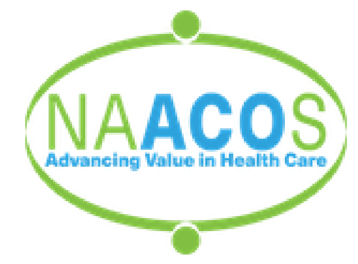


Independence, Partnership, or Outside Capital? How ACOs and Value-based Care Providers Are Responding to Consolidation

Chair: Stephen Nuckolls, Coastal Carolina Quality Care

Independence, Partnership, or Outside Capital?

How ACOs and Value-Based Care Providers Are Responding to Consolidation

April 24, 2026

Who is CCPN?

Community Care Physician Network (CCPN)

- Largest integrated network of ***independent*** physicians in North Carolina
  - Over 4,100 providers; 1,100+ practice locations; 420+ groups
- Not-for-profit and 100% physician led and managed
- Provides the resources, support, and alignment to manage medical practices at the highest levels.
- Focuses on collaboration and a dedication to improving quality and proving value to payers and patients (Value-Based Care)
- Shares best practices for practice administration and management

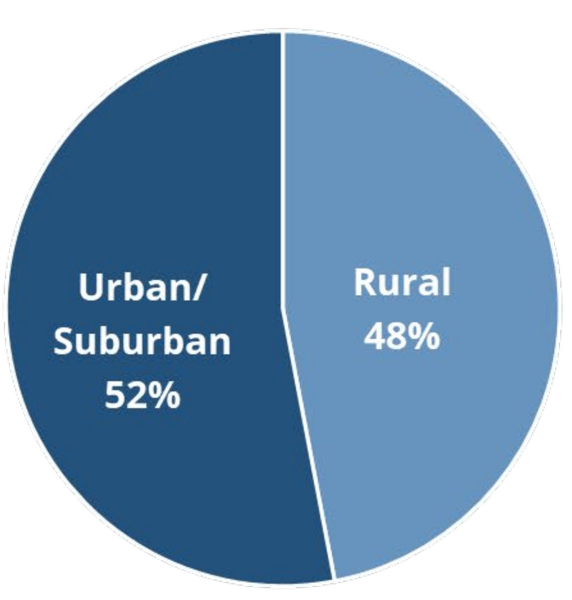
Who is CCNC?

Community Care North Carolina (CCNC)

- Mission is to support community-based Primary Care Physicians
- Management Services Organization (MSO) that supports CCPN
- Longest running medical home system in the U.S. – over 30 years!
- Currently manages over 800,000 NC Medicaid patients
- Supports primary care practices to more effectively manage patients:
  - Care management (nurses, pharmacists, social workers, etc.)
  - Disease management programs
  - Population health expertise

CCPN Statewide Scope and Infrastructure

Practice Locations	Practice Groups	Clinicians
1,136	426	4,130



CCNC MSO Services and Practice Support

Revenue Cycle Management
Front end, charge capture, billing, coding, denial management, AR follow up, patient collections, provider enrollment & credentialing, and KPI monitoring

Accounting/Finance
Monthly financial statements, accounts payable, budgeting, forecasting, cash flow management, variance analysis, and performance benchmarking

Human Resources Oversight
Employee handbook review, payroll, benefits administration, recruitment & staffing, labor law adherence, conflict and grievance resolution

Contracting and Negotiation
Payer contract negotiation, CIN and ACO participation, value-based care (VBC) arrangement management.

Practice Engagement
50+ statewide practice support staff including Practice Managers, Medical Directors, Quality, Coding, and EHR Support

Care Management
350+ care managers across 97 counties (RN/LCSW/CHW, pharmacists, behavioral health), CM programs, disease registries

Population Health
Technology infrastructure, Innovaccer platform (1.2M lives), data analytics & reporting, ADT feeds, integrated with 130+ EMRs

Partnership Options
Comprehensive suite of transition and partnership options, including succession planning; full acquisition, medical groups, and MSO services

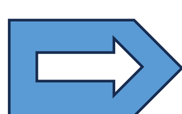
Choosing the Right Path

The question of the impact of consolidation ultimately is determined by the uniqueness of each organization

Primary Consideration

What problem are you trying to solve?

Identify the core challenge driving your decision



Secondary Consideration

What are you giving up or risking to solve it?

Understand trade-offs before committing

What Problem Was CCNC Trying to Solve?

Identifying a partner for a Medicare ACO Offering

Despite significant infrastructure and VBC experience, gaps existed within CCNC

Medicaid-First Infrastructure

Primary experience was 800K Medicaid lives and some commercial — not Medicare

Multiple ACO Options Needed

Required both MSSP and ACO REACH pathways for practices

New Platform Implementing

Innovaccer population health platform contact just signed and being implemented

Insufficient Member Volume

Late market entry required moving practices from existing relationships to hit the 5k threshold to launch our own ACO

No Medicare ACO Experience

First foray into managing and operating a Medicare ACO program

Risk Aversion

Hesitant to accept downside risk — at least initially

What Are You Looking For in a Partner?

CCNC Partner "Wish List"

Proven ACO Track Record

Experience and demonstrated success operating a Medicare ACO

Physician-Aligned Model of Care

Care model designed around and supported by physician leadership

Multiple ACO Pathways

Support for both MSSP and ACO REACH options for practices

Practice Support

Technology platform with dashboards and patient stratification; Coding support focused on 'defensible accuracy'

Data Operations and Reporting

Robust data management and reporting infrastructure

60%+ Provider Payout

Target a high percentage of savings returned directly to providers

CCNC Performance Ringfencing

Willingness to isolate CCNC's performance and limit shared downside risk

Transparent Reconciliation

Clear accounting of gross savings, admin costs, and practice-level vs aggregate splits

What Are You Looking For in a Partner?

Other CCNC Considerations

	Viability	Seek understanding of expected growth plans and potential impact on support; dollars of risk under management, necessary funding, and whether past expenses are being paid with current prepayments
	References	Verify references from current and prior ACO participants about their experience; ideal if you can speak to a reference not recommended by potential partner
	Payment Track Record	Confirm history of timely and correct savings distributions to participants, both monthly payments (if applicable) and reconciled annual savings
	Admin Cost Clarity	Confirm understanding of what services will be provided (care management, technology platform, reporting tools, etc.) and at what costs; and how and when costs are deducted — savings distribution methodology

Decision Framework: Assessing Your Path

Key questions to ask – and what each answer suggests about your strategic fit

> *There is no universally correct answer - only the right answer for your organization's specific circumstances, capabilities, and values.*

How much governance and control are you willing to give up?

Unwilling to cede control --> Independence

Willing to trade control for capital/competencies --> PE Convener

Comfortable in an enterprise operating model--> Public Operator

What is your capital runway to fund VBC infrastructure?

Significant reserves/ strong shared savings--> Independence

Capital constrained; need infrastructure/funding now --> PE Convener

Want greater capital certainty --> Public Operator

How do you prioritize mission vs growth speed?

Mission is non-negotiable --> Independence

Growth or market move is urgent; willing to manage tension --> PE Convener

Mission expressed through scale and outcomes--> Public Operator

What operating capabilities are you missing today?

One or two gaps; can hire, engage or license --> Independence

Multiple gaps; need platform lift now --> PE Convener

Need enterprise infrastructure --> Public Operator

How sophisticated are your payor relationships?

Strong relationships; can negotiate favorable terms --> Independence

Payor leverage is a gap --> PE Convener or Public Operator

Want national enterprise-level contracts --> Public Operator

What is your organization's risk tolerance?

Low tolerance for external uncertainty --> Independence

Trade governance risk to limit financial risk --> PE Convener

Want predictability; greater certainty --> Public Operator

Critical Considerations Across All Three Paths

There is no guarantee of success in any model, but best to be aware of what could go wrong

Independence – What Goes Wrong	PE Convener – What Goes Wrong	Public Operator – What Goes Wrong
Underestimating Build Cost: The internal investment required to build analytics, technology care management, and quality programs is routinely underestimated by 2–3x in time and cost.	**Growth to Failure:** Pursuing hypergrowth without operational rigor strains working capital, limits support and erodes margins - ultimately turning rapid expansion into a fast track to failure.	**Mission Subordination:** Quarterly earnings pressure is real/structural. Investments in community health, relationships, underserved populations get evaluated against shareholder return.
Talent Attrition: Without platform brand or competitive comp, key operational talent (data, leaders, clinical ops) will be recruited away by better-capitalized competitors/offers of equity.	**Platform/Model Immaturity:** Platform capabilities and care models are often still under development and do not yield results as purported. Many highlighted features often 'on the roadmap.'	**Brand and Identity Loss:** Local brand - often the strongest patient retention and physician recruitment asset –gets overpowered by national identity and will be off-putting to some.
Payer Leverage Erosion: As consolidation reduces counterparty options, independent organizations can lose negotiating leverage - particularly in markets where one health system or conveners are dominant.	**Exit Uncertainty:** When the PE firm exits, you have no control over who buys the platform. A strategic acquirer or public company with a different culture may not honor/align with existing philosophies.	**Culture Clash:** Public company operating cadence (dashboards, KPIs, national rollout timelines) conflicts sharply with local culture and priorities.
Downside Risk Exposure: In two-sided ACO models, a single bad year of spending variance can erase years of accumulated shared savings reserves.	**Fee Extraction:** Platform fees (technology, data, coding, care management, etc.) and admin costs meaningfully compress shared savings distributions to practices.	**Earnings Above All Else:** What feels like a stable choice leads to rapid unraveling or abandonment of entire business if earnings are lower than expected.

Commonwealth Primary Care ACO

SPRING . 2026

LANCE DONKERBROOK CEO
COMMONWEALTH PRIMARY CARE ACO

ACO EXECUTIVE DIRECTOR
P3 COMMONWEALTH INNOVATION MSO

About Us

First cohort of Medicare ACOs, REACH in 2024

✅ **Physician-Owned & Governed**

Independent primary care clinicians

✅ **Top-Tier Performance**

100% Quality (2023 & 2024), several years in MSSP too

What Providers Get

Practice Enablement

- CCM, TCM, AWVs
- Consistent workflows across MA & ACOs

Collaboration Model

- Resource sharing
- Competitive, yet collaborative culture

Operational Relief

- Care Management
- Education & compliance support

Our Focus is for Providers. What We Do:

- Maintaining independence is key, provider-owned
- Future goal of being a risk-bearing entity across all payer types, not just ACO
- Excellent care management and value-based care support
- Provide education with HCC capture, AWV, Care Management, and other opportunities
- Anything to assist & lessen the burden for providers, even if not related to ACO specific activities

Our Focus is for Providers - Anywhere

- In 2024 formed a partnership with Coastal Carolina to join our REACH ACO
- We have had another ACO join us in the early years for MSSP
- We think this type of collaboration is a necessary evolution for ACOs like us
- In 2025 created and ACO Management JV with P3 Health Partners
    - Together we have market density throughout AZ for Medicare Advantage and ACO
    - We now have 2 ACO with operations in AZ, CA, NC, NV, OR
    - We have finally proven collaboration and resource sharing works

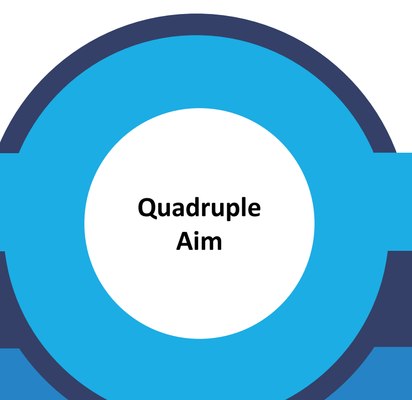
How Do We Continue as Independents?

We need to support the strategic and operational functions of the ACO, it doesn’t get any easier.

- CMS Compliance
- Financial Wherewithal
- Program Governance
- Audit & Reporting
- Vendor Coordination
- Provider Communications

Better Health Outcomes

Lower Health Costs



Improved Patient Experience

Improved Clinical Experience

Clinical and Analytics

What we do for Independent Providers

- Participate in Management and Leadership strategic and operational planning
- Promote culture building and value setting
- Oversee Clinical and Practice Coach Team
- Data analytics:
  - Overall ACO financial performance drilling down to TIN/NPI/MBI
  - Identification of utilization variance against regional national metrics
  - Identification of FWA suspects
  - Performance analysis reported back to the board
- Clinical Interactions with practices / providers
  - Variance in utilization
  - Clinical red-flag identification (e.g. skin substitutes)
- Development and oversight of implementation of Incentive Plan

The Challenge

Why Independence Was At Risk

- No access to capital
- Increasing CMS complexity
- MA-like economics
- Long term sustainability concerns

The Decision

We created a Joint Venture with P3 Health Partners

- Preserve physician ownership
- Share resources without selling
- Scale responsibly

The Outcome

What the JV Enabled (to name a few…)

- ✅ Centralized Analytics
- ✅ Legal, CMS Expertise, Payments & Incentives
- ✅ Access to resources (Financial, Care Teams, etc)
- ✅ No longer bootstrapped

For the Future

- We have a shared mission that provider independence and patient care are the priorities over profit, but is necessary to make a profit to survive and thrive.

- A jointly owned MSO has the purpose of efficiency & management of ACOs. Not just for us, but hopefully others to join us in this pursuit

- It would be extremely daunting to look at a 10 year program like ACO LEAD if we were still doing this on our own

Thank You

Supporting independent primary care offices through Care Management Strategies

Lance Donkerbrook

ldonkerbrook@commonwealthaco.com

602-492-8388

Commonwealth Primary Care ACO

Mosaic Health Partnerships NAACO's Spring 2026

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Mosaic Health Vision

Mosaic Health is a national care delivery platform focused on expanding access to comprehensive primary care for consumers with coverage across all populations

Community clinic, employed PCP model with capability to rapidly acquire and integrate new providers

200+ clinics ~1,000 Providers across 4 geographies • 900k total patients • 4,100 team members

Navigation and primary care clinics in partnership with employers and health plans; designed for Commercial

30 clinics in 12 geographies • 75k total members • 900 team members

Fully delegated, clinic + IPA model focused on high-cost, high-needs seniors; largely focused on the west coast

25 clinics in 7 geographies • 56k total members • 1,300 team members

1. **Multi-LOB Risk:** Able to take full-risk across both Commercial (FI, ASO, ACA) and Medicare populations (both Medicare Advantage and ACO REACH)
2. **Broad clinical model:** Clinical model covers full spectrum from high-risk patient model to community practices and purpose-built clinics to virtual care and digital navigation – able to deploy best solution for each member
3. **National scale:** Operations in 17 states today, with rapid expansion plans into new states – ability to partner at scale with payors and employers

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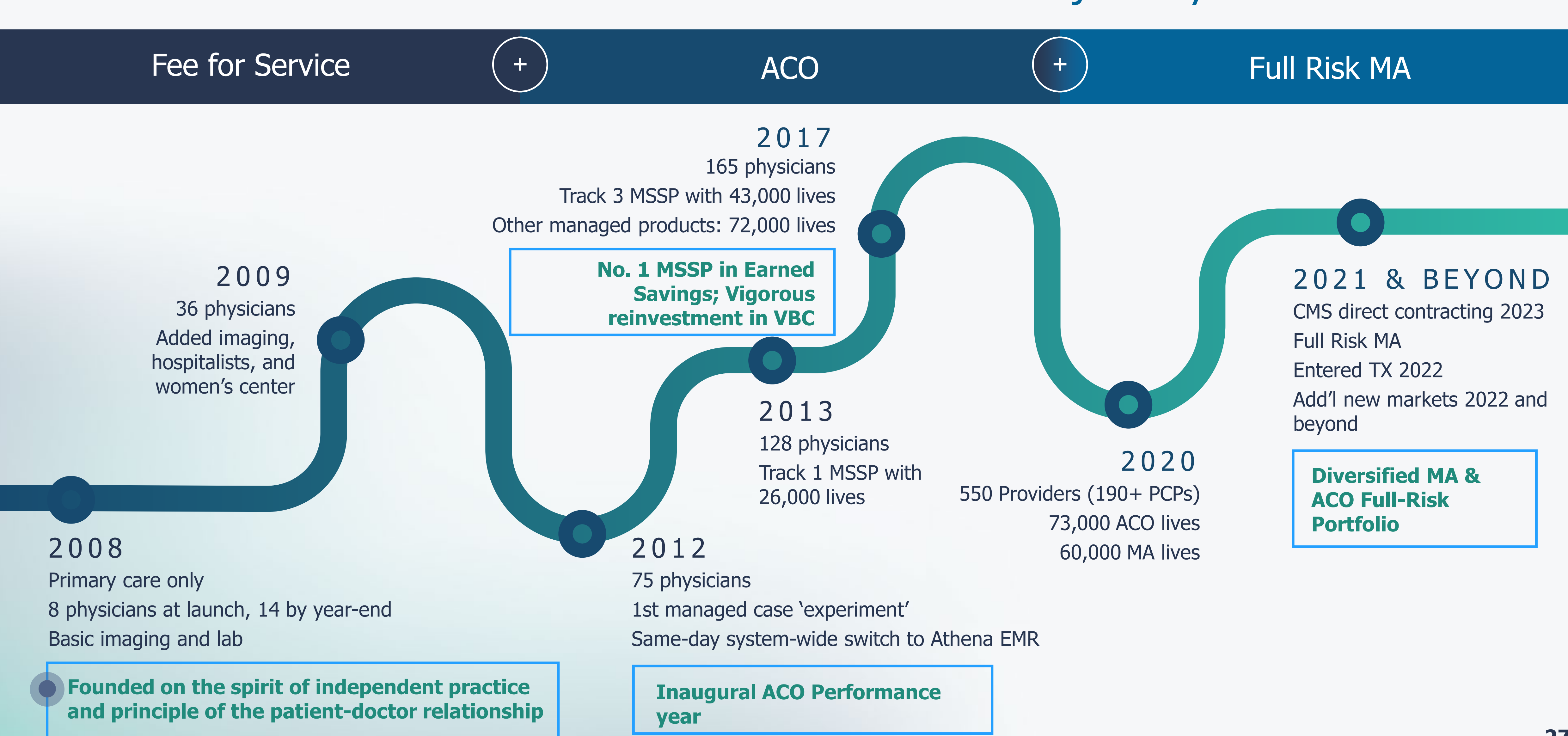
The MPG Model Has Evolved Over Time

… which means we can take others on the journey too



~1000 Total Physicians & Advanced Providers	**~700** Primary Care Providers
25 Specialties	**180+** Specialists
110+ Hospitalists	**740K** Patients
200+ Healthcare Locations	**10+** Walk-In Centers

MPG ACO Historical Performance

Year	Beneficiary Count	CAGR	Savings Rate	Earned Surplus	PMPY Paid	PMPM Paid	Track
2013	28,957			$ 3,800,089.90	$131	$11	1
2014	36,355		4.9%	$ 7,977,169.00	$219	$18	1
2015	43,959		8.4%	$ 17,636,121.00	$401	$33	1
2016	38,313		6.3%	$ 18,530,680.00	$484	$40	3
2017	41,837		8.9%	$ 29,731,563.00	$711	$59	3
2018	41,803		8.2%	$ 29,044,557.00	$695	$58	3
2019	56,229		8.2%	$ 41,914,673.00	$745	$62	Enhanced
2020	66,651		7.4%	$ 40,667,398.00	$610	$51	Enhanced
2021	69,681		4.0%	$ 24,560,405.00	$352	$29	Enhanced
2022	70,501	10.4%	5.4%	$ 34,087,230.00	$483	$40	Enhanced
2023	72,153	9.6%	8.7%	$ 99,357,263.67	$1,377	$115	REACH
			Ave: 7%	**Total: $347M** **Top 1% all-time**	**Never negative**		

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What Does Mosaic Health Do?

1. Make Medicare more valuable
2. Increase value of the commercial base
3. Make PCP groups more profitable
4. Align physicians in a high-performing network

VALUE CREATION

Accelerate PCP growth

Vision Statement

An integrated care delivery platform focused on expanding access to primary care and producing superior outcomes for patients

Who We Have Worked With

Durham Internal
Medicine Associates

Scion/St. Francis Partnership Case Study

- St. Francis-Emory Healthcare (SF) is a two-hospital system located in Columbus, GA owned by ScionHealth
- St. Francis employed Columbus Clinic physicians to provide primary care services and limited specialty services
- Rationale for spin out:
  - Hospital faced significant PCP losses but feared PCPs joining competition if relationship were terminated
  - Parent Company also faced pressures to pivot to VBC but lacked resources or expertise
- Solution:
  - MPG employed PCPs and entered into a Risk-Based arrangement with St. Francis
  - Governance and Operating structure ensure long-term alignment between MPG and St. Francis

Result: St. Francis eliminates PCP losses and generates new economic stream through Medicare risk

Partnership Models: Overview

CIN 2.0	Co-Sourced Model	Platform Model
Mosaic layers ACO and MA capabilities onto existing PCP infrastructure; can leverage existing ACO assets	PCP assets and staff transition to Mosaic MSO; PCPs remain employed by hospital; PSA to Mosaic	Mosaic acquires assets of PCP group; staff and providers sign employment agreements with Mosaic
1 No change to physician or clinical staff employment	1 PCPs maintain employment at health system	1 PCPs, staff, and physician assets transition into Mosaic wholly-owned group
2 Mosaic leverages existing risk-based infrastructure to enable your physicians to participate in risk	2 Staff transitions to MSO operated by Mosaic (ownership flexible)	2 Hospital recognizes immediate relief on PCP losses
3 Health System and physicians participate in surplus share	3 Health System and physicians participate in surplus share	3 Health System participates in surplus share

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