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Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts

Historically, most state Medicaid programs delivered and paid for services for Medicaid beneficiaries on a fee-for-service (FFS) basis, directly paying participating physicians, clinics, hospitals, and other providers a fee for each service they furnish. The FFS payment model, by definition, rewards volume, irrespective of patient health outcomes or quality of care. Also, care provided in a FFS system can often be fragmented because there is no coordinating entity, and both redundancies and gaps in patient care can result. In addition, beneficiaries are on their own in FFS systems to identify providers who participate in Medicaid and are taking new patients.

Increasingly, state Medicaid programs have been expanding their use of managed care as well as other service delivery and payment systems, as an alternative to traditional FFS. States may have different purposes in doing so, including to improve beneficiary access to care, improve the quality of care, increase Medicaid budget predictability, and reduce Medicaid spending. On May 26, 2015, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule that seeks to modernize Medicaid managed care regulations. State innovation in Medicaid service delivery and payment systems has been further catalyzed by new demonstration and pilot programs and state plan authorities provided by the ACA. Underpinning many of these new opportunities for innovation are important principles, including patient-centered care, cost and quality accountability, and population health management.

There is wide state variation in Medicaid health care delivery and payment systems, as states design and combine service delivery models and payment approaches in a multitude of ways (see [Mapping Medicaid Delivery System and Payment Reform](#) to learn more about activity across states). To help those interested in understanding the diversity of Medicaid reform initiatives underway or in development in states across the country, this guide defines key terms organized under two major headings: Delivery System Models and Payment Models. Under these headings, established/long-standing terms are defined first followed by newer, more emerging terms and concepts.

Delivery System Models

Medicaid Managed Care

- Primary Care Case Management (PCCM)
- Risk-Based Managed Care/Managed Care Organization (RBMC/MCO)
- Prepaid Health Plan (PHP)
- Managed Long-Term Services and Supports (MLTSS)

Other Delivery System Models

- Patient-Centered Medical Home (PCMH)
- Health Home (HH)
- Accountable Care Organization (ACO)

Payment Models

- Fee-for-Service (FFS)
- Capitation
- Care Management Fee
- Pay-for-Performance (P4P)
- Shared Savings Arrangements (Gain-Sharing)
- Shared Risk Arrangements (Risk-Sharing)
- Episode of Care (EOC) Payment
- Global Bundling
- Delivery System Reform Incentive Payment (DSRIP)

Delivery System

MEDICAID MANAGED CARE

Primary Care Case Management (PCCM): PCCM is a model of Medicaid managed care that is outlined in the Medicaid statute. In PCCM programs, state Medicaid agencies contract with primary care providers to provide, locate, coordinate, and monitor primary care services for Medicaid beneficiaries who select them or are assigned to them by the state.^{1 2} In effect, the primary care provider – usually a physician or a physician practice, but sometimes a nurse practitioner, physician assistant, or other provider – serves as a beneficiary’s “medical home” for primary and preventive care. Under their contracts with primary care providers, states pay them a small monthly case management fee in addition to regular FFS payments; unlike in risk-based managed care (see definition below), providers do not assume any financial risk under this model. States set requirements for the participating primary care providers, such as minimum hours of operation at each location, specific credentials or training, and responsibility for referrals to specialists. State staff carry out, or contract out, administrative functions related to PCCM (e.g., network development and credentialing). “Enhanced” PCCM refers to PCCM programs that include additional services and responsibilities to strengthen care coordination.

Risk-Based Managed Care/Managed Care Organization (RBMC/MCO): MCOs are health plans that contract with states to provide comprehensive Medicaid benefits to enrolled Medicaid beneficiaries for a pre-set per-member-per-month (PMPM) premium, or capitation payment.³ This arrangement is known as risk-based managed care because MCOs are at financial risk for the Medicaid services specified in their contracts. States develop and oversee their own Medicaid managed care programs, subject to federal requirements. MCOs must meet federal and state-specific requirements that address matters such as: protocols for enrollment, disenrollment, and member support; ensuring an adequate provider network and access to care; grievances and appeals, and collection and reporting of data. Although MCOs are at financial risk for comprehensive Medicaid benefits, many states “carve out” certain services from their MCO contracts, such as prescription drugs or behavioral health services. These carved-out benefits may be provided and financed under a separate contract with a prepaid health plan (see definition below) or on a FFS basis. Alternatively, some MCOs may subcontract with prepaid health plans to provide such benefits.

Prepaid Health Plan (PHP): As distinct from an MCO, a PHP is a *non*-comprehensive health plan that provides only certain services, such as dental services or non-emergency medical transportation.⁴ Most PHPs are paid on a risk, or capitated, basis. There are several types of PHPs:

- **Prepaid Ambulatory Health Plan (PAHP):** A PAHP is a non-comprehensive prepaid health plan that provides only certain outpatient services, such as dental services or outpatient behavioral health care, and does not cover any inpatient services.⁵
- **Prepaid Inpatient Health Plan (PIHP):** A PIHP is a non-comprehensive prepaid health plan that provides only inpatient hospital or institutional services, such as inpatient behavioral health care, and does not have a comprehensive risk contract.⁶

Managed Long-Term Services and Supports (MLTSS): MLTSS refers to risk-based arrangements for the delivery of Medicaid long-term services and supports, which often include institutional and home and community-based services (e.g., adult day care), enabling Medicaid beneficiaries to live independently in their homes and communities rather than receive care in an institution.⁷ Some MLTSS programs provide only long-term services and supports (e.g., operate as PHPs), but, in other arrangements, MLTSS are provided through comprehensive MCOs.

OTHER DELIVERY SYSTEM MODELS

Patient-Centered Medical Home (PCMH): In 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association released key principles that define a PCMH: (1) the personal physician leads a team that is collectively responsible for the patient's ongoing care; (2) the physician is responsible for the whole person in all stages of life; (3) care is coordinated and/or integrated; (4) quality and safety are hallmarks of a medical home; (5) enhanced access to care is available through all systems; and (6) payment appropriately recognizes the added value to the patient.⁸ The National Committee for Quality Assurance (NCQA) is one of a small number of organizations that has issued specific standards that the PCMHs must meet to receive its accreditation.⁹ Providers or provider organizations that perform PCMH functions are often paid (by state Medicaid agencies directly or through MCO contracts) a PMPM fee in addition to regular FFS payments for their Medicaid patients. Providers or provider organizations seeking PCMH recognition may also be supported through upfront grants (to cover PCMH infrastructure costs) and/or through performance-based payments (i.e., P4P).¹⁰

Health Home (HH): Section 2703 of the Affordable Care Act (ACA) established the Medicaid health home (HH) program. The Medicaid HH model builds on the patient-centered medical home concept.¹¹ Targeted to individuals with multiple chronic conditions, including serious mental illness, HHs are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, long-term services and supports, and social service supports. HHs establish care plans for Medicaid beneficiaries, and coordinate and integrate clinical and non-clinical services.¹² Medicaid HHs must provide the following services: comprehensive care management, care coordination and health promotion, transitional care, referrals to community and social services, patient and family support, and use of health information technology. States receive a 90% federal match rate for HH services (not to exceed eight quarters) and have considerable flexibility to design their own methods for paying

HHs. HH providers are required to report quality measures established by CMS.¹³ States may implement multiple HH programs that target different populations.

Accountable Care Organization (ACO): There is currently no uniform federal definition of an ACO and the concept continues to evolve.¹⁴ Generally, an ACO is a group of health care providers or, in some cases, a regional entity that contracts with providers and/or health plans, that agrees to share responsibility for the health care delivery and outcomes for a defined population. The organizational structure of ACOs varies, but, in concept, ACOs generally include primary and specialty care providers and at least one hospital. Providers in an ACO are expected to coordinate care for their shared patients to enhance quality and efficiency, and the ACO as an entity is accountable for that care, specifically for the quality and total cost of care. An ACO that meets quality performance standards that have been set by the payer and achieves savings relative to a benchmark can share in the savings. Some states that are pursuing ACOs for Medicaid beneficiaries are building on existing care delivery programs (e.g., PCCM, medical homes, MCOs) that already involve some degree of coordination among providers and may have developed key infrastructure necessary to facilitate coordination among ACO providers (e.g., electronic medical records). States use different terminology in referring to their Medicaid ACO initiatives, such as Coordinated Care Organizations (CCOs) in Oregon and Regional Care Collaborative Organizations (RCCOs) in Colorado.

Payment Models

Fee-for-Service (FFS): In a FFS system, the state Medicaid agency establishes the fee levels for covered services and pays participating providers directly for each service they deliver to Medicaid beneficiaries. Providers do not bear any financial risk. Beneficiaries seeking care in the traditional FFS environment must identify providers who participate in Medicaid and accept new patients. Except in the context of PCCM programs, there is generally no organized provider network in the FFS environment.

Capitation: Capitation payment refers to the fixed per-member-per-month (PMPM) amount that a state Medicaid agency pays a managed care organization (MCO) to provide or arrange for covered Medicaid services delivered to enrolled beneficiaries. Capitation rates are pre-set, so MCOs are at financial risk for the services they actually provide. States adjust capitation rates for Medicaid enrollees based on their demographic characteristics, such as age and gender, and often based on other factors as well. Medicaid MCOs may pay the providers in their network on a capitation basis, a FFS basis, or on other terms.

Care Management Fee: FFS providers or provider organizations operating as patient-centered medical homes and/or health homes are often paid a supplemental per-member per-month care management fee for Medicaid patients assigned to them. These care management fees may be adjusted based on patient demographics and/or health status, or on characteristics of the provider entity, such as its score by an accrediting body.¹⁵

Pay-for-Performance (P4P): P4P is a health care payment model that rewards providers or managed care organizations (MCOs) financially for achieving or exceeding specified quality benchmarks or other goals.¹⁶ P4P payments may be made based on performance on structure, process, and/or outcome measures, with providers evaluated against benchmarks or by comparison with other providers. Some state Medicaid programs contracting with MCOs incorporate a P4P component into their payment methods. For example, they may

withhold a portion of the capitation payment, which the MCO can earn back by demonstrating high performance, or make performance-based bonus payments in addition to the regular capitation payments.

Shared Savings Arrangements (Gain-Sharing): Under shared savings arrangements, sometimes referred to as gain-sharing, provider organizations or ACOs have an opportunity to share in any net savings that accrue to a payer for a defined panel of patients over a specified time period (usually 12 months). Actual costs for the patient panel are compared to a pre-established benchmark that is determined using historical utilization and/or cost data for the patient panel or a similar population. To be eligible for savings, provider organizations/ACOs must meet performance/quality requirements while also reducing costs.^{17 18} In shared savings-only models, provider organizations/ACOs do not face downside risk. That is, they face no financial penalty if actual costs exceed the benchmark. Most typically, the shared savings model is used by ACOs and some PCMHs.

Shared Risk Arrangements (Risk-Sharing): Entities that enter into shared savings arrangements with payers may also agree to share in losses. Risk-sharing is often added to shared savings arrangements after some experience has been accumulated. Under a shared risk arrangement, if actual costs for the defined patient population exceed the benchmark, the provider group/entity is accountable for a portion of the excess costs and must return funds to the payer.

Episode of Care (EOC) Payment: Episode of care payments are single, pre-established amounts paid to providers for the set of services involved in treating a patient's health event, such as a knee replacement, or a particular health condition, such as Attention Deficit Hyperactivity Disorder (ADHD), over a specified period of time. Episodes have a defined beginning and end and usually involve payment for multiple services and providers.^{19 20} Payment amounts are set based on established clinical protocols and guidelines and are typically adjusted to account for the severity of the patient's condition. Episode of care payments can be prospective or retrospective. Under the prospective model, a single payment is made for a defined "episode of care." Under the retrospective model, providers and hospitals involved in the episode receive payment as they normally would according to the payer fee schedule, but actual expenditures are later reconciled against the pre-set price for the episode, which may trigger gain- or risk-sharing. As distinct from global bundling (see definition below), episode-based payment is a tool for managing costs incurred over a shorter time period, such as 30 or 90 days, usually beginning with initial treatment of the health event or condition. Other terms sometimes used to describe the concept of episode of care payments include bundled payment, episode-based payment, and episodic bundling.

Global Bundling: Global bundling involves a single, pre-set payment for a wide range of services delivered to an individual over a defined period of time, usually one year. Global payment amounts are risk-adjusted based on the patient's health and other characteristics that may affect the services needed, such as age or gender. In addition, global payment models incorporate outcome or quality measures to safeguard against under-service and reward high performance.²¹ Other terms sometimes used to refer to the concept of global bundling include risk-adjusted global fees, comprehensive care payment, global payments, and global budgets.

Delivery System Reform Incentive Payment (DSRIP): DSRIP initiatives, which are part of broader Section 1115 demonstration waiver programs, provide states with significant funding to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries. DSRIP waivers are not grant programs – they are performance-based incentive programs. The concept is that states undertake initiatives expected to save Medicaid funds and then use the available savings for new investments in delivery system reform. To obtain DSRIP funds, eligible entities, including hospitals and other providers and/or provider coalitions, must meet certain milestones or performance metrics. While the exact structure and requirements of DSRIP initiatives vary, there is often a focus on meeting process-oriented metrics in the early years of the waiver, such as metrics related to infrastructure development or system redesign, and a focus on more outcome-oriented metrics in later years.²² For example, infrastructure related metrics might pertain to implementation of chronic care management registries or enhanced interpretation services. System redesign metrics might relate to expansion of medical homes or physical and behavioral health care integration. Outcome measures might address clinical care improvements or population health.

Appendix

The table below provides links to relevant federal legislation, regulations, and other guidance where available for Medicaid delivery system and payment models. Some terms originate from authorizing legislation, regulations, or other CMS guidance while other terms, which may be used by other federal programs or in the private sector, may not be specifically defined by the Medicaid program.

Medicaid Delivery System and Payment Model Legislation, Regulations, and Other Guidance	
Primary Care Case Management (PCCM)	<p>Primary Care Case Management, Social Security Act §1905(t). 42 C.F.R. Part 438. CMS regulations on Medicaid managed care. 42 CFR Parts 431, 433, 438, 440, 457 and 495. Notice of Proposed Rulemaking (NPRM). Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability. CMS Medicaid Director Letter regarding primary care case management services and section 1905(t) of the Social Security Act. January 1998.</p>
Risk-Based Managed Care(RBMC)/ Managed Care Organization (MCO)	<p>State Option to Use Managed Care, Social Security Act, §1932. Medicaid Managed Care Organization, Social Security Act, §1903(m). 42 C.F.R. Part 438. CMS regulations on Medicaid managed care. 42 CFR Parts 438, 440, 456, and 457. Notice of Proposed Rulemaking (NPRM). Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans. 42 CFR Parts 431, 433, 438, 440, 457 and 495. Notice of Proposed Rulemaking (NPRM). Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.</p>
Prepaid Health Plans (PHP)	<p>42 C.F.R. Part 438. CMS regulations on Medicaid managed care. 42 CFR Parts 431, 433, 438, 440, 457 and 495. Notice of Proposed Rulemaking (NPRM). Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.</p>
Prepaid Ambulatory Health Plan (PAHP)	<p>42 C.F.R. § 438.2. CMS regulation regarding prepaid ambulatory health plans. 42 CFR Parts 431, 433, 438, 440, 457 and 495. Notice of Proposed Rulemaking (NPRM). Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.</p>
Prepaid Inpatient Health Plan (PIHP)	<p>42 C.F.R. § 438.2. CMS regulation regarding prepaid inpatient health plans. 42 CFR Parts 431, 433, 438, 440, 457 and 495. Notice of Proposed Rulemaking (NPRM). Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.</p>

Managed Long-Term Services and Supports (MLTSS)	<p>42 CFR Parts 431, 433, 438, 440, 457 and 495. Notice of Proposed Rulemaking (NPRM). Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.</p>
	<p>CMCS Informational Bulletin: Long Term Services and Supports Delivered Through Medicaid Managed Care Programs. May 21, 2013.</p>
	<p>CMCS Informational Bulletin: Long Term Services and Supports Delivered Through Medicaid Managed Care Programs – Continued Technical Assistance. October 22, 2013.</p>
Patient-Centered Medical Home (PCMH)	<p>American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of a patient-centered medical home. Released March 2007.</p>
	<p>CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #1. July 10, 2012.</p>
	<p>CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #2. July 10, 2012.</p>
Health Home (HH)	<p>State Option to Provide Coordinated Care through Health Homes for Individuals with Chronic Conditions, Social Security Act §1945.</p>
	<p>CMS State Medicaid Director Letter regarding implementation of the ACA provision on health homes for enrollees with chronic conditions. November 16, 2010.</p>
	<p>Health Homes (Section 2703) Frequently Asked Questions. May 2012.</p>
	<p>CMS State Medicaid Director Letter regarding Health Home Core Quality Measures. January 15, 2013.</p>
Accountable Care Organization (ACO)	<p>Pediatric Accountable Care Organization demonstration Project, ACA §2706. This demonstration is not currently funded.</p>
	<p>CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #1. July 10, 2012.</p>
	<p>CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #2. July 10, 2012.</p>
	<p>Currently, there is no uniform Medicaid ACO definition. While outside the Medicaid context per se, a useful definition of an ACO can be found within the Medicare Shared Savings Program, ACA § 3022.</p>
	<p>42 C.F.R. Part 425. CMS regulation regarding the Medicare Shared Savings Program and Accountable Care Organizations.</p>
Shared Savings Arrangements (Gain-Sharing)	<p>CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #1. July 10, 2012.</p>
	<p>CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #2. July 10, 2012.</p>
	<p>CMS State Medicaid Director Letter regarding Shared Savings Methodologies. August 30, 2013.</p>

Shared Risk Arrangements (Risk-Sharing)	<p>CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #1. July 10, 2012.</p> <p>CMS State Medicaid Director Letter regarding policy considerations for Integrated Care Models #2. July 10, 2012.</p> <p>CMS State Medicaid Director Letter regarding Shared Savings Methodologies. August 30, 2013.</p>
Episode of Care (EOC) Payment	<p>Demonstration Project to Evaluate Integrated Care around a Hospitalization, ACA § 2704. This demonstration is not currently funded.</p>
Global Bundling	<p>Medicaid Global Payment System Demonstration Project, ACA § 2705. This demonstration is not currently funded.</p>

Endnotes

¹ *Medicaid and Managed Care: Key Data, Trends, and Issues*. Kaiser Family Foundation, 2012. Available at: <http://kff.org/medicaid/issue-brief/medicaid-and-managed-care-key-data-trends/>.

² *Medicaid Managed Care Enrollment Report*. Centers for Medicare and Medicaid Services (CMS). 2012. Available at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2012-medicaid-managed-care-enrollment-report.pdf>.

³ *Medicaid and Managed Care: Key Data, Trends, and Issues*. Kaiser Family Foundation, 2012. Available at: <http://kff.org/medicaid/issue-brief/medicaid-and-managed-care-key-data-trends/>.

⁴ Rosenbaum S and Sonosky C. 2002. *Prepaid Ambulatory Health Plans (PAHPs): Implications for Safety Net Providers*. The George Washington University, Center for Health Services Research and Policy. Available at: <http://publichealth.gwu.edu/departments/healthpolicy/CHPR/downloads/PAHP.pdf>.

⁵ Rosenbaum S and Sonosky C. 2002. *Prepaid Ambulatory Health Plans (PAHPs): Implications for Safety Net Providers*. The George Washington University, Center for Health Services Research and Policy. Available at: <http://publichealth.gwu.edu/departments/healthpolicy/CHPR/downloads/PAHP.pdf>.

⁶ Rosenbaum S and Sonosky C. 2002. *Prepaid Ambulatory Health Plans (PAHPs): Implications for Safety Net Providers*. The George Washington University, Center for Health Services Research and Policy. Available at: <http://publichealth.gwu.edu/departments/healthpolicy/CHPR/downloads/PAHP.pdf>.

⁷ *Medicaid and Managed Care: Key Data, Trends, and Issues*. Kaiser Family Foundation, 2012. Available at: <http://kff.org/medicaid/issue-brief/medicaid-and-managed-care-key-data-trends/>.

⁸ Defining the Medical Home. Patient-Centered Primary Care Collaborative. Available at: <https://www.pccpc.org/about/medical-home>

⁹ *NCQA Patient-Centered Medical Home*. National Committee for Quality Assurance (NCQA). Available at: <http://www.ncqa.org/Portals/o/PCMH%20brochure-web.pdf>.

¹⁰ Takach M. 2012. "About Half Of The States Are Implementing Patient-Centered Medical Homes For Their Medicaid Populations." *Health Affairs* 31(11): 2432-2440. Available at: <http://content.healthaffairs.org/content/31/11/2432.full.pdf+html>.

¹¹ CMS State Medicaid Director Letter regarding implementation of the ACA provision on health homes for enrollees with chronic conditions. November 16, 2010. Available at: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>.

¹² *Medicaid Health Homes: An Overview*. Centers for Medicare and Medicaid Services (CMS). 2015. Available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/medicaid-health-homes-overview.pdf>.

¹³ Health Homes (Section 2703) Frequently Asked Questions. Centers for Medicare and Medicaid Services (CMS). 2012. Available at: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Health-Homes-FAQ-5-3-12_2.pdf.

¹⁴ There is no uniform Medicaid definition of an ACO nor a uniform definition across payers. Medicare, as part of their Pioneer ACO program, defines and ACO as follows: "Under the program regulations, an ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the Medicare Fee-For-Service patients they serve. The goal of an ACO is to deliver seamless, high-quality care for Medicare beneficiaries, instead of the fragmented care that often results from a Fee-For-Service payment system in which different providers receive different, disconnected payments. The ACO will be a patient-centered organization where the patient and providers are true partners in care decisions. The Affordable Care Act specifies that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services: ACO professionals (i.e., practitioners meeting the statutory definition) in group practice arrangements, networks of individual practices of ACO professionals, partnerships or joint ventures arrangements between hospitals and ACO professionals, hospitals employing ACO professionals, or other Medicare providers and suppliers as determined by the Secretary." "An ACO professional is defined as a physician, as well as a physician assistant, nurse practitioner or clinical nurse specialist." See: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Providers_Factsheet_ICN907406.pdf.

¹⁵ Takach M. 2012. "About Half Of The States Are Implementing Patient-Centered Medical Homes For Their Medicaid Populations." *Health Affairs* 31(11): 2432-2440. Available at: <http://content.healthaffairs.org/content/31/11/2432.full.pdf+html>.

¹⁶ Kuhmerker K and Hartman T. 2007. *Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs*. The Commonwealth Fund. Available at: <http://www.commonwealthfund.org/publications/fund-reports/2007/apr/pay-for-performance-in-state-medicaid-programs--a-survey-of-state-medicaid-directors-and-programs>.

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- ¹⁸ Berenson R, Brantes F, and Burton R. 2012. *Payment Reform: Bundled Episodes vs. Global Payments*. Urban Institute. Available at: http://www.urban.org/research/publication/payment-reform-bundled-episodes-vs-global-payments/view/full_report.
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- ²² Gates A, Rudowitz R, and Guyer J. 2014. *An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers*. Available at: <http://kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/>.