Center for Public Policy Solutions

HEALTHCARE DEFINED

Healthcare policy decisions often hinge on public understanding of complex medical concepts. Our Healthcare Defined series provides clear explanations of healthcare terms and frameworks to support informed policy discussions. This resource offers an overview of population health programs and related models.

Understanding Population Health Programs

Accountable Care Organization (ACO)

ACOs are provider-led model in which physicians, hospitals, and other care settings voluntarily collaborate to deliver more coordinated, high-quality care for a defined patient population. ACOs are designed to improve outcomes and reduce unnecessary utilization—such as avoidable hospitalizations—by emphasizing prevention and chronic disease management. When ACOs meet certain benchmarks for quality and cost savings, they are eligible to share in those savings. One of the most widely adopted examples is the Medicare Shared Savings Program (MSSP).

Managed Care Organization (MCO)

MCOs are insurer-led models that contract with networks of providers to deliver care in a more structured and cost-effective manner. Commonly used in Medicaid managed care and Medicare Advantage programs, MCOs apply tools such as provider networks, utilization management, and benefit design (e.g., HMOs, PPOs) to guide patient care decisions and control costs. Increasingly, MCOs incorporate value-based payment arrangements to incentivize provider performance on cost, quality, and patient experience metrics.

Clinically Integrated Network (CIN)

CINs are legal arrangements among independent healthcare providers, such as hospitals, physicians, and outpatient centers, that allows them to share data, coordinate services, and collectively improve quality and efficiency. While similar to ACOs in structure, CINs offer greater flexibility by supporting multiple payer contracts and patient populations. They often serve as the operational foundation for health systems participating in value-based care initiatives.

Alternative Payment Model (APM)

APMs are payment structures that depart from the traditional fee-for-service model by tying provider reimbursement to quality, efficiency, and patient outcomes. APMs include arrangements such as shared savings and risk models, bundled payments for episodes of care, and population-based payments like capitation. These models aim to align financial incentives with better care coordination, lower costs, and improved health outcomes—and are often deployed within ACOs, MCOs, and CINs.