'If You Give a Mouse a Cookie' & other healthcare myths

“If we did have a Medicare for All system, physical therapists especially would be incentivized to do one-on-one treatments, which would increase, I think, patient satisfaction a lot.” -Ariel Wynne

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 Gazar.**

(music)

This time on **Code WACK!** How does the way health insurance works discourage patients from seeking care in the first place? What other challenges do physical therapists face when dealing with a variety of insurance plans and regulations?

To find out, we spoke to **Ariel Wynne,** a physical therapist and board certified pelvic health clinical specialist in Chicago. Ariel recently opened her clinic, **Ground Floor Physical Therapy,** which specializes exclusively in pelvic floor physical therapy for all genders. This is the second episode in a two-part series.

Welcome back to **Code WACK!**, Ariel.

Wynne: Thank you for having me.

Q: Last time we talked about how physical therapy costs can be all over the place depending upon patients' insurance. How do patients even know what they're expected to pay? Is that something you have to research and then tell them?

Wynne: Most insurance companies nowadays have an online website that we can go and we can put in our patient's information and we can kind of get that information pretty quickly as far as – do they have prior authorization issues, do they have a copay 'cause we are supposed to collect that. Have they met their deductible? What are their co-insurance rates? So we are expected to know that and explain it to them. And this is a little thorn in my side as a healthcare provider, but we are expected to collect that money.

It's hard. It's a really hard situation. Yeah... It's something that's been just a weird quirk of the insurance company. I think it's up there with that changing to copays and changing to having a quote unquote skin in the game where there's been this assumption that people need to pay out of pocket to appreciate and to mitigate overspending. If people have to pay their own money, they won't use it as often.

But I think one of the big problems is we have this myth of people overusing healthcare when really Americans under utilize health care. How many people do you know that avoid going through their doctor because they don't know how much it'll cost. They're scared. They don't want to deal with what might be a minor health issue before it becomes a major health issue and so people are avoiding and they're missing the opportunity to catch these preventative healthcare issues because they just don't know what it's going to cost. They're avoiding healthcare because of the skin in the game concept. But if we got rid of it, people would use more health care and that inevitably is more expensive and that's unpalatable to people who are then paying in taxes and things like that. It gets very, if you give a mouse a cookie is my usual explanation.

Q: Oh, interesting. I had never heard that expression before. What does that mean?

Wynne: Okay, so there's a children's book called 'If You Give a Mouse a Cookie' and the whole story book is, there's this little cartoon mouse and it's if you give a mouse a cookie, he's gonna want a glass of milk and if you give him a glass of milk, he's gonna want a straw. And if you give him a straw, he's gonna want a blanket. And so it sets off this chain reaction of dominos essentially. So it's kind of like we were talking about earlier with those barriers to care where if you have a copay that might limit the amount of times you can go to physical therapy per week because you can't afford to. And let's say you move from twice a week to once a week so that it's more affordable, but then you miss your once a week because you missed your bus and you're not gonna make it in time.

Or the babysitter fell through and now you've missed two weeks of physical therapy and life gets busy and so you don't come back. And now that preventative of care that we were going for, that pain kind of adds up and now you're getting surgery which is overall much more expensive. So it becomes these very expansive social determinants of health very quickly after you get outside of the health insurance issue itself. Right. And it's what we talk about all the time in health care where as healthcare providers we can do as much as we can, but if somebody is unhoused, we're not gonna be able to help as much as somebody getting them a house. And so we get back into this patchwork.

Q: Yeah, great explanation. Thank you so much. So we talked a little bit about reimbursement and how PTs are compensated compared to other healthcare specialties. Did you wanna add anything to that?

Wynne: No, nothing huge. Like it could get really wonky if I got into like the 15 minute rule and, and all the ways that we need to like, like bill by the minute, which is just in some ways it's helpful because if you are having a short visit with someone and it's only gonna be 10 minutes, you wanna get paid for that. So you want to make sure that there's this allowance for short visits as well as long visits. And this allows us to kind of chunk it up and say, okay, I did this for 10 minutes and I did this for 25 minutes and so I get three units but it makes interpreting your physical therapy bills very confusing 'cause you're saying, well I went to physical therapy, but they're saying they did two units of neuromuscular reeducation. What on earth is that? And they're saying they did one unit of therapeutic activities, what is that?

And if you dig down deeper, I was on the table doing coordination exercises. I was standing up and sitting down in a chair and so we know what each thing is, but we need to go and say minute by minute. And it's not unusual, especially with Medicare

in skilled nursing facilities, to go back and really go minute by minute and say, ‘ah, you didn't do 25 minutes, you did 22 minutes. And so because of that we take away one unit’ and so that can remove essentially 30% of what that bill was because of this kind of arbitrary number system. So that's when people get frustrated with Medicare, a lot of times it's because of these sort of burdensome regulations where you need to keep track of it. And it's that rule was made in response to other things that were going wrong.

It’s like we made one change to help a different thing but created a different issue. Like my usual example with my patients is a lot of Medicare and other insurances will require us to report our patients' BMI in order to get paid. And that's because they want us counseling our patients on weight and obesity and health changes associated with that. But a lot of my patients deal with weight stigma and the medical office is the first place and usually the worst place that they deal with it. They're like, Ariel, why are you talking to me about BMI? This isn't even relevant to my pain or the issue that I'm having. And I'm like, I know that, you know that, but I need to collect your height and weight in order to get paid. And so again, it's another one of those issues where it creates a barrier between your healthcare provider and the patient. And as a healthcare provider, we want to be there for our patients in the best way possible, but with all these regulations we just have to like check boxes.

Q: So are those regulations only with Medicare or also with Medicaid?

Wynne: A lot of insurances just follow Medicare's lead. So that's one of the reasons why healthcare providers will fight so hard against Medicare reimbursement cuts because if Medicare lowers reimbursement, it's a signal to all these other insurance companies that they should also bring their reimbursement down. And if Medicare says we're no longer gonna pay for this ineffective care. So if they say, Hey, you know what? Manual therapy and physical therapy has been proven in research to not be long-term effective compared to exercises. And exercises also make people stronger. And so Medicare said, Hey, we're going to reimburse less for that hands-on joint mobilization and muscle work that people associate with physical therapy. So now people feel better with manual therapy and so they feel better and so they can exercise more. So as physical therapists, we still value what that does for our patients. We still value the way that it helps us diagnose them and see what's going wrong and see where the issue is. But we get reimbursed less so we can't do 30 minutes of it, we have to do 10 to 15, we have to wean people off of it faster. And then people say, well, I'm not getting the hands-on care that I associate

with physical therapy. I'm not going to keep going now that I'm getting better and doing more exercises. And so it creates these weird inconsistent incentives for patients and for providers.

Q: Wow. You can see how many challenges you have as physical therapists.

Wynne: Yeah, so I'm also one of the chair members of the Academy of Physical Therapy Association, Academy of Pelvic Health, so the APTA, the (American) Pelvic Health Academy Inclusion, Diversity, Equity and Access (IDEA) Committee. And so we always talk about how can we increase access, how can we reduce barriers to care? How can we as physical therapists be better and how can we advocate for better for our patients? So I'm also weirdly in tune with a lot of these issues from a pelvic health standpoint at the very least.

Q: Right, right. What a great vantage point you have. So you used to work for a hospital. What was that like for you as a physical therapist?

Wynne: So I worked for the University of Chicago, so it's on the south side of Chicago so it was a nonprofit based hospital, which is important to me. And it was really a great experience because we all used the same electronic medical record so I could see what other doctors were doing, what tests had been done, patients didn't need to remember and kind of telephone them to me like that game of telephone. And I got to see much more complex patients and talk directly to their medical providers. They were always an email away. So there was this really direct communication, really complex caseloads.

And actually a majority of my caseload at the university was Medicaid patients, which in my entire career as a physical therapist, I never got that opportunity because I've always practiced in Illinois and Illinois Medicaid reimburses so poorly that I never actually got the opportunity to treat Medicaid patients. Even though they're 25% of Illinois so one in four people in Illinois are on Medicaid, but not able to access physical therapy outside of nonprofit hospitals because of that difficulty making ends meet with it. And so it obviously varies so widely between states. Like I have friends who work in different states that say, ‘yeah, Medicaid reimburses essentially the same as private insurance here so of course we take it.’

Q: Really. So in some states that's the case?

Wynne: In some states it is absolutely the case where they say, Hey, you know what? It reimburses exactly the same as Medicare because legislatively we've decided to tie the two together. And so if we take Medicare, we take Medicaid, of course it just makes financial sense. But in Illinois it's so wildly, drastically different. And that's one of the things that we are advocating for here is trying to get it tied to Medicare and so even though Medicare reimbursement keeps getting cut, at the very least it would bring the floor up.

Q: Right. Do you happen to know what the Medicaid reimbursement currently is?

Wynne: Yes. $36 for an hour of one-on-one care. Yeah, it's not a lot. And for example, like I am a one person shop, I do everything myself, but it still costs me about $80 to treat somebody for an hour. So that's not even 50% of my costs, not even counting profit.

Q: And then what about Medicare? What would be the comparison?

Wynne: Medicare is a little bit different, but you can usually expect somewhere in the range of $100 to 110 for an hour. Obviously it depends on did I do a lot of manual therapy? Did I do a lot of exercises? There's variation in the units, but at the end of the day, it's going to be a pretty fair cost anywhere from $80 on the low end to like $110 on the high end for an hour of one-on-one care. Now the issue with a lot of large orthopedic practices is they're trying to see a lot of patients at once, so they're seeing two to four people and so if you're not one-on-one with that Medicare patient, you're only getting 15 minutes of one-on-one care, then it's harder. Whereas if I'm seeing three different private healthcare companies, they don't have those same rules as far as one-on-one care.

And so I can see three different private insurance patients at once and get paid the same amount from all three, which is much more financially viable than seeing three Medicare patients at the same time. Right. Because now I can't bill that way and so it doesn't make sense financially. I think that's another really big difference in if we did have a Medicare for All system, physical therapists especially would be incentivized to do one-on-one treatments, which would increase I think, patient satisfaction a lot because if you are going to a large physical therapy clinic, you're not getting much one-on-one time with the physical therapist, you're doing a lot of your exercises on your own with very loose supervision, you're going to say, I could just do these at home. I don't see value in this even though it's again, conservative non-pharmaceutical function focus. So even though it hits all of these really important value-based care boxes, if physical therapists are juggling so many people, those people don't feel that value. That's one of the reasons I started my

clinic was so that I could practice one-on-one for a full hour, even with my private health insurance patients.

Q: Oh, okay. And how long ago did you start your business?

Wynne: Just a little less than a year ago.

Q: Wow. And how's it going so far?

Wynne: It's going pretty good. I always joke that I definitely work more because I'm doing marketing and all that stuff as well as being a physical therapist. But I think that that sense of autonomy is so important and a lot of times we talk about that with burnout where people have these really high expectations put on them that they can't meet because they're just physically impossible. Like seeing three patients an hour as a physical therapist, but I'm arguably working more, but I have autonomy. I'm the one putting those expectations on myself.

And so I think that's another thing we see a lot with healthcare consolidation and private equity coming into healthcare. People get these really high expectations that are unreasonable put on them and they can never downshift, they can never make a change. They can never have a voice in that system because it's so big and it's so focused on profit. But with my clinic, I can make a choice. I can say, you know what, I'm going to have a sliding scale so that people who are uninsured can still see me hopefully for an affordable amount of money.

Right, right. And that must be more rewarding to be able to do that as well for you and fulfilling.

Wynne: Much, much. And for me, it was also extremely important to make my clinic gender neutral because I do see people of all genders. And so if you have a pelvic floor clinic specialty, a lot of times you'll have pink walls, female people on all the posters, all the assumptions on the medical forms are about somebody who's female. And then I have a male patient walk in and they're like, ‘oh, oh, I feel so out of place. I feel so uncomfortable even though I'm in the right place.’ And so it was really important to me to control my marketing and my education and my materials and that was one of the things, weirdly, that was a sticking point for me as an employee a lot.

Thank you Ariel Wynne.

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