MEDICAID ACO LANDSCAPE

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EXECUTIVE SUMMARY

In 2015, Leavitt Partners published an assessment of the rise and future of Medicaid accountable care organizations (ACOs). At that time, Medicaid ACOs covered about 3.8 million lives and the Medicare ACO program created by the Affordable Care Act (ACA) and the Medicare Shared Savings Program (MSSP)—the largest ACO program—was only three years old. In 2019, Leavitt Partners is reevaluating the Medicaid ACO landscape to examine what has changed and how Medicaid ACOs compare to their Medicare and commercial counterparts. Although Medicaid ACOs showed promising early quality and financial outcomes, they have not grown to the extent expected in 2015, either in terms of the number of lives covered or the number of ACO contracts.

BACKGROUND

In 2015, Leavitt Partners examined and commented on the rise and future of Medicaid ACOs. The 2015 paper noted that the “jury was still out” on the efficacy of Medicaid ACOs. In this paper, we revisit the Medicaid ACO landscape to identify what has changed over the last several years and to better understand how the landscape of Medicaid ACOs and compares to those of their Medicare and commercial counterparts. Previous research has generally focused on either the growth and spread of all ACOs or has focused on state-specific approaches to Medicaid ACOs. This paper complements the existing research by providing a variety of stakeholders including policymakers, state officials, providers, payers, and researchers with insight into the number, geographic dispersion, characteristics, and success to date of Medicaid ACOs.

As of the end of 2018, 13 states had implemented Medicaid ACO programs, up from nine in 2016 (Figure 1). Although the number of state Medicaid ACO programs has grown by over 40 percent, the number of Medicaid ACO contracts and covered lives remains low compared to Medicare and commercial ACOs. Medicare ACOs covered over 11.2 million lives in 2018 (29 percent of the traditional Medicare population), whereas Medicaid ACOs only cover 3.7 million lives (5 percent of the Medicaid population). Since the creation of the MSSP in 2012, Medicaid ACOs have not proliferated to the same extent as their Medicare and commercial counterparts. Even so, early evaluations indicate that Medicaid ACOs remain a promising way for states to reduce costs and provide more coordinated care for their Medicaid populations, although more studies would be useful to assess longer-term results.
DATA

For this analysis, we used ACO data from the Leavitt Partners Torch Insight database. All data was current as of the end of 2018.

Figure 2: Total Number of Medicaid ACOs by Payer

FINDINGS

Number of ACO and ACO Contracts

Medicaid ACOs, defined as ACOs with at least one Medicaid contract, make up only 8 percent of all ACOs. Of the 1,013 ACOs that existed at the end of 2018, only 86 were Medicaid ACOs (Figure 2). By comparison, there were 647 ACOs with at least one Medicare contract and 477 ACOs with at least one commercial contract.

TOTAL NUMBER OF ACOS BY PAYER

The total number of ACOs displayed in this graph (1,510) exceeds the total number of ACOs that existed at the end of 2018 (1,013) because of ACOs that have contracts with multiple payers.

1 Torch Insight™ is a proprietary, cloud-based health care market analytics platform and compendium of unique health care data. For more information, visit www.leavittpartnersinsight.com.
Measuring the change in contracts over time represents another way to assess the movement of ACO activity. As shown in Figure 3, the number of Medicaid ACO contracts has not grown at the same rate as the numbers of either Medicare or commercial ACO contracts.

**Figure 3: Accountable Care Contracts Over Time**

![ACO CONTRACTS OVER TIME](image)

MEDICAID ACO ENTRANTS AND EXITS

Examining ACOs that have entered and exited Medicaid ACO programs provides another level of insight into Medicaid ACO trends. Figure 4 shows new Medicaid ACO entrants and dropouts over time. Entrants are defined in this graph as ACOs that gained one or more Medicaid contracts that did not previously have any, while dropouts are Medicaid ACOs that dropped all their Medicaid contracts in the given year. The observation of 28 entrants in 2012 is likely due in part to Oregon’s implementation of its coordinated care Medicaid program and other states beginning large accountable health programs. The net annual increase of Medicaid ACOs has been lower and quite variable since 2012. In 2018, 16 new Medicaid ACOs entered the market, while five Medicaid ACOs ended or dropped out of all Medicaid contracts that year. The variability in entrants and exits is likely due to the start and end of various programs at the state level, including the end of Illinois’ ACO program and transitions to new state programs such as the MassHealth initiative. Most ACOs that left the market during this time period were Medicaid-only ACOs; only two of the 17 dropouts had other contracts outside of Medicaid.

**Figure 4: Medicaid ACO Entrants and Dropouts**

![MEDICAID ACO ENTRANTS, DROPOUTS](image)
Figure 5 looks at entrants and exits from a different metric. Instead of examining new Medicaid ACO entrants and those that dropped all Medicaid ACO contracts (Figure 4 above), Figure 5 shows Medicaid ACO payment arrangement starts and stops. What this means is that a Medicaid ACO may have ended one or more Medicaid payment arrangements but did not drop all Medicaid contracts. Despite there being more ACO dropouts, there was still a net increase in contracts, indicating that the ACOs that are staying in Medicaid are maturing and taking on more contracts.

**Figure 5: Medicaid ACO Payment Arrangements Starts and Stops**

<table>
<thead>
<tr>
<th>Year</th>
<th>Started</th>
<th>Ended</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>6</td>
<td>-3</td>
</tr>
<tr>
<td>2012</td>
<td>32</td>
<td>-1</td>
</tr>
<tr>
<td>2013</td>
<td>12</td>
<td>-8</td>
</tr>
<tr>
<td>2014</td>
<td>16</td>
<td>-13</td>
</tr>
<tr>
<td>2015</td>
<td>16</td>
<td></td>
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<tr>
<td>2016</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>27</td>
<td></td>
</tr>
</tbody>
</table>

**COVERED LIVES**

At the end of 2018, Medicaid ACOs covered an estimated 3.7 million lives while Medicare and commercial ACOs together covered 30.2 million lives. Covered lives is important for gaining critical mass for change in care delivery, which is an important success factor for ACOs. While Medicaid ACOs cover fewer lives than Medicare and commercial ACOs, those lives tend to be more concentrated across fewer contracts, giving Medicaid ACOs greater scale in the markets where they operate.

**CONTRACTS**

An examination of Medicaid ACOs’ contracts provides a more granular view into different ACOs’ engagement with accountable care. Medicaid contracts have the highest number of lives per contract, at 43,500 on average, compared to Medicare contracts at 17,500 and commercial contracts at 24,300 lives on average. The majority of Medicaid ACOs (60 percent) only have 1 contract (their Medicaid ACO contract), and another 22 percent have two contracts.
Figure 6 shows the breakdown of Medicaid ACOs and contracts by payer. Medicaid ACOs are more likely to also have both Medicare and commercial contracts. This shows that providers participating in accountable care are often active in several different types of contracts, suggesting that the care delivery changes within a practice to serve one population may be more successful when they scale to other populations as well.

**Maturity**

One of the reasons an ACO’s number of contracts matters is because it is an indication of the ACO’s maturity. A high number of active contracts signals an ACO’s desire and readiness to assume responsibility for a patient population. If Medicaid ACOs with more than one contract across several payers commit more of their revenue through value-based contracts than through fee-for-service, it may be an indication that those ACOs are more committed to value and are making the meaningful care delivery changes that are required to successfully improve outcomes and lower costs. This measure of maturity also distinguishes between ACOs “in name only” and those that tie a meaningful amount of their revenue to value-based contracts. Figure 7 shows the average maturity score for active payment arrangements.

All else equal, we would expect ACOs with more than one type of contract to have higher maturity scores, since the maturity score depends in part on the number of active contracts. By definition, a Medicare-only ACO has only one contract, while an ACO with two contract types has more than one. That said, there are other factors involved, so differences may still be meaningful if they are large enough.
GEOGRAPHIC DISTRIBUTION

Figure 8 shows the penetration of Medicaid ACOs in each state. Colorado and Massachusetts have the most lives covered by a Medicaid ACO out of all the states. Minnesota, Ohio, Oregon, Utah, and Rhode Island also have high numbers of lives covered in Medicaid ACOs.

Figure 8: Medicaid ACO Covered Lives, in 1,000s
ACOs by Sponsoring Entity Type

ACOs are provider-led organizations by definition. The sponsoring entity of an ACO may be a physician group, hospital, or both. The sponsoring entity matters because ACOs face different enabling and challenging factors based on which type of provider is the sponsor. For example, physician-led ACOs may be best positioned to achieve savings by keeping their patients out of the hospital through better management of their patients’ chronic conditions. Hospitals may have less incentive to reduce hospitalizations but more influence over which post-acute care (PAC) providers care for their patients, which is especially significant given the documented high costs of PAC sites.

In 2018, 21 percent of Medicaid ACOs were physician-led, compared to 33 percent that were hospital system-led, and 46 percent that were led by an integrated physician-hospital system (Figure 9). In comparison, a larger percentage of Medicare ACOs are physician-led (47 percent) and a lower percentage are hospital-led or integrated (21 percent and 32 percent, respectively).

Although not a Medicaid ACO program, research on the MSSP found that physician-led ACOs are more likely to save money. An analysis of the 2017 MSSP results found that physician-led ACOs on average saved $69 per beneficiary, integrated ACOs saved $42 per beneficiary, and hospital-led ACOs averaged net losses of $26. Understanding the proportion and nature of Medicaid ACOs that are physician group-led, hospital-led, or integrated can help policymakers know how best to support the development of all types of Medicaid ACOs.

Figure 9: Medicaid ACOs by Sponsoring Entity Type

<table>
<thead>
<tr>
<th>Sponsoring Entity Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Group</td>
<td>21%</td>
</tr>
<tr>
<td>Hospital System</td>
<td>33%</td>
</tr>
<tr>
<td>Both</td>
<td>46%</td>
</tr>
</tbody>
</table>

State Accountable Care Models

In a previous paper, Leavitt Partners examined different state approaches to their Medicaid ACOs programs and identified four models (outlined above), depending on whether an MCO operated in the state and the state’s level of involvement with the ACO (Table 1). The fact that states with higher Medicaid ACO activity have different approaches to their Medicaid ACOs indicates that one approach may not necessarily be more successful or appropriate than another. Further evaluation is needed, and the variety in state Medicaid ACOs gives ample opportunity to test different models.

Some Medicaid ACOs operate in states that do not have formal Medicaid ACO programs. These states include California, Florida, Michigan, Missouri, and Ohio. In these cases, providers or other stakeholders in the state are coming together to form Medicaid ACOs, generally contracting with MCOs in some fashion. This is an early indication that Medicaid ACOs are gaining traction and are being considered outside of any state influence or pressure.

As indicated in our previous analyses of Medicaid ACOs, financial savings and patient outcome improvements take time. However, below we highlight several analyses that have found promising financial and patient quality outcome results. For example, Colorado’s ACO programs experienced a net savings of $77 million and lower emergency department rates, high-cost imaging, and hospital readmissions. Similarly, Minnesota realized $213 million in net savings over four years and reduced hospital readmissions and emergency department visits by 14 and 7 percent, respectively. All of Oregon’s coordinated care organizations (CCOs) showed improvements in quality measures. These results are promising and provide an indication of the potential cost savings and quality improvements that ACOs are intended to make.
Our examination of Medicaid ACOs indicates that substantially fewer Medicaid ACOs exist and growth in covered lives has been slow compared to Medicare or commercial ACOs. However, there is some evidence to suggest that, although fewer in numbers, Medicaid ACOs are on average more mature than either Medicare or commercial ACOs. ACO maturity matters because it is one indication of an organization’s engagement with and commitment to accountable care. It indicates that ACOs are making the type of care delivery changes that meaningfully impact outcomes and costs.

The discrepancy in number of lives covered by Medicaid ACO contracts and their Medicare and commercial counterparts is important to understand in the context of the joint federal and state nature of Medicaid. Because Medicaid is a jointly-funded program administered by the states, the Centers for Medicare & Medicaid Services cannot implement a large Medicaid ACO program equivalent to the Medicare Shared Savings Program or compel states to adopt such a model. Some states, such as Oregon and most recently Massachusetts, have shown considerable enthusiasm and initiative for Medicaid ACOs while many have not. The joint funding of Medicaid introduces other challenges as well for Medicaid ACOs, including how to allocate the percentage of program savings that should go to the state versus federal government.

Characteristics of the Medicaid population also introduce unique challenges for Medicaid ACOs. Medicaid beneficiaries often have greater need for behavioral health support and are more likely to struggle with social determinants of health (SDOH) concerns, such as income, housing, food, and transportation insecurities. Additionally, compared to Medicare and commercial enrollees, Medicaid beneficiaries are more likely to “churn,” or to cycle on and off Medicaid. Not only does this churn complicate ACO attribution efforts, but it also undermines the opportunity for long term investments in prevention and chronic disease management that can result in care savings. In addition, Medicaid ACOs are more likely to encounter individuals who may go for long stretches of time without health insurance and have pent-up health care needs when they do regain Medicaid coverage. Each of these considerations contributes to the substantial challenges of launching and maintaining an effective Medicaid ACO.

These challenges also demonstrate the significant need among the Medicaid population for the care delivery changes that ACOs are intended to facilitate, including better population health management and care coordination. Medicaid beneficiaries often have high health care needs and low health literacy. The right care delivery interventions have the potential to substantially lower costs and improve the health of this population. Some Medicaid ACOs have attempted this through addressing social determinants of health, such as access to healthy food. For example, Colorado requires contractors to establish relationships with community-based organizations, Rhode Island’s Accountable Entities require screening for and addressing social determinants of health, and Massachusetts risk adjusts ACOs’ rates and cost targets based on stability of housing status.

While significant growth in Medicaid ACOs and covered lives has been slow, a growing collection of research demonstrates promising results across different states’ ACO programs. For example, one study found that Oregon’s establishment of its CCO Medicaid ACO program in 2012 was associated with a seven percent relative reduction in expenditures across a number of services, which the authors primarily attribute to a reduction in inpatient utilization. A different study evaluated Oregon’s CCOs and Colorado’s Medicaid ACO programs and found successes in both programs. As indicated above, 15 of Oregon’s 16 CCOs earned 100 percent of their potential quality pool bonuses and Colorado’s ACO programs experienced a net savings of $77 million. The positive outcomes of Oregon, Colorado, and other states should serve as an encouragement for other states considering a Medicaid ACO program.
POLICY IMPLICATIONS

A growing collection of research has identified promising results in some early ACO programs across states. Policymakers and state officials can learn from the maturity and other characteristics of successful ACOs as they decide whether and how to implement or improve Medicaid ACO programs in their states.

Moderate to high levels of Medicare and commercial ACO activity in a state may indicate that providers are already making progress with the care delivery changes and information technology infrastructure needed to achieve success as an ACO. Such a state may be well positioned to launch a Medicaid ACO program, which would support providers in reaching a critical mass of ACO patients needed to create system-level change. Conversely, states with low ACO activity across payers may need more up-front investments and a higher number of Medicaid lives in order to support their provider communities’ transition to a Medicaid ACO program.

CONCLUSION

Since our examination of the rise and future of Medicaid ACOs in 2015, Medicaid ACOs have not significantly expanded across the country as we may have expected. While we have seen a small increase in states with Medicaid ACOs over the last several years, the number of Medicaid ACOs and Medicaid ACO-covered lives continues to lag behind Medicare and commercial ACOs. However, positive financial and quality health outcomes in early Medicaid ACO programs should be encouraging for states seeking options to improve Medicaid outcomes and costs.

Medicaid ACOs may be particularly attractive in those states whose broader health care ecosystems are transitioning to value and may provide a conducive environment for ACO adoption. Yet more research is needed to give states—and providers aspiring to form Medicaid ACOs—more insight into the policies and characteristics that distinguish successful Medicaid accountable care programs and organizations respectively.
<table>
<thead>
<tr>
<th>State</th>
<th>Approach</th>
<th>Number of ACOs</th>
<th>Quality/ Financial Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>A: State contracts directly with ACO</td>
<td>7</td>
<td>Regional Care Collaborative Organizations (RCCOs) have generated approximately $77 million in net savings; lower rates of ED visits, high-cost imaging, and hospital readmissions.</td>
</tr>
<tr>
<td>Iowa</td>
<td>B: State contracts with the MCO, who then contracts with an ACO selected by the state (SIM Model)</td>
<td>5</td>
<td>In 2014, 51 percent of ACO members achieved at least one healthy behavior and 28 percent achieved both healthy behaviors.</td>
</tr>
<tr>
<td>Maine</td>
<td>A: State contracts directly with ACO</td>
<td>4</td>
<td>Year one results between August 2014 and July 2015 show a 3.16 percent savings in Medicaid costs, netting $4.56 million for the Medicaid program.</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>B: State contracts with the MCO, who then contracts with an ACO selected by the state</td>
<td>17</td>
<td>Launched in March 2018; no results reported to date.</td>
</tr>
<tr>
<td></td>
<td>C: State contracts with the MCO, who then contracts with an ACO with no state involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>D: State contracts directly with the MCO-ACO joint entity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>A: State contracts directly with ACO</td>
<td>16</td>
<td>Savings of $277 million in four years; reduced hospital readmissions by 14 percent and ED visits by 7 percent.</td>
</tr>
<tr>
<td>New Jersey</td>
<td>B: State contracts with the MCO, who then contracts with an ACO selected by the state</td>
<td>3</td>
<td>Launched in 2011, no results have been reported to date.</td>
</tr>
<tr>
<td>New York</td>
<td>B: State contracts with the MCO, who then contracts with an ACO selected by the state</td>
<td>Unknown; began with 11</td>
<td>Launched in 2016, no results reported to date.</td>
</tr>
<tr>
<td>Oregon</td>
<td>A: State contracts directly with ACO</td>
<td>16</td>
<td>All CCOs showed improvement in quality measures (15 of 16 earned 100 percent of their potential quality pool bonuses).</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>B: State contracts with the MCO, who then contracts with an ACO selected by the state</td>
<td>5</td>
<td>Between July 2016 and June 2017, Accountable Entities (AEs) generated nearly $3.2 million in savings.</td>
</tr>
<tr>
<td>Utah</td>
<td>D: State contracts directly with the MCO-ACO joint entity</td>
<td>4</td>
<td>Launched in 2013, no results have been reported to date.</td>
</tr>
<tr>
<td>Vermont</td>
<td>A: State contracts directly with ACO</td>
<td>2</td>
<td>In the first year of Vermont’s Medicaid Shared Savings Program (VMSSP), the state reported savings of nearly $14.6 million.</td>
</tr>
</tbody>
</table>