Continuum of Integrated Care Models and Features: For Illustrative and Discussion Purposes Only

Little/No Accountability for Quality and Cost Outcomes → *Significant Accountability for Quality and Cost Outcomes*

Care Models	FFS Only	PCCM	PCCM Plus P4P	PCMH	PCMH + Health Home	Network of PCMH	ACOs	Comprehensive ACOs	MCOs	Other ICMs
Services Accountable for	Who and what are closely related and this can vary significantly							Must be primary care-oriented and include hospitals, specialists		
Providers										
Payment	Made to individual PCP| Fixed $ amount $15-service / $5–quality Possible bonus pool Individual Service-Focused				Made to individual providers or entity Upfront $, savings & FFS $10-service / $10-quality/savings			Made to entity| $ based on savings $5-service / $15–quality/savings Population-Focused		
System Performance Metrics	*Data capturing & sharing*				*Improved clinical processes*			*Improved outcomes (costs down, patient experience up)*		
Success Indicators	Process measures indicate improved care in future, yield data collection for policy development and baseline				Clinical processes and new benchmarks informed by data collection; benchmarks adjusted for cont. improvement			Improved care outcomes, not volume; pt. experience		
Metrics/ valuation	Some MU core set; some adult/child core sets measures				Practice measurement changes and process measures that will lead to outcomes improvement			Population health, functional status, total cost of care		
Accountability	What information would confirm that care is integrated and coordinated?									
Examples				Oklahoma PCMH	Missouri PCMH HH	North Carolina CCNCs	Colorado RICOs		Minnesota ACOs	Oregon CCOs