

## COMMENTARY

# The Patient-Center Medical Home and Managed Care: Times Have Changed, Some Components Have Not

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I am a full supporter of the patient-centered medical home as an organizational model for practice, and I am hopeful this model will provide an enduring change for better primary care. I have seen evidence that some physicians enjoy this new model but are also describing rather easily the flaws of “managed care” from the last generation of systemic payment model changes in US health care. I think we must be careful to have a more balanced understanding of “managed care” of the 1990s, just as we wish others to have a balanced approach to the patient-centered medical home. The list of attributes from one state academy (Figure 1) could have come from any state. It creates temporary comfort for us but does not necessarily provide a productive stance toward the future. To explain, I will share my perspective on the dangers of creating a slogan and “scapegoat” out of any part of this nationwide systemic struggle to improve the patient experience, improve measured health outcomes, and reduce overall costs. The older payment and practice model we called “managed care” and payment incentives that support the evolving medical home have many things in common, as well as some differences.

During the 1990s, the United States had a brief period of nearly flat cost curves for health care, mostly via the application of “managed care” systems of payment for well-organized practices. During some of those years I helped lead one moder-

ate-sized integrated primary care system under the title of “managed care” at HealthPartners in Minnesota. Others of you may have had similar roles. We did hold down costs and we improved care for many populations. This was achieved partially by restricting choices for patients and providers via a variety of methods that led to measurable improvements to care in most integrated systems. But the public was not fully informed that their health care costs were flat or declining for those 5 to 6 years partially because they were, for example, “encouraged” or forced to choose a primary care practice, use preferred drugs on a formulary, and use a defined network of specialists and hospitals linked to tightly controlled payment contracts. Physicians were left the task of explaining this without much support. Some of the improved outcomes and lowered costs also derived from patient education and prevention efforts, although that is harder to document. In my dealings with large employers during that time, I saw them grow tired of paying \$1 to \$2 per member per month for phone-based care support, health education, and lots of outreach to patients—all of which was not what they considered “real care,” (ie, visits). When they saw the cost curve was merely flat and not declining, they gradually withdrew their contracted financial support for these “added” services and saved several dollars per member per month. Capitated payments to providing systems, physicians, and health plans declined for most of that “nonvisit” care.

Simultaneously, employers became worried about the backlash over restricted choices and disowned the job of explaining to the public and employees that they could opt for wider choices only if they paid the associated higher costs. Employees and employers could save money mostly if they agreed to more limited options. Negative feedback regarding constrained choices was felt keenly by benefits managers and executives in many administrative layers

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**Figure 1. Attributes of Medical Home and Managed Care.**

Medical Home means. . .	Managed Care means. . .
<ul style="list-style-type: none"> <li>• Physician-patient relationship</li> <li>• Patient-centered, personalized care</li> <li>• Preventive services, fewer ER visits</li> <li>• Less hospitalization, better tracking</li> <li>• Physician support and feedback</li> <li>• Healthier, engaged patients</li> <li>• Fiscal savings through comprehensive, coordinated care.</li> </ul>	<ul style="list-style-type: none"> <li>• Systematic “gatekeeper” relationship</li> <li>• Contractually-dictated care</li> <li>• Patients get “partialist” care--</li> <li>• Services that are “carved out”</li> <li>• Physicians handcuffed by “one size fits all” rules</li> <li>• More rules and unhappy patients</li> <li>• Fiscal savings by limiting access to services</li> </ul>

within large employers. However, many employees and employers preferred to avoid the conflict associated with restricted choices and simply shifted the rising costs of health care to the employees and families by raising premiums, increasing copays, and reducing or flattening salaries. Soon the health care costs grew again. Both physicians and employers blamed the same “managed care” systems for being the enemy, and many acted as if we could have unlimited choice at no added cost. Since then, many factors—including technology; overuse of specialty services, emergency rooms, and hospitals; and an aging population—have contributed to the upward cost spiral, but only now are we redesigning systems of care and again creating new payment models via the benefits of consciously (I hope) limiting choices. We must be honest that this redesign of health care is a derivative of what we learned during the era of “managed care” and what the rest of the world has learned about limiting some choices. We may not like it, but we will save money and improve care by influencing or restricting both provider and patient choices to some degree. The new practice model, called the “medical home,” will be funded partially with money saved by connecting patients to specific medical homes, using specific formularies, and seeking specialty care through selected, contracted consultants. I hope this time we discuss this openly and avoid creating a need for a scapegoat from some other part of the system.

In the managed care era, we physicians grew angry at being asked to follow formularies, use best practices, and use preferred referral networks. Evidence-based practice has many failures and limitations, but we did, as a nation, gradually reduce some completely irrational care based on the available evidence about what works, what is safe, and what costs less.

Now, in the era of patient-centered medical homes, we see the evolution of some similar characteristics of health care homes that parallel “managed care” via:

- Asking patients to select a medical home and seek most of their primary care through that enterprise (not a gatekeeper, but a physician and a multiprofessional team that includes a care manager or coordinator)
- Accepting evidence-based practice patterns that reduce the random variations and excesses of care that some patients and physicians might prefer (evidence-based care)<sup>1</sup>
- Using medications that might be preferred by a medical home to keep costs down (if the medication is equivalent to the most expensive brand advertised on television and in magazines, ie, formulary and generic medications)
- Seeing consultants that are closely linked with their medical home rather than a random set of consultants (tighter referral networks)
- Learning more about “self-directed care,” which can improve care and costs less (less expensive self-care)
- Having annual visits to create a patient-centered care plan (care management and coordination)

There is a familiar pattern here. But we are better at many things in 2011 than we were in 1995.<sup>2</sup>

1. We have much more interest and skill in gathering and honoring patient/family input. We even have names for it now: shared-decision making, patient advisory panels to guide a medical home, group visits during which patients help with each others’ care rather than follow a care plan created mostly by physicians and

health professionals. Citizen Health Care is a new model to engage patients, in which the professional is “on tap not on top.”<sup>3</sup>

2. All provider and insurance systems have learned to pay close attention to patient satisfaction and have many programs to improve the patient experience and celebrate “top physicians.” We reward insurance plans for highly satisfied insured members. We train physicians in practice, not just residents, how to improve their personal connection with patients and families. Hospitals strive to become known as “baby friendly” or “family friendly,” and scoring methods are available commercially to track our progress in this are. Fifteen years ago, such efforts were sporadic, poorly measured, and much less systematic.
3. Evidence-based medicine is slowly maturing. We are more aware of the limitations of protocols that are less effective, if not customized, to the needs of a specific patient, but still we recognize the evidence for some specific patterns of care versus making it up entirely in each case. We routinely measure our population-based outcomes and learn from the clinics that perform best. However, now we are seeking more knowledge about which protocols and published evidence may have been inappropriately influenced by an industry sponsor for research or by articles influenced in other ways by industry at the expense of rational science.<sup>4</sup>
4. Patients are more aware of the cost and quality consequences of their desire for “more care.” They are exposed to some of the added costs and risks of optional medications and repeated diagnostic explorations, and they are sometimes asking for evidence for aggressive treatment. “Do I really need to see this doctor?” versus “I want it all, Doc!” Less frequently are patients seeking medications when none are indicated (eg, antibiotics).
5. Consultants, hospitals, and primary care practices are increasingly linked via a shared electronic medical record. This adds momentum to selecting a specific set of consultants versus a random selection from the community. This “restricted choice” is more rational and potentially less irritating than the previous generation of restricted choice decisions summarized as gatekeeping.

My purpose is to suggest that we avoid the short-term satisfaction in creating a villain out of the old model of “managed care” as we create a new and improved model of the coordinated, patient-centered, team-based medical home. (In Minnesota we call it the health care home to include more easily other disciplines in primary care.) However, we should be clear: this new model will be funded by the savings achieved as we restrict some of our choices in our efforts to improve the patient experience, improve outcomes, and reduce costs. Whatever the delivery model will be that follows the medical home, there are parallels to the previous generation of payment and practice designs. Future leaders will be tempted to create another scapegoat from what preceded their even newer model. Therefore, only a few years from now the medical home will be the next in line for this unfortunate role of absorbing blame for what does not work well (a scapegoat). We have the opportunity to avoid that common and repeated cycle during our turn at the helm. Let us show our future leaders a different and more balanced way to improve an older model. We must be clear about the choices we are making in both payment methods and practice redesigns to promote better outcomes at lower cost. We are improving, but public trust will be maintained more easily this time if we are forthright in describing our options.

No villains allowed! Not even the old managed care model. That is my hope as we go forward.

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