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Medicaid Reform

OPTIONS FOR NORTH CAROLINA

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1 EXECUTIVE SUMMARY

With the North Carolina legislature actively considering options for Medicaid reform, attention has focused on the distinction between Accountable Care Organizations (ACOs) and Managed Care Organizations (MCOs). Competing reform proposals rely on one, the other, or both of these privatized systems for controlling costs and maintaining quality. This issue brief describes how these two contrasting models have performed, both in North Carolina and in two other states, Oregon and Ohio, that have recently reformed their Medicaid programs.

The main advantage of Managed Care Organizations is their budget certainty. For a fixed fee per person (capitation), MCOs contract to provide all needed care, and so they absorb any budget shortfalls. In contrast, the Accountable Care Organization advantage is a greater focus on quality standards and providing patient-centered care. ACOs are paid primarily on a fee-for-service basis, and are rewarded for reducing costs while maintaining quality. Also, ACOs are controlled by doctors and hospitals, whereas MCOs are typically, but not necessarily, controlled by a for-profit insurance company or corporation.

Other states, Oregon and Ohio for example, have achieved positive results by modifying the traditional features of ACOs and MCOs. Oregon based its Medicaid reform around Coordinated Care Organizations (CCOs), which are mostly nonprofits owned either by providers or by MCOs. These CCOs are focused on quality and are paid for most of their services on a capitated basis. Ohio's reform relies on more conventional MCOs, but pays for some services based on fixed fees for episodes of care. Ohio also ties a percentage of capitated payments to meeting quality goals.

Drawing from experience both in North Carolina and elsewhere, a workable approach to Medicaid reform should combine the best of both MCOs and ACOs by using a fixed-fee payment system that ties payments to quality performance and accountability, and that includes nonprofit and provider-based organizations.

2 INTRODUCTION

Reform of Medicaid has taken on renewed importance in North Carolina in the wake of the Affordable Care Act (ACA). Medicaid is the government health insurance program that covers many, but not all, people in poverty. It is funded jointly by the state and the federal government. The potential influx of additional federal funding has caused many states, including North Carolina, to take a second look at their current Medicaid programs with an eye toward controlling costs and improving quality and efficiency. The Affordable Care Act offers to pay most of the costs of expanding Medicaid to cover several hundred thousand additional people in North Carolina who would otherwise remain uninsured. Legislative leaders, however, insist that Medicaid should not expand until the current program is reformed. This issue brief discusses current ideas for reform in North Carolina.

North Carolina's Medicaid program currently covers 1.8 million people, which is about 18% of the state's population. Over two-thirds of Medicaid recipients are children,

accounting for about half of all NC children. North Carolina's Medicaid program currently costs over \$12 billion a year. The state pays about a third of Medicaid's cost, and the federal government pays for two-thirds. Over the past few years, Medicaid's costs have increased about three percent a year—which is more than general inflation but less than the increases in medical costs generally.

North Carolina's Medicaid program often has budget shortfalls, but these deficits were especially large following the Great Recession, amounting to over a billion dollars a year in the 2010–2012 period. Shortfalls have improved more recently, however, dropping to around \$82 million in 2014, which is about two percent of the state's total spending on Medicaid. Despite this recent improvement, many public officials see even small budget shortfalls as too much, and they wish to reform the system further in order to create a predictable budget that will not unexpectedly draw funds away from other state programs.

The goals of slowing the increase in Medicaid spending and creating a more predictable Medicaid budget have led to a mixture of reform priorities that must be met for any reform plan to be accepted by both the Governor and the General Assembly. Reform efforts now focus on proposals for two different types of private-sector organizations that would receive the bulk of Medicaid funding. One proposal is for the state to contract with Managed Care Organizations (MCOs). Although technically not insurance companies, MCOs are similar to, and often owned by, them; they are private or public entities that are licensed to assume financial risk for providing a full range of normal medical care.

It is this assumption of risk for the cost of services that makes MCOs an appealing option for Medicaid reform. The state would pay each MCO a fixed amount each year, and the MCO would then become responsible for providing or arranging the required medical services. If the MCO's medical and administrative costs come in under budget, the MCO earns a profit, but if costs go over budget, the MCOs must absorb these shortfalls and pay any excess out of their own pockets. Usually, this is done using a "capitated" payment structure. In a capitated system the state pays MCOs a flat amount per person determined in advance, which does not vary according to how much care a person receives. In North Carolina MCOs are non-profit public organizations; however, Medicaid MCOs in a number of other states are owned by national for-profit health insurers.

An alternative reform proposal focuses on Accountable Care Organizations (ACOs). ACOs are a fairly new idea, launched by Medicare, the federal insurance program for those who are elderly or disabled. ACOs have a few defining characteristics: 1) they are composed of and run by health care providers such as hospital and doctors; 2) they use evidence-based medicine, coordinated care, patient-centeredness, and other techniques to improve quality of care; and 3) they share in the savings they achieve. In ACOs providers still receive "fee-for-service" payment (rather than fixed payments per insured patient – or "capitation"), but, unlike a traditional fee-for-service system, ACOs are rewarded for keeping their expenditures low and quality high; ACO payments vary by how well they achieve explicit cost and quality goals.

An ACO can theoretically create as much savings as an MCO, but in its standard form it lacks the MCO's budget certainty. ACOs, however, are expected to have more focus

than MCOs on sustaining and improving health care quality. ACOs also are more popular with providers, as they allow hospitals or doctors more of a leadership role, and free them from the oversight of outside owners or managers.

ACOs and MCOs are not the only options for Medicaid reform, but they are the most prominent, the most visible, and have the most backing in North Carolina. This issue brief describes and evaluates these two options, using the criteria specified by the General Assembly. It has declared that a reform plan must create a Medicaid program that, statewide, has: 1) a predictable and sustainable budget with shared financial risk; 2) a more efficient administration; and 3) defined and measurable goals for quality. This brief will focus mostly on the first and third issues: budget and quality.

Currently, there are three bills filed in the NC Senate proposing different versions of reform: Senate Bill (SB) 568 proposes something akin to ACOs with a capitated payment system and a state-wide quality metric. SB 696 proposes a system where both ACOs and MCOs are capitated and compete with each other. Finally, bill SB 703 proposes a traditional MCO capitated program with no mention of special quality programs.

To evaluate these proposals, this issue brief will: 1) profile ACOs and MCOs currently active in North Carolina; 2) look outside North Carolina to see how Medicaid reform has been attempted in other states; and 3) compare the results that North Carolina and other states have achieved with their unique programs to the General Assembly's goals.

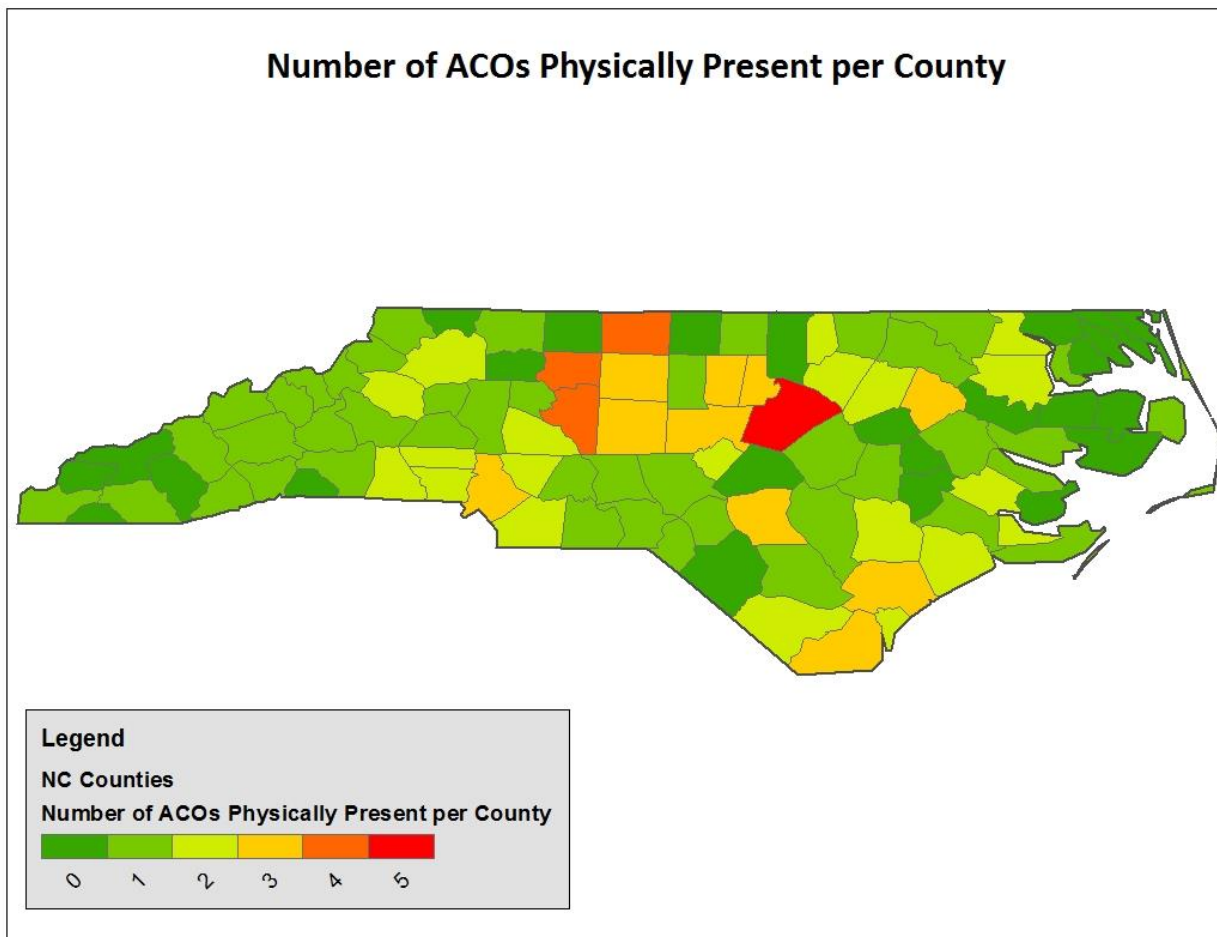
3 ACOS AND MCOS IN NORTH CAROLINA

Both ACOs and MCOs are already present within North Carolina, as part of Medicaid, Medicare, or the private sector. ACOs exist as a moderate but growing number of provider networks that serve both Medicare and private insurance companies. These current ACOs are in early stages of development that are testing new payment methods and quality improvement programs. The MCOs within North Carolina are a group of nine entities formed by local governments that provide Medicaid's mental and behavioral health care services. Divided regionally, these nine mental health MCOs together cover all of North Carolina.

By putting a face to the ACOs and MCOs that are currently active in the state, this issue brief aims for better insight into their strengths and weaknesses in practice. Exploring their characteristics gives us greater understanding of how these organizations might function if handed the responsibility of administering North Carolina's Medicaid program.

3.1 ACCOUNTABLE CARE ORGANIZATIONS

As shown in the map below and Appendix, there are currently about two dozen ACOs operating within 75 North Carolina counties. Because areas currently without ACOs are rural, the covered counties account for about 90% of the state's population. Seventeen of these ACOs meet the requirements to participate in Medicare; the other half dozen are like-minded partnerships and cooperatives. All of them appear to reflect the core ACO goals of accountability for quality, patient-centered care, and provider control of health care.



About half of the Medicare ACOs are led by physician groups, and half by hospitals or hospital groups. In addition, about half have affiliated with an insurance company. For example CaroMont Health is a Medicare ACO centered on CaroMont Regional Medical Center Hospital in Gastonia, and includes a range of other medical facilities and service providers. It has contracted with a larger insurance company, Cigna, for enhanced technical and administrative support rather than building this infrastructure from the ground up. This form of cooperation allows the ACO to be in charge of delivering health care, but uses “care coordinators” provided by the insurance company to monitor individual patients across various interactions with the health care system. In this way, patient records are integrated across all primary care, specialist, and hospital visits for quick in-system access. This promotes patient-centered care and provides patients a medical home. A patient-centered medical home (PCMH) gives patients a central point of contact with a primary care provider who can then treat patients with full coordinated knowledge of their other health care interactions. The goal is more accurate care, increased quality, and increased efficiency by reducing wasted time and redundant tests and procedures. Medical homes also promise better preventative care because the primary physician can track current or potential chronic health conditions.

All of the major private insurers in North Carolina have affiliated with one or more ACOs. Doing so helps achieve two goals: 1) giving the insurance company's beneficiaries access to the ACO provider structure, and; 2) establishing a payment model between the insurance company and the ACO based on quality and value rather than traditional fee-for-service. This development indicates that not only is the ACO model viable for both Medicare and Medicaid patients, but also for private insurers.

North Carolina also has an important organization that is similar to, but not officially, an ACO. Community Care of North Carolina (CCNC) is an award-winning program that focuses on primary care for Medicaid. Covering the entire state, Community Care of North Carolina consists of 14 regional networks of physicians and other care providers, affiliated through a central non-profit organization. Medicaid pays CCNC physicians a flat "capitated" monthly payment to serve as a primary care medical home for enrolled patients, in order to better coordinate and manage their care.

Community Care of North Carolina has many of the hallmarks of a Medicare ACO in that it is physician led, community based, and focused on saving money by increasing the quality of care that a patient receives. CCNC also has a strong focus on care coordination and preventative care. However, Community Care of North Carolina's main focus is on primary care delivery, and its payment structure does not encompass specialist services or hospitalization.

3.1.1 PREDICTABLE AND SUSTAINABLE BUDGET

Given what we know about current ACOs in North Carolina, can the ACO model provide a predictable and sustainable budget for Medicaid? A sustainable budget, maybe, a predictable one, not necessarily. The majority of ACOs in North Carolina still rely on fee-for-service as their primary reimbursement model. As a result, their budgets still fluctuate throughout any given year. Accordingly, the standard Medicare ACO model may generate savings, but the extent of savings is not predictable.

So far, Medicare ACOs in North Carolina have not generated substantial savings. Instead, the eight North Carolina ACOs participating in Medicare in 2012 or 2013 spent an average of \$677,272 *more* than what the federal government estimated that traditional Medicare would have cost. In total, only three of the eight ACOs saved money, but those savings were fairly substantial. While Medicare ACOs have done better in other states, the current North Carolina participants are having trouble hitting their savings stride.

As explained below, the one aspect where Medicare ACOs have performed well is their quality metrics. Many of ACOs' quality goals also have the potential to reduce costs in the long term. However, it is currently unclear whether these quality improvements are actually producing savings; more time is needed to measure the longer-term effects.

The financial sustainability picture presented by Community Care of North Carolina (CCNC) is very different. This network of primary care physicians and other service providers has been part of North Carolina's Medicaid program in some form since 1983, and it frequently has been held out as a model for other states looking to improve their Medicaid programs. Repeated studies have shown substantial savings, with the most recent study reporting savings of almost \$1 billion over four years. CCNC demonstrates

that an ACO model can achieve substantial savings in North Carolina's Medicaid if it supplements the fee-for-service reimbursement present in Medicare with capitation payments. Otherwise, current evidence from Medicare ACOs in North Carolina suggests only the possibility of future savings.

3.1.2 DEFINED AND MEASURABLE QUALITY GOALS AND ACCOUNTABILITY

Medicare ACOs emphasize the goal of sustaining and improving quality. Since the Medicare ACO program began, the government has monitored participating ACOs on 33 quality metrics. In order to share in the savings they achieve an ACO must demonstrate that it places no lower than the bottom 30th percentile of the national performance benchmark. This requirement strengthens commitment to quality improvement by tying reimbursement to meeting concrete quality measures.

It is more difficult to judge the quality performance of ACOs that are not part of Medicare. All ACOs at least aim to provide quality care. One of the major ideas driving these organizations is that they are accountable to their patients for the care and outcomes that patients experience. The most visible and quantifiable way this occurs outside of Medicare is through self-reporting and self-study. Once again Community Care of North Carolina is a good example; it has provided detailed reports about meeting specific goals in its quality improvement process.

3.2 MANAGED CARE ORGANIZATIONS

Managed care organizations (MCOs) are the other type of entity that Medicaid reformers are considering. A number of other state Medicaid programs use MCOs. A recent study by Caswell and Long (2015) found that, nationally, Medicaid MCOs did not reduce costs or improve quality, they only made spending more predictable. Confirming other research, this study found that, for non-disabled adults, Medicaid managed care was associated with increased emergency department visits, difficulty seeing specialists, and unmet prescription drug needs. This national experience, however, does not necessarily reflect how MCOs might function in North Carolina. MCOs are not an entirely new idea in North Carolina. The state's Medicaid program currently uses MCOs to provide mental and behavioral health care services. These specialized MCOs were formed out of non-profit organizations called Local Management Entities (LMEs) that are composed of local government authorities, such as county health departments. In addition to controlling costs, these MCOs are charged with maintaining systems for patient feedback, and establishing care coordination systems.

These MCOs receive capitated payments (fixed amounts per person) from the state, to provide mental health, substance abuse and developmental disability services to Medicaid patients. To set the capitation rate, the state considers the history of spending on mental health, substance abuse, and developmental disability services. The mental health MCOs provide services by contracting with various health professionals and service providers.

3.2.1 PREDICTABLE AND SUSTAINABLE BUDGET

The mental health MCO model produces a highly predictable budget as a result of its capitated payment structure. Instead of providing an estimated budget at the start of a

fiscal year and having to add to it at the end of the year, the capitated model allows the state to set the payment amount at the start of a fiscal year, and then not worry about adjusting the amount later.

The ability to adjust capitation payment rates each year also produces budget sustainability, because the state can set these rates to meet budgetary demands. For the MCOs themselves, financial sustainability is less certain. The mental health MCOs are under pressure to consistently reduce costs to remain under budget. They struggle with whether they can keep costs low enough to stay in business. Despite this pressure, or perhaps because of it, most mental health MCOs in North Carolina currently appear to have sufficient financial assets and reserves, and sustainable budgets.

3.2.2 DEFINED AND MEASURABLE QUALITY GOALS AND ACCOUNTABILITY

The mental health MCOs of North Carolina were born out of a prior attempt at behavioral health reform that began in 2001. The reform moved away from institutionalization in government facilities to treatment in community settings. As a part of this move, health professionals previously associated with the government became private contractors for care services. North Carolina created “local management entities” (LMEs) in 2001 to administer this switch to private providers. At the time there were about 40 LMEs and the General Assembly frequently added to or changed the governing rules. As a result, beneficiaries often criticized the system as fragmented and convoluted. This privatized system also had problems with running over budget, behavioral health professionals leaving en masse, and accusations of the newly privatized companies’ cherry-picking services for profits by performing unneeded services for some patients and leaving other patients without needed treatment. Quality and continuity were in shambles.

In an attempt to fix the earlier reform, in 2005 the General Assembly began to test an improved approach that reassigned some counties to a better-performing LME and transformed the local government-affiliated entity into a non-profit MCO. By 2013, this pilot program had expanded to cover the entire state, by consolidating the original several dozen LMEs into about a dozen MCOs, with subsequent consolidation to the current number of nine, and further consolidations still being considered.

One of the goals for North Carolina’s mental health MCO program has been to improve behavioral health care quality and outcomes. These MCOs established new quality review systems, and the state tracks over two dozen quality performance measures. Access to care is one of the most important of these quality reporting criteria; mental health MCOs must ensure that their beneficiaries are receiving prompt access within accepted guidelines. Two of the most publicly reported quality criteria, telephone response time and grievance response rate, reflect favorably upon the MCOs in that they have consistently kept their rates below the set benchmarks. A more patient-oriented benchmark that some mental health MCOs report, readmission rates, also reflects favorably on their ability to help people get the treatment they need and ensure that they have proper outpatient support.

However, some indications directly call into question the performance of North Carolina’s mental health MCOs in meeting their quality goals. In a 2012 study, North Carolina was found to have the lowest staffing level out of 8 states for staff devoted to

quality management, with a ratio of 21,215 beneficiaries to 1 quality-assurance staff. Additionally, the quality reporting requirements for current MCOs are sporadic and uncoordinated. Their annual reports sometimes mention hardly any quality criteria at all, and when quality is discussed, the criteria mentioned are usually administrative in nature and have very little to do with patient care or health outcomes. That is not to say that these MCOs are unconcerned with their populations—a few have done very detailed studies of unmet needs—but their lack of measured quality achievements and accountability falls short of what the General Assembly seeks.

4 MEDICAID REFORM IN OTHER STATES

Many other states have tried similar reforms to those proposed in North Carolina. This “laboratory of the states” allows us to learn from those that have already tested different approaches, some with greater success than others. Although some Medicaid reform efforts have failed in other states or fallen significantly short of their goals, we select two of the more recent and successful efforts, as encouraging examples. Oregon and Ohio each represent the potential for ACOs, MCOs, or both to succeed in North Carolina.

4.1 OREGON

Oregon has chosen a novel way to reform its Medicaid program, using Coordinated Care Organizations (CCOs). CCOs are regional non-government entities affiliated with local physicians, hospitals, or clinics, that contract with Oregon to provide health care. They may be a single corporate structure, like an MCO, or a provider network, like an ACO. Oregon’s CCOs are composed of all kinds of local organizations, private and public, from hospitals (mostly nonprofit) to public health departments. Of the 16 CCOs currently operating, there is an even split between centralized organizations and local provider networks, each one with their own structure. Most of the CCOs are for-profit entities, but most are formed by nonprofit providers or local governments.

Oregon’s CCOs are responsible for administering the state’s medical, behavioral, and dental health care systems. Much like MCOs, the CCOs are paid on a capitated (per member) basis. At the start of Oregon’s program CCOs were not fully at-risk for all services; the number of at-risk services gradually increased over time. At the moment, the capitated payments are focused on primary care, with other more specialized services to be added later.

The CCOs also resemble MCOs in that, even though many are formed by providers, they are organized to manage health care providers. With regard to quality focus, the CCOs are more akin to the ACOs that have been set up in North Carolina. The CCOs must engage in defined quality reporting, and part of their funding depends on achieving certain quality benchmarks.

Initial results from this new Oregon program are promising. Eleven of the 15 CCOs have hit their 100% targets with regard to the quality incentive metrics. And none were below the 70% mark. While CCOs will eventually be fully capitated payment systems, the payment change is being phased in. The CCOs began with a core set of services covered by the capitated payments from the state, with all other services covered by a

separate payment method. Every six months after the start of the program in August 2012, new services have been removed from the separate payment structure and added to an enlarged capitated payment. At the end of June 2014, over half of all plan payments were capitated, showing promise for budget predictability. So far the Oregon Health Plan has succeeded in reducing spending growth by at least 1%. As the program matures, additional savings may be achievable.

4.2 OHIO

Ohio's Medicaid reform is primarily focused around for-profit MCOs based out-of-state. The vast majority of participants in the Ohio Medicaid system are enrolled in one of five MCOs that cover all of Ohio. All but one of Ohio's MCOs are national corporations, with the fifth being a local Ohio program, and all but two are for-profit organizations. Ohio's MCOs are also responsible for behavioral health. Because of this combination, Ohio has been able to make use the medical home model to reduce waste, increase communication, and de-institutionalize its mental health system.

Ohio primarily uses a capitated reimbursement method, supplemented by payments for specific episodes of care, and quality-based incentive payments. Episodic payment means that the MCO pays the provider a set amount for a specific illness. Thus, an episodic payment covers all services to treat a particular condition for a single patient until completion of treatment. Like capitation, episodic payment is a set amount regardless of the services actually used. This incentivizes providers to achieve acceptable health outcomes without overspending. Ohio's quality-based payment incentive links almost 10% of nursing home reimbursement to quality, and 1% of health plan reimbursement to quality performance. Through this combination of various reimbursement methods Ohio has found a way to achieve both cost and quality accountability, as well as more specific accountability on a patient by patient level.

Ohio has dramatically cut Medicaid's annual cost growth to 3%, saving an average of \$1 billion per year over three years. The quality incentive payment also seems to have had a positive effect. In 2013 the majority of MCOs showed an upward trend across all reported quality measures as measured against national standards. However, there is still room for improvement, as only one provider achieved above the 75th percentile on any quality measurement. On balance, Ohio's plan has achieved a notably more sustainable and predictable budget, and its quality accountability program appears to be helping.

5 A NORTH CAROLINA WAY FORWARD

North Carolina stands at a crossroads on Medicaid reform. With the recent filing of three different bills in the General Assembly, it appears that legislative leaders have not reached consensus. However, there is a discernible way forward guided both by North Carolina's experience and that of other states. First, it appears that capitation (fixed payment per person) or other forms of shifting financial risk, like episodic payments, have the potential to achieve a predictable and sustainable budget. Community Care of North Carolina has achieved notable success under capitated payments for primary

care coordination, and capitation for the state's mental and behavioral health MCOs have produced stable and sustainable budgets. Also, both examples demonstrate that a capitated payment system does not necessarily mean sacrificing quality, especially when used with nonprofit organizations. However, North Carolina's mental and behavioral health MCOs do not have the best quality reporting track record, nor is their system set up to reward or hold them fully accountable for quality.

North Carolina's ACOs provide a good model for how quality improvement might be monitored and rewarded. While not yet demonstrating cost control on the whole, the ACOs participating in Medicare are models of quality accountability. Their reporting of quality measures is consistent, meaningful, and easy to find. Oregon's Medicaid reform shows that that capitated organizations with ACO-like quality reporting can work. Oregon has experienced a stable and predictable Medicaid budget, and its capitated Coordinated Care Organizations have, for the most part, met their quality benchmarks while remaining within or under budget.

The Ohio experience reinforces the appeal of conditioning a portion of capitated reimbursement on meeting quality benchmarks. Ohio's payment system appears to have both greatly reduced cost increases and encouraged quality improvement. The Ohio's reform measures also demonstrate that cost-control payments can take forms other than capitation by introducing the idea of paying for episodes of care on a more individualized level.

By combining the two contrasting ideas of MCOs and ACOs, do we create a better-functioning Medicaid system, or a Frankenstein's monster? Recall the two primary concerns of budget control and quality improvement. A Medicaid reform that uses capitated or other cost-controlled payment, but conditioned in part on quality outcomes, could achieve both of these stated goals. Experience shows that such a system can make overall budgets much more predictable, and incentivize both quality improvements and reporting. By themselves, neither MCOs nor ACOs have yet achieved a strong track record of making health care organization and providers accountable for both costs and quality. But, a combination of both approaches to could achieve all of the General Assembly's key goals, as long as administrative expenses and profiteering are minimized.

Appendix: North Carolina ACOs				
Name	Home Base	Provider Composition	Medicare Participant?	Private Insurer Affiliation
Accountable Care Alliance	Wilmington	New Hanover Regional Medical Center, Wilmington Health (a physician network)	No	BlueCross BlueShield of North Carolina
Accountable Care Coalition of Caldwell County	Lenoir	Caldwell Memorial Hospital and Collaborative Health Systems	Yes	
Accountable Care Coalition of Eastern NC	New Bern	Atlantic Integrated Health Network, and Collaborative Health Systems	Yes	
AnewCare Collaborative	Johnson City, TN	Mountain States Medical Group, Crestpoint Health Insurance Company	Yes	Crestpoint Health Insurance Company
Boice Willis Clinic	Rocky Mount	Multispecialty group practice	No	Cigna
Cape Fear Valley Health System	Fayetteville	Regional hospital system	Yes	BlueCross BlueShield of North Carolina
Carolina Medical Home Network	Raleigh	Goshen Medical Center, Roanoke Cowan Community Health Center, Rural Health Group, Wake Health Services, and North Carolina Community Health Center Association	Yes	
Carolinas ACO	Fort Mill, SC	Small group of practicing physicians	Yes	
Carolina Advanced Health	Durham	UNC Health Care	No	BlueCross BlueShield of North Carolina
Carolinas Healthcare System	Charlotte	Carolinas Healthcare System, large hospital and physician practice group	No	Aetna

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CaroMont Health	Gastonia	CaroMont Regional Medical Center, surrounding specialty practices	Yes	Cigna
Coastal Carolina Quality Care	New Bern	Physician members of Coastal Carolina Health Care, P.A.	Yes	
Coastal Plains Network	Greenville	Separate legal entity formed by eight hospitals, a hospital-owned insurer, and numerous physician practices	Yes	Vidant
Cornerstone Health Care	High Point	Large multispecialty physician group	Yes	Cigna, Aetna, United Healthcare.
Duke Connected Care	Durham	Duke Integrated Network (A physician and hospital network)	Yes	Cigna
Key Physicians	Raleigh	Multispecialty physician group	No	Cigna, BlueCross BlueShield of North Carolina.
Meridian Health Systems ACO Corporation	Charlotte	Physicians and medical suppliers	Yes	
Mission Health Partners	Asheville	Hospital, and specialty physician group	Yes	
Novant Health	Winston-Salem	Hospital, specialist provider network	No	Cigna
Physicians HealthCare Collaborative	Wilmington	Wilmington Health, and New Hanover Regional Medical Center	Yes	BlueCross BlueShield of North Carolina
Pinehurst Accountable Care Network	Pinehurst	Medical and surgical clinics	Yes	
Triad Healthcare Network	Greensboro	Moses H. Cone Memorial Hospital and physician network	Yes	
WakeMed Key Community Care	Raleigh	Key Physicians Group and WakeMed Health	Yes	BlueCross BlueShield of North Carolina

Bibliography: Research Sources and Further Reading

- 1) INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM (2001).
- 2) KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *Emerging Medicaid Accountable Care Organizations: The Role of Managed Care* (May 2012), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8319.pdf>.
- 3) NC ACOs, TOWARD ACCOUNTABLE CARE CONSORTIUM, www.tac-consortium.org/nc-acos/.
- 4) CENTERS FOR MEDICARE & MEDICAID SERVICES, *Medicare Shared Savings Program Accountable Care Organizations Performance Year 1 Results*, <https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/youq5-65xt>.
- 5) Mark McClellan, S. Lawrence Kocot & Ross White, *Early Evidence on Medicare ACOs and Next Steps for the Medicare ACO Program*, HEALTH AFFAIRS BLOG (Jan. 22, 2015), <http://healthaffairs.org/blog/2015/01/22/early-evidence-on-medicare-acos-and-next-steps-for-the-medicare-aco-program/>.
- 6) ROBERT COSWAY ET AL., MILLIMAN, INC., ANALYSIS OF COMMUNITY CARE OF NORTH CAROLINA COST SAVINGS (2011), www.communitycarenc.org/elements/media/files/milliman-executive-summary.pdf.
- 7) KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *Medicaid Managed Care: Key Data, Trends, and Issues* (Feb. 2012), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8046-02.pdf>.
- 8) Kate T. Christensen, *Ethically Important Distinctions Among Managed Care Organizations*, 23 J.L. MED. & ETHICS 223, 223–229 (1995).
- 9) Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver, NORTH CAROLINA DIVISION OF HEALTH AND HUMAN SERVICES (2012), www.ncdhhs.gov/dma/lme/Innovations_Amendment_5.pdf.
- 10) KELLY CROSBIE, NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, MEDICAID WAIVERS (2011), www.nciom.org/wp-content/uploads/2011/11/Crosbie_3-8-12.pdf.
- 11) Kyle Caswell & Sharon Long, *The Expanding Role of Managed Care in the Medicaid Program: Implications for Health Care Access, Use, and Expenditures for Nonelderly Adults*, 52 INQUIRY (2015).
- 12) Oregon Health Authority, *Oregon Health Plan: Section 1115 Annual Report*, (2014), www.oregon.gov/oha/healthplan/DataReportsDocs/Annual%20Report,%202013-2014.pdf.
- 13) Jon Barley, Ohio Department of Medicaid, *2013 P4P Summary & Plan Ranking, Ohio Dept. of Medicaid* (2013), <http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/2013-SFY-P4P-Summary.pdf>.
- 14) NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, PROPOSAL TO REFORM NORTH CAROLINA'S MEDICAID PROGRAM: REPORT TO NORTH CAROLINA GENERAL ASSEMBLY (2014), http://ncdhhs.gov/pressrel/2014/DHHS_Medicaid_Reform_Legislative_Report-2014-03-17.pdf.