Medicare privatization, ACO REACH & the ethics of for-profit health care

Dispatcher: 911, what's your emergency?

Caller: America's healthcare system is broken and people are dying! (ambulance siren)

Welcome to **Code WACK!**, where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host, **Brenda Gazzar.**

This time on **Code WACK!** Why are some physicians sounding the alarm over the privatization of Medicare? How could a program called **ACO REACH** be influencing the way physicians treat patients and patient care? To find out, we spoke to **Dr. Philip Verhoef**, president of Physicians for a National Health Program, a physician-led organization that advocates for single-payer health care in America. Dr. Verhoef is an adult and pediatric intensive care doctor and clinical associate professor of medicine at the John A. Burns School of Medicine at the University of Hawaii-Manoa.

Welcome back to Code WACK! Dr. Verhoef.

(00:58):

Verhoef: Thank You. It's great to be here again.

(01:00):

Q: Tell us a little bit about yourself and your background.

(01:03):

Verhoef: Sure. So I am an ICU physician. I take care of both pediatric intensive care unit patients as well as adults who require the ICU and I've been doing this for about 15 years. I'm currently based in Hawaii, so I'm an associate clinical professor of medicine at the John A. Burns School of Medicine at the University of Hawaii and have been here for about four years taking care of patients.

I've been active in the single-payer movement since I was a resident at UCLA when I first heard a talk about our healthcare system and how single payer might be a potential solution, and this was back in 2006, I was absolutely blown away by the prospects and so decided to start getting more active in healthcare reform and healthcare advocacy at that time.

(01:48):

Q: Thank you. Today we're facing a formidable challenge to Medicare. It's increasing privatization through a government program called ACO REACH. Can you briefly explain what ACO REACH is in layman's terms?

(02:03):

Verhoef: ACO stands for Accountable Care Organization and we saw ACOs be introduced into the healthcare system with the Affordable Care Act or the ACA and the notion of an ACO is that it's an organization or a group where the outcomes for how patients do determine how much reimbursement doctors get in that context. And so that's the accountable part of it, right?

So the idea is if your patients do well, then that's a good thing. If your patients don't do well, that may impact how much reimbursement that you get and it's honestly not that different from the old school HMO or health maintenance organization. We saw the rise of those back in the eighties and nineties. The real difference is that ACOs are now groups of physicians. That's kind of the idea. The idea behind the

ACO REACH program is that the government will support enrolling Medicare patients into one of these ACO REACH programs.

(03:05):

You know, a Medicare patient would become a part of an ACO as a function of their doctor and their doctor would be a part of this ACO and then that would determine the kind of care that patients get, at least at some level. Now, this is a pilot program that's been introduced through the Centers for Medicare and Medicaid Innovation and the reason that that's important is [that] programs introduced under CMMI are not subject to the same degree of congressional oversight. In essence, the Centers for Medicare and Medicaid innovation was created also in the ACA back in 2010. The idea was "let's create a program to allow innovative ideas to be tested out on Medicare patients potentially, or Medicaid patients." Well, that seems like a nice idea in the sense that maybe this lets us get engaged in quality improvement more easily without having to have an act of Congress or some other kind of massive bureaucratic obstruction.

(04:00):

I think the problem here is with the ACO REACH program, the pilot is to take Medicare patients and put them in an ACO. That happens without the patient necessarily knowing. It happens, without Congress being able to oversee that and the reason that's a problem is that these ACOs, even though they're comprised of docs, they can actually be run by pretty much anybody. It could be run by a health insurance company. It could be run by a private equity company. It could be run by some individual who just wants to run their own ACO and that means that this is a defacto form of privatization of Medicare. And you know, I guess you'd ask yourself, why would an investor want to get involved in this? Well, if docs are reimbursed as a function of the patients that they have in their ACO and how much it costs to provide care for them, this is one of the common criticisms of capitation that if I give you x amount of money to take care of this patient, the only way you make money is by doing the least that you can for them.

(05:00):

And so ACO REACH is another way of saying to the doc, 'Hey doc, do the least amount that you can for this patient because that's the way that you are going to make the most money.' Or more importantly, to the private equity investor, they are operating under the same sort of idea that they want to do the least that they can for patients in these ACOs because that means they recap the most money and so this kind of privatization is I think really sinister because it's not putting patients'

health first, it's putting the shareholders and whoever is vested in these ACOs, whoever's running them, it's putting their profits first.

(05:37):

Q: Mm-Hmm. You said ACO REACH is supposed to hold physicians or providers accountable for patient outcomes. So does it do that?

(05:44):

Verhoef: The short answer is potentially, but the problem is we're creating financial incentives that are linked to outcomes and I think that that's always going to be a problem, right? The real reason I take care of patients is to make people better and that's enough. I don't actually need financial incentives to improve the health of my patient. I want them to get better. So when you create a company or an organization or a process that gets in the middle of that and says, 'hey, there's an opportunity to make money here,' you know, I think it sort of creates this problematic scenario where you're saying, 'Hey, you can make money and have healthier patients.' People are making money, but that's money that's going into people's pocket. It doesn't necessarily mean that patients are absolutely getting better health. How do you measure that somebody's doing better? I think that's a really, really difficult thing to measure.

(06:33):

And in the end, we'll see, or we would anticipate the same kinds of processes within these ACO REACHs that we see in Medicare Advantage, which is to say you do what we call cherry picking. You pick only the healthiest patients to bring them into your ACO because of course if they're healthy, they're not going to cost you any money. And you get to keep all of the money that you get for having that patient. And then you do what we call lemon dropping, which is get rid of the patients who cost the most, right? Find ways to kick them out or not provide care for them because again, they cost too much money and so those kinds of incentives are not geared towards the health of the population on the whole, it's geared towards making money for somebody at, you know, within their own scale.

(07:16):

Got it. Thank you for explaining that.

(07:18):

Verhoef: Let me add one more point. The thing about the ACO REACH program is that it's effectively a rebranding of a program that was initially going to be rolled out

in the Trump administration called DCE – Direct Contracting Entity. These were plans that were designed to group patients from traditional Medicare into these ACOs and a DCE was no different, but they rebranded the program because, you know, the Biden administration doesn't want to roll out a Trump administration program so let's basically change the name, call it ACO REACH, where REACH stands for realizing equity access and community health and it really sounds like it's a well-intentioned program, but I think the truth of the matter is it's relying on a bunch of mechanisms that are really simply easily able to be gamed, mechanisms that involve opportunities for profit depending on what your outcomes are.

(08:10):

And whenever you do that, I think that it's going to inevitably provide inequitable care. It's not going to actually realize equity at all. It's just going to allow organizations to find the patients that do the best and not take care of the ones that are the sickest and need it the most. And the thing that's bothersome for us at PNHP is that one, this is a move towards privatizing Medicare, but also it's done without Congressional oversight and it's done without patients even knowing that they're being enrolled into such a program. And the only way a patient could get out of an ACO REACH program is by changing their doctor cuz their doctor is getting enrolled into it and so you actually have to leave your doctor if you don't want to be a participant in a program like this. And you know, it's sort of ironic that people are talking about choice, right? I mean, what more does a patient want but to be able to stay with their doctor? And yet here we are creating a system where if a patient doesn't want to be involved, they actually have to change doctors and that's actually, I think, counter to the notion that you could see whatever doctor that you want and get the kind of care that you need that's appropriate. These kinds of agreements actually limit that for patients.

(09:20):

Q: Hmm. I guess one of the questions I have is if doctors or providers are incentivized to not spend money on their patients and the concern is that doctors aren't going to do the best thing for their patients to make more money. Isn't that an awful thought?

(09:35):

Verhoef: And I think that's a really astute question, right? You have to understand that the opportunities to make money are twofold. It's doing the least that costs money, but it's also trying to, because there are going to be incentives for you to, as a function of the outcomes for your patients, you know, you'll actually get paid

extra money, right? So the capitated part is you may not be penalized, but you may not have access to the additional money if all of your patients – sort of just trying to be much more of a carrot than a stick, right? You'll still get paid for taking care of them under the regular fee for service agreements. You're just not gonna get the extra amount of money that you would get depending on their outcomes or depending on whatever metric the ACO is using. So for instance, if the goal is to have patients have the least long length of stay in the hospital and you don't achieve that, then you're basically not going to get that bonus.

(10:28):

Right? If that makes sense. And so there is an inherent conflict in all of this with doing the right thing for the patient. I actually think the vast majority of doctors do want to do the right thing for the patient. And to be honest, I've actually heard from docs who like the idea of an ACO REACH where they've said, 'look, this extra money that we've been given based on the good work that we're doing has given us a little bit more flexibility to be able to provide other kinds of care for our patients.' Right? I love that. Right? I love that it's actually liberating for some docs and that's exactly what the program was intended to do.

The problem is the program doesn't have any restrictions on profiteers getting in there and finding a way to skim money off and make money themselves. And so, you know, like many things, I think this program was perhaps designed with good intentions, but there were enough back doors left open that you could get your way in there and in effect, privatize this thing and really be motivated more by at least somebody would be motivated more by finances than by truly the health of patients.

(11:36):

Right,or maybe they could convince themselves that this other treatment or this other option might be just as good, it costs less, let's try this first and maybe you're wasting precious time in the patient's treatment.

(11:49):

Verhoef: Yeah, it's interesting. I think the fear also is that if you're a doc enrolled in an ACO and you end up having patients that tend to be pretty expensive, that an ACO can actually just kick the doctor out and therefore sort of deny them the opportunity to get, you know, this additional funding to support taking care of patients and this gets at sort of a different but still really important problem with Medicare as we currently know it. The reimbursement rates are not terrific. You know, in general, Medicare's reimbursement rates are less than they are for

commercial insurance and so many physicians have to sort of ask themselves this question, can I even afford to take Medicare? Does the reimbursement that I get from Medicare, is it enough for me to pay the rent? Is it enough for me to pay my staff? Is it enough for me to keep the lights on and continue to do the work that I want to do?

(12:41):

And so physicians or physician group practices will very clearly monitor the number of commercially insured patients they have versus the number of Medicare patients versus the number of potentially Medicaid patients. And so one of the real problems is that Medicare reimbursement isn't always very high relative to commercial reimbursement. And so, you know, this is in a way, a way of incentivizing docs to take Medicare patients cuz you can get this additional money on top of that. The problem is that that then begins to set up some incentives that aren't really very sound right, where we're doing things to make money more than anything else. Now, I would love to see Medicare overhauled, I would love to see reimbursement rates better than they are and so that physicians wouldn't even have to make this choice. You know, I've, I've certainly known docs who don't want to stop taking Medicare, but they simply can't afford to based on the rates that Medicare reimburses if you're in a particularly expensive area to practice medicine.

(13:41):

And so in a way a program like this can attract physicians because they want to take care of Medicare patients. They say, 'oh, this is an opportunity for me to get a little additional income in the context of maybe meeting some of these metrics and whatnot and then that's good for me, it's good for patient care, it's good that I can continue to take Medicare patients.'

There are more and more physicians who simply don't take Medicare at all. Or even worse, they just choose to not even accept commercial insurance because they don't like the headaches of having to deal with, you know, insurance companies denying care or limiting who you can go see or prior authorizations. The good thing about Medicare is it doesn't have prior authorizations. It doesn't have denial of care, it doesn't have narrow networks like commercial insurance does, but commercial insurance just pays a whole lot better.

(14:28):

You know, and so this is definitely something that PNHP thinks about too, is it's not just fighting the privatization of Medicare, it's also how do we just make Medicare better? You know, how do we make it function more effectively for more people?

You know, how do we make it so that you don't have to buy separate insurance for your hearing and your dental? How do we make it so you don't have to buy separate insurance to cover the co-payments, right? You know, Medicare doesn't provide first dollar reimbursement for all of your care. And so there are certainly ways that Medicare itself can be improved.

We certainly don't think that privatizing Medicare is the key to that improvement, but there are a number of ways that we could make it better. These ACO REACH programs are not it though. We really feel like this is, you know, privatization and potentially if all of traditional Medicare gets involved in this, that will make our job so much harder to try and actually advocate for a government-run insurance program that doesn't have any middlemen in it.

(15:32):

Thank you Dr. Verhoef.

Do you have a personal story you'd like to share about our wack healthcare system? Contact us through our website at heal-ca.org.

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