



Primary Care and Accountable Care — Two Essential Elements of Delivery-System Reform

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With discussions about U.S. health care reform focused heavily on insurance reforms, relatively little attention has been paid to the delivery-system reforms that will be required to improve

the quality and coordination of health care and slow the growth of spending. The “patient-centered medical home” (PCMH) and the “accountable care organization” (ACO) are two widely discussed models for delivery-system reform that take complementary approaches to achieving these goals. The PCMH model emphasizes the creation of a strong primary care foundation for the health care system, and the ACO model emphasizes the alignment of incentives and accountability for providers across the continuum of care. With support from the Commonwealth Fund, we recently met with other leaders involved in the development of these models to clarify their key elements and identify

ways of ensuring that such reforms are mutually reinforcing.

The PCMH model builds on substantial evidence demonstrating that greater emphasis on primary care can result in higher-quality care at lower cost. The model combines the core tenets of primary care (first-contact care that is continuous, comprehensive, and coordinated across the care continuum) with 21st-century practice innovations such as the use of electronic information systems, population-based management of chronic illness, and continuous quality improvement. One important cornerstone of this model is a focus on meeting the needs and preferences of patients; another is payment reform that

improves reimbursement to primary care practices and rewards high performance. The model is widely endorsed by purchasers, payers, physicians, and patient-advocacy groups, and multipayer medical home demonstration projects are under way throughout the country.

The challenges to implementation of the PCMH model include two issues that lie beyond the direct control of the primary care practice.¹ First, although the model calls for primary care practices to take responsibility for providing, coordinating, and integrating care across the health care continuum, it provides no direct incentives to other providers to work collaboratively with primary care providers in achieving these goals and optimizing health outcomes. Second, although evidence suggests that increased investment in primary care can result in savings from several

types of reductions — for example, inappropriate use of tests and procedures, emergency department utilization, and hospitalizations for conditions that could be treated in an outpatient setting — most primary care practices do not have financial arrangements that allow them to share in these savings. The effect on total costs of implementing the PCMH model alone could be limited, because primary care physicians have little direct leverage over other providers in the care continuum, and under the largely fee-for-service payment system it is unlikely that other providers will respond to reductions in the number of referrals or admissions by allowing their incomes to fall. These limitations could be addressed most readily if the model were implemented in the context of a larger entity such as an ACO.²

An ACO is a provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population. Multiple forms of ACOs are possible, including large integrated delivery systems, physician-hospital organizations, multispecialty practice groups with or without hospital ownership, independent practice associations, and virtual interdependent networks of physician practices.³ ACOs could receive fee-for-service payment and share in any cost savings achieved relative to a risk-adjusted projected spending target for their patient population; alternatively, payment could be partially or fully capitated, with risks and gains both being shared by all providers. Performance measurement to evaluate the quality of care and to prevent potential overuse (in fee-

for-service organizations) and underuse (in capitated ones) is a cornerstone of the model. Some evidence suggests that more fully integrated ACOs provide higher-quality, more efficient care than smaller, more loosely organized ones.⁴ Challenges to the implementation of the ACO model include the need for strong leadership to address the cultural, legal, and resource-related barriers to creating new provider organizations in many communities.⁵

Regardless of the organizational structure, an ACO will not succeed without a strong foundation of high-performing primary care. The current shortage of primary care capacity and the outdated infrastructure of most primary care practices could limit the successful implementation of ACOs; conversely, investment in the PCMH model could accelerate the development of high-performing ACOs. The fact that the ACO model does not explicitly require support for primary care has led to considerable concern that ACOs dominated by hospitals or specialists would not adequately invest in primary care — or that hospitals and specialists would garner a disproportionate share of any savings. Because it is widely recognized that increased investment in primary care is needed to slow the overall rate of growth in spending, finding a way to ensure adequate support for primary care will be critical to the design and implementation of ACOs.

As both models move through pilot programs toward implementation, we have identified several strategies for ensuring that they are mutually reinforcing. First, accreditation and certification processes should be aligned. The National Committee on Quality

Assurance (NCQA) has a voluntary PCMH recognition program that has been used in many of the early medical home initiatives. There is ongoing debate about the best criteria for recognizing a practice as meeting the standards of a PCMH, and the NCQA is seeking input on this topic from stakeholders. No ACO accreditation or certification process has yet been developed, but when one is, it will be critical to include criteria that ensure sufficient primary care capacity for the patient population and to closely align the standards with those of PCMH recognition.

Second, because successful implementation and evaluation of both models will require measurement of performance, a common set of primary care performance measures should be developed; these should be consistent with the domains outlined in the Commonwealth Fund's "2020 Vision of Patient-Centered Primary Care" (e.g., timely access to care, coordination of care, and engagement of patients) and endorsed by the National Quality Forum. Performance measurement for determining the amount of shared savings or other financial incentives for ACOs must weight primary care measures heavily rather than focus narrowly on metrics related to hospital care.

Third, the payment mechanisms used must align the incentives of the two models to increase accountability for total costs across the continuum of care while ensuring that a sufficient investment is made in primary care capacity. In Medicare and other demonstration projects, incentives should be aligned so that primary care practices could benefit financially from simultaneous participation in both PCMH and

ACO pilots. Because transforming primary care in accordance with the medical home model requires considerable resources, incentives for both quality and savings should emphasize high levels of primary care performance to ensure that ACOs provide adequate support to their primary care providers to enable them to attain and sustain the essential capabilities of a PCMH.

These two approaches are synergistic models of delivery-system reform that, together, promise to redirect the U.S. delivery system toward reduced cost growth and improved quality. ACOs will require a strong primary care core to succeed and, in turn, can provide essential delivery-system infrastructure beyond the primary care practice to ensure the full realization of the PCMH model. Ongoing evaluation of both models, preferably in combination and in diverse settings, is essential. Demonstrations should be de-

signed as pilot tests that can be continued if successful, modified as necessary, and (when successful) implemented broadly, with continued adaptation. Finally, one of the most important elements of federal health care reform will be expanding the capacity of federal agencies, including the Centers for Medicare and Medicaid Services and the Agency for Healthcare Research and Quality, to implement, support, and evaluate these promising delivery-system reforms.

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Robert Berenson, M.D., Karen Davis, Ph.D., Kevin Grumbach, M.D., David Meyers, M.D., Hoangmai Pham, M.D., M.P.H., Robert L. Phillips, Jr., M.D., M.S.P.H., and Dana Gelb Safran, Sc.D. The consensus that emerged from the discussion and that is summarized in this article should not be taken to be the perspective of any specific individual or organization.

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The Supreme Court, Process Patents, and Medical Innovation

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On November 9, the U.S. Supreme Court heard oral arguments in *Bilski v. Kappos*, one of the most closely watched cases in the Court's current term. The central question involves the legitimacy of a patent on a method for hedging risk in commodities trading, but the outcome will have important implications for health care delivery and research. Although patents covering medicines, devices, and research targets such as DNA sequences have become commonplace, in recent years there has been a surge in new patents on medical processes.¹ Patents have

been awarded for processes such as making diagnoses, performing surgery, making prescribing decisions, and other methods for treating patients and engaging in research. The *Bilski* case represents the first time in nearly three decades that the Supreme Court has considered the standard for issuing process patents.

Patents — government-sponsored monopolies allowing inventors to exclude others from using their intellectual property for 20 years — are granted under the constitutional authority to “promote the progress of Science and the Useful Arts” and are con-

sidered necessary by some observers to encourage investment in innovation. The Patent Act establishes that patentable inventions must fall within one of four categories: process, machine, manufacture, or composition of matter.

Efforts to define a patent-eligible “process” have been fraught with controversy. The Supreme Court has long rejected attempts to patent scientific observations, mathematical formulas, or abstract principles — such as Samuel Morse's effort to patent the concept of using electromagnetism to communicate language (see table). Yet patents have been