination line 19 calls for.

Bottom line

- **Almost every state draws regions; what differs is how many contractors serve each region and what they are responsible for.** There are three broad patterns: one accountable entity per region (Colorado, Oregon's coordinated care organizations, and North Carolina's Tailored Plans); several competing plans within each region (Arizona, Washington, Florida, Texas, and North Carolina's Standard Plans); and statewide contractors with no regions (Connecticut's administrative services organizations).
- **Colorado has already consolidated.** In July 2025 it went from seven RAE regions to four, with the stated aim of easing the administrative load on providers and standardizing across RAEs. Other states have moved the same way: North Carolina from six behavioral health entities to four, and Arizona to three aligned service areas.
- **Colorado's model is unusual.** RAEs hold the capitated behavioral health benefit, but physical health is still paid fee-for-service by HCPF. In most regional states, the regional entity carries full risk for physical and behavioral health together.
- **There is little evidence that a particular number of regions saves money.** Where regional models show results, the results come from what the entity is accountable for (integrated physical and behavioral health, a spending-growth target, published quality measures), not from the map.
- **Line 19's adopted approach is common practice.** Setting performance standards and publishing results by entity is how Oregon, Arizona, and others manage regional contractors, and it gives the state the evidence it needs before deciding to change the number of entities.
- **The critical question is not whether RAEs have performance measures – they do – but whether the measures are meaningful and what happens when a RAE misses them.** Colorado's incentives draw on a small slice of RAE payments, several measures track process rather than outcomes, and the

main consequence for missing contract standards is reinvesting profit in the program. With one RAE per region, the state cannot move members to a competitor, so meaningful measures and clear consequences matter more here than in states with competing plans.

Where Colorado starts

- **The ACC is the main delivery system.** It began in 2011. Phase II (2018) created seven RAEs, combining physical health care coordination with the capitated behavioral health benefit.
- **ACC Phase III began July 1, 2025, with four regions:** Region 1, Rocky Mountain Health Plans; Region 2, Northeast Health Partners; Region 3, Colorado Community Health Alliance; and Region 4, Colorado Access. Denver Health Medicaid Choice remains a capitated managed care plan alongside them, and all members were reassigned under the new boundaries at launch.
- **What a RAE does.** RAEs administer capitated behavioral health, build and support primary care networks, and coordinate care. They do not administer the physical health benefit: HCPF keeps benefit policy, coverage rules, and fee-for-service payment.
- **One entity per region.** Members are assigned to the RAE for where they live; they do not choose among competing RAEs.
- **BHASOs sit beside the RAEs.** The Behavioral Health Administration's Behavioral Health Administrative Services Organizations, which also started in July 2025, manage safety-net behavioral health services outside Medicaid, in regions drawn to align with the RAE map.
- **Accountability tools already exist.** HCPF monitors RAEs through contract deliverables, performance standards, key performance indicators, and a Phase III evaluation plan. Line 19 would add published, entity-by-entity results across both RAEs and BHASOs. The section on RAE performance measures below looks at how much is at stake and what happens when a RAE falls short.

Models in other states

State	Regions	Contractors per region	What the regional entity is responsible for	Notes
Colorado	4 (since July 2025; 7 before)	One RAE; Denver Health Medicaid Choice also in the metro area	Capitated behavioral health, care coordination, and primary care network support; physical health paid fee-for-service	BHASOs cover non-Medicaid behavioral health in aligned regions
Oregon	16 coordinated care organizations (CCOs), each with a defined service area	Usually one per area	Full risk for physical, behavioral, and dental care under a global budget; local governance with community advisory councils	Since 2012; 3.4% annual per-person growth target; quality pool tied to published metrics
North Carolina	Standard Plans: statewide plans plus regional provider-led plans; Tailored Plans: one per county	Standard: several; Tailored: one	Tailored Plans serve people with serious mental illness, substance use disorder, intellectual or developmental disability, or brain injury, covering physical health, behavioral health, and pharmacy	Behavioral health entities consolidated from six to four before Tailored Plans launched July 1, 2024, after repeated delays

State	Regions	Contractors per region	What the regional entity is responsible for	Notes
Arizona	3 geographic service areas (North, Central, South)	Several integrated plans per area; one plan per area also holds the regional behavioral health contract for people with serious mental illness	Integrated physical and behavioral health since October 2018	Service areas realigned in 2022 so all programs share one map
Washington	10 regional service areas	Several integrated managed care plans per region, plus one behavioral health administrative services organization per region	Plans carry physical and behavioral health; the regional behavioral health organization handles crisis and non-Medicaid services	Phased in region by region, 2016–2020; nine regional Accountable Communities of Health support local planning
Florida and Texas	Florida: 9 regions; Texas: service areas	Several competing plans per region	Full-risk managed care	Large competitive-plan states
Connecticut	No regions	One statewide administrative services organization per service type	Non-risk care management and utilization management; the state pays claims	See the separate Connecticut briefing

Arizona and Washington are the closest parallels to Colorado's BHASO arrangement: both pair integrated health plans with a separate regional entity for crisis and safety-net behavioral health. Oregon is the closest parallel to the idea of one locally governed entity per region.

What the evidence shows

- **Oregon.** The independent evaluation by Oregon Health & Science University found that Coordinated Care Organizations (CCOs) slowed spending growth in the early years, mainly through lower inpatient and outpatient spending and a shift toward primary care; one analysis found a 4.2% per-person reduction in service spending. Whether Oregon has held to the 3.4% annual per-person growth target depends on the measure. CCO capitation rates have generally been set at the target, but the state's report of total spending showed growth above 3.4% in all but one year after 2013-14, and in 2019 the state trimmed CCO quality bonuses to stay near the target. Growth also varies widely from one CCO to another.
- **Washington.** Washington integrated physical and behavioral health managed care region by region between 2016 and 2020. The first region (Clark and Skamania counties) showed early gains in its first year, but later evaluations did not confirm them: a 2023 peer-reviewed study found integration was disruptive to behavioral health providers and produced no sustained change in mental health access, and the state's independent final evaluation (approved by CMS in 2025) found no substantial changes in access, use, or quality, and no evidence that enrollees were worse off.
- **North Carolina.** The 2023–24 consolidation was meant to get Tailored Plans launched after repeated delays and to reduce the number of entities providers must contract with. Tailored Plans are too new for outcome results; the state has acknowledged open questions about board representation across larger regions. For context, North Carolina moved most members into five competing Standard Plans in July 2021, then launched Tailored Plans on July 1, 2024, run by the four remaining regional behavioral health entities (Alliance, Partners, Trillium, and Vaya), with about 220,000

members at launch; after consolidation, Trillium alone serves 46 eastern counties. The state's interim evaluation of Standard Plans (November 2019 to February 2023, pending CMS review) found 8 of 35 broad quality measures improved, 12 unchanged, and 15 worse, with per-member spending in many areas below projections but emergency department spending up. The evaluators caution that the period overlapped the pandemic and had no comparison group. Since 2024 the state has withheld part of each Standard Plan's capitation, returned only if the plan meets quality targets, and it plans similar withholds for its other plans.

- **Arizona.** Integrating physical and behavioral health in one plan per member is the core of its design; AHCCCS reports more than nine in ten members in managed care. Published comparisons isolating the effect of its regional map are limited. AHCCCS Complete Care has integrated physical and behavioral health since October 2018, with several plans in each of three service areas and one plan per area also holding the regional behavioral health agreement for people with serious mental illness. Arizona ties money and escalating steps to performance: AHCCCS withholds part of each plan's payment and returns it based on scores against benchmarks, redistributing unearned amounts to plans that achieved or improved, and it can issue notices of concern, notices to cure, corrective action plans, and sanctions. Having the tools is not the same as using them: a 2023 Auditor General report found AHCCCS had not reviewed contracted health plans on schedule. Procurement, the ultimate consequence, has also proved hard to use. A 2023 award narrowing long-term care to two statewide plans was protested, replaced in a 2025 settlement with four plans, and then terminated, with a new procurement planned for 2026.
- **Florida and Texas.** Both use several competing plans per region and have used procurement to narrow the field. Florida's contracts that took effect in February 2025 cut its regions from eleven to nine, with some plans statewide and others regional, and its new program builds quality incentives into payment. Texas limits each of its 13 service areas to four plans and puts up to 3% of a plan's capitation at risk on quality measures, but its latest attempt to re-award contracts, its third, was blocked by a court in October 2024 after losing bidders sued.
- **Michigan.** Michigan is the closest parallel to consolidating Colorado's behavioral health entities. Ten public regional prepaid inpatient health plans manage about $4.9 billion in Medicaid behavioral health. In August 2025 the state issued its first competitive procurement for them, consolidating ten regions into three, saying the change would address problems that compromise quality, accountability, and efficiency; none of the existing entities could bid. A court upheld the state's authority to reduce the number of regions but in January 2026 found the request for proposals conflicted with state law, and the state withdrew it on January 29, 2026. The ten-region structure remains.
- **Across states.** There is no strong evidence that a specific number of regions or entities lowers cost on its own. Fewer entities reduce provider administrative burden and create larger risk pools; more entities preserve competition and local relationships. A small number of national companies already hold a large share of Medicaid managed care enrollment, so consolidation can increase dependence on a few contractors.
- **Colorado.** Phase III is about 16 months old. HCPF's Phase III evaluation plan is the natural place to measure whether the move from seven regions to four has reduced provider burden or changed results.

RAE performance measures: are they meaningful, and what happens when they are missed?

RAEs already have performance measures. The more useful question for line 19's examination is whether those measures track what matters to members, providers, and the budget, and what happens to a RAE that misses them.

- **What exists now.** HCPF withholds part of each RAE's care management payment and returns it through key performance indicators and a performance pool; a separate pool funds the Behavioral Health Incentive Program. Phase III RAE-only measures cover behavioral health assessment after release from state prison, prenatal and postpartum care, transitions of care, and primary care practices' clinical results, and the behavioral health program adds five follow-up and screening measures. About 50 contract performance standards, such as resolving 95% of appeals within 10 business days, sit alongside them, and an external quality reviewer audits each RAE's compliance every year and requires corrective action plans for findings.
- **Is the money meaningful?** In Phase II, a RAE could earn up to $4.43 per member per month for performance. The incentives draw on the care management payment, not the much larger capitated behavioral health payment, so the share of a RAE's revenue at stake is small. Texas, by comparison, puts up to 3% of capitation at risk, and Arizona and North Carolina withhold part of capitation itself.
- **Are the measures meaningful?** Several standards measure process (staff training, timeliness) rather than outcomes, and the most recent published results are still from Phase II because of data lag. Problems providers raised this fall – members reassigned between regions mid-treatment, networks closed at capacity, and the same therapy session paid differently by region – are not clearly captured by current measures.
- **What happens when a RAE misses?** Under Phase III, a RAE that meets fewer of its contract standards must reinvest more of its profit margin in the program: nothing at 90% or more, rising to 25% below 80%. That money stays in the program, so it works as a redirection. HCPF's public performance page does not describe sanctions or liquidated damages. With one RAE per region, the state cannot move members to a competitor, which leaves replacing a RAE at procurement – a disruptive step – as the main consequence beyond money.
- **What other states pair with measures.** Escalating steps (notice, a cure period, a corrective action plan, then financial sanctions), capitation withholds a plan must earn back, and published plan-by-plan results. Arizona, Texas, and Michigan show that procurement, the last resort, is slow and legally fragile, which is why the earlier steps matter.

Lessons and questions for Colorado

1. **Separate the count from the job.** What a regional entity is accountable for (risk, integration, care coordination, network) has shown more effect than how many entities there are.
2. **Standardize what providers feel.** Prior authorization rules, forms, credentialing, billing, and quality measures that differ by entity are what make multiple entities costly for providers. Standardizing these does not require changing the map, and it was a stated goal of Phase III.

3. **Publish results by entity.** Oregon publishes CCO-level measures and ties a quality pool to them; Arizona and Washington report by plan. Comparable, public results are the basis for any later decision about the number of entities, which is the approach line 19 adopted.
4. **Make measures count.** Tie a meaningful share of payment to a small set of outcome measures that reflect what members and providers experience, publish results by entity on a timely schedule, and write an escalating set of consequences into the contract – corrective action, withheld payment that is not returned, and financial sanctions – before replacement at procurement.
5. **Balance rural scale with local relationships.** Oregon uses community advisory councils, and Washington uses regional Accountable Communities of Health, to keep local voice inside larger structures. North Carolina's consolidation raised board representation questions that Colorado would also face.
6. **Count transition costs.** Every remap reassigns members and providers, as happened in Colorado in July 2025, and North Carolina's launch was delayed repeatedly while networks were built.
7. **Mind contractor risk.** The fewer the entities, the more depends on each one. States with competing plans usually keep at least two per area; states with one entity per region rely on strong contract standards and the ability to replace a contractor at procurement.

Questions the examination could answer: How do the four RAEs and the BHASOs compare on cost (including administrative payments), quality, and provider experience? Which processes differ across entities in ways that add provider cost? Are RAE and BHASO boundaries and responsibilities fully aligned, and where do members fall between them? How do rural members and providers fare under the four-region map? What standardization requirements should go into the next procurement? Which RAE measures track outcomes members and providers notice, and what share of RAE revenue depends on them? What happened to RAEs that missed targets or standards in Phase II, and what consequences short of rebidding should the next contracts include?

Sources

- HCPF, Accountable Care Collaborative Phase III, Phase III RAE region fact sheet (December 2023), draft contract top takeaways, behavioral health provider fact sheet (October 2025), member communications toolkit, and June 2025 subcommittee minutes on monitoring
- HCPF, Commission package for August 27, 2026
- Commission record of decisions, November 10, 2026 (line 19)
- Oregon: PMC article on CCOs; The Actuary, Oregon Medicaid transformation; Becker's, Is Oregon's Medicaid reform plan working?; The Lund Report, Is Oregon holding to a 3.4% cap? and 2019 spending goals; OHA, 2024 risk-adjusted rate of growth memo
- North Carolina: NC Health News, consolidation order; NC Medicaid, contracting with Tailored Plans; WFAE, Tailored Plan launch; Carolina Public Press, board representation
- Arizona: AHCCCS, AHCCCS Complete Care, service area realignment, and behavioral health services; AHCCCS overview to the Oregon Legislature
- Washington: CHCS, Washington's transition to integrated care; CHCF, summary; DSHS, Southwest Washington first-year evaluation; HCA, integration savings report
- Health Affairs Forefront, Medicaid managed care market concentration (January 2025)
- Colorado performance measures: HCPF, ACC program performance, Accountability in ACC Phase III (September 2025), and Phase III quality program (December 2024); Commission office hours summary, October 5, 2026

- North Carolina (added): NC Medicaid, managed care interim evaluation, 2026 Standard Plan withhold guidance, and 1115 monitoring report, May–July 2024; WFAE, Tailored Plan launch
- Arizona (added): AHCCCS, withhold and quality incentive policy (ACOM 306) and sanctions policy (ACOM 408); Arizona Auditor General, Report 22-112; The Hertel Report, ALTCS-EPD awards terminated (September 2025)
- Florida and Texas: Florida AHCA, new SMMC regions and SMMC 3.0; Texas HHSC, Medical Pay-for-Quality Program; Becker's, Texas procurement limits; KERA, court halts Texas awards (October 2024)
- Michigan: Open Minds, first competitive PIHP procurement; Michigan Court of Claims, Region 10 PIHP v. MDHHS (October 2025); Bridge Michigan, state withdraws procurement (January 2026)