'You're not safe':
How middlemen are corrupting traditional Medicare

“Our healthcare system - by definition - corrupts because it's a profit-seeking healthcare system. It's a market-based healthcare system that promotes consolidation, that increases costs, and it lowers quality of care.” – *Ana Malinow, MD*

911. What's your emergency?

America's healthcare system is broken and people are dying.

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.**

(music)

This time on **Code WACK!** You probably have heard by now about the dangers of Medicare Advantage, but did you know that traditional Medicare is being privatized too? How is this corrupting our healthcare system even more and what does this mean for patients? To find out, we spoke to **Dr. Ana Malinow,** who spent three decades working as a pediatrician with immigrant, refugee and underserved children in Ohio, Texas, Pennsylvania, and California before retiring as Clinical Professor of Pediatrics from the University of California San Francisco School of Medicine. She’s past president of **Physicians for a National Health Program** and

is currently a lead organizer for **National Single Payer** and **The Movement to End Privatization of Medicare.** This is the first episode in a two-part series with Dr. Malinow.

Welcome back to Code WACK! Dr. Malinow!

Malinow: Thank you. It's so nice to be here again with you and to see you and to do this.

Q: We're so excited to have you. So it's well known that American health care is insanely expensive and it's getting more expensive every day. We keep tweaking the system to hold down costs with an alphabet soup of solutions like HMOs and ACOs but nothing seems to help. All these tweaks seem to be related to something called value-based care. What is that exactly?

Malinow: I like to think of Medicare like a pie, where the whole pie is 65 million beneficiaries, which costs the federal government about a thousand billion dollars every year. It's a lot of money.

A thousand billion dollars?

A thousand billion. That's a trillion, almost a trillion dollars is the Medicare budget for 2024. So half of that pie is already privatized through Medicare Advantage. Those are individuals who choose in quotation marks, and we can get into that later, a Medicare Advantage plan to manage the care of their medical needs once they apply and once they have Medicare. Now, the other half of the pie is what we call traditional Medicare. These are seniors who have rejected Medicare Advantage and pay extra to be able to choose their own doctors, go to their own providers, and so forth. Those are the people on traditional Medicare. So about half of the people choose Medicare Advantage and the other half choose traditional Medicare.

Now, a lot of attention has been paid to Medicare Advantage, but I think what people have done is, as they have trained their focus on Medicare Advantage and all the problems with Medicare Advantage, we have shifted and forgotten about the other half of the 65 million beneficiaries that are on traditional Medicare and

these individuals on traditional Medicare are at risk of being privatized as well. And this is what a lot of people don't realize and how is it that beneficiaries on traditional Medicare are at risk of having their benefits privatized? Well, it's through something called value-based payment. So let's go through what value-based payment is and how it started. Well, everything that I answer is always going to be sideways because there's always something to explain before we explain what we're going to explain, right?

<Laugh>. Okay. So I need to explain how the reimbursement system is in traditional Medicare. Under Medicare Advantage, we have capitation, and we can talk about what capitation is later. But under traditional Medicare, providers, doctors and hospitals are reimbursed through a mechanism called fee-for-service. Now, it sounds complicated, but it actually is not complicated at all. Fee for service is the way that a provider or a doctor gets reimbursed. So for example, say you are on traditional Medicare, you go to your doctor, your doctor performs a service, then that doctor bills Medicare for that service, and Medicare pays the doctor directly. See, it's very simple, <laugh>. There's no middleman, there's nothing in between, nothing managing your care, right? It's a very, very direct relationship. There's nothing in between Medicare and the doctor or between the doctor and the patient. That's fee-for-service. Now, fee-for-service has been blamed as being the root cause of all problems in our healthcare system.

And according to healthcare policy experts, it is the reason why we have such high healthcare costs in the United States because they say that it incentivizes greedy doctors to order more tests and more procedures so that they can be reimbursed more by Medicare to increase volume – and that greedy American patients get too much care and too many procedures and that's also driving up costs. So the problem, according to healthcare policy experts since the 1970s, has been that the reason our healthcare costs are high is due to fee-for-service.

Now, unfortunately, there is no evidence to back that up because we know what really drives up costs in the U.S. are prices and consolidation, because if you look at other countries that have universal health care, that have better outcomes and have lower costs, they all use fee-for-service to reimburse their providers. So it cannot be that it's fee-for-service that is driving our high health care costs.

Furthermore, we know that up to almost 40% of Americans say that they skip care due to cost. So if patients, if Americans are skipping care due to cost, it's not because they're getting too much care. In fact, they're getting too little care. So the myths about fee-for-service driving up volume from greedy doctors and greedy patients is just not true and so unfortunately, what has happened is that Medicare has the wrong diagnosis – that fee for service is the problem, and as a result, they have come up with the wrong prescription, right? Mm-Hmm. <Affirmative>, the prescription for Medicare has been to either do capitation, which is managed care under Medicare Advantage, or to do something called value-based payments for patients on traditional Medicare to control costs. Now, how are they doing that? Well, value-based payment inserts a middleman between Medicare and the provider. Remember, fee-for-service has no middleman. It's direct, but now they're inserting a middleman between Medicare and the doctor and between the doctor and the patient. And so it's this middleman that gets to manage the care of the patients on traditional Medicare.

Now remember, patients on traditional Medicare rejected Medicare Advantage's middleman, and they're willing to pay more money to be on traditional Medicare, but now they find themselves in these middleman arrangements. And how is that happening? Well, there's a middleman that now is managing the care of patients on traditional Medicare. Not only do they have a middleman, but also they have performance measures that physicians and doctors have to meet that are financial incentives.

So doctors are now on the hook to control costs, because if they do not control costs, then they're not going to be able to share in the savings that supposedly these middlemen are creating.

Okay so you have performance measures for doctors, you have middlemen, and then you have something called spending targets. Very similar to capitation, spending targets is what Medicare gives these Accountable Care Organizations, which is really what they are, they give these accountable care organizations, these spending targets. So for Mr. Smith, we're going to give you a thousand dollars every month. If you only spend $800 on Mr. Smith, then you get to share a

certain percentage of the savings. But if you spend $1,200 on Mr. Smith that month, you are on the hook for paying Medicare back.

Wow.

Malinow: Right. That is value based payment. The important thing about value-based payment is it has nothing to do with value. It has little to do with care. It has much more to do with payment and everything to do with managed care. So I know that if I tell you don't think of a tsunami, right? What is the first thing you're gonna think about?

A tsunami!

Malinow: Exactly. So if I tell you value-based care, the first thing you're going to think about is value. And then you're gonna think about care. But the problem is is that value-based care or value-based payment, which is basically very similar and people use it interchangeably, is that it has nothing to do with value, little to do with care, and a lot more to do with payment, everything to do with managed care, because that's what it's doing. It's inserting a middleman to manage the care of people on traditional Medicare. That is value-based payment.

Q: And the middleman, is actually, is it a company or a private equity or who is the middleman exactly?

Malinow: Very good question. Who is that middleman? Well, again, sideways <laugh>, another step backwards. How did we even start with these value-based payment schemes? Well, the Affordable Care Act that was passed in 2010 dramatically changed the way that providers on traditional Medicare would be reimbursed. They would be reimbursed to push them away from fee-for-service towards value-based care. They said, you can do this in one of two ways.

One is we're going to create this thing called Medicare Shared Savings Program and in order to have this shared savings that we were just talking about, you create these entities called Accountable Care organizations and they become the middleman. Now, who are these ACOs? Well, yes, they can be Medicare Advantage plans that run ACOs, like Humana runs an ACO. They can be private equity, they can be venture capitals. They can be large health systems.

They can be for-profit physician practices, they can be other health systems. So that becomes sort of the middleman. They're not all for profit, like some health systems, you know, academic health systems that are ACOs are not necessarily for profit, right? They're not for profit, but they're profit seeking because their incentive is to try to share as much of those savings as possible and then to try to avoid losing <laugh>, you know, or having to pay Medicare back.

Now the other way that it changed the reimbursements mechanism, not only through the Medicare Shared Savings Program, but it was also through the Centers for Medicare and Medicaid innovation and that was a center that was set up to control the cost of Medicare and improve, or at least not worsen the care of seniors on traditional Medicare by moving them away from fee for service towards value-based care through these models and one of the models is ACO Reach that some people have heard about. It used to be Direct Contracting Entities, DCEs under Trump. It was rebranded by President Biden's administration into ACO reach, and those are middlemen, those are another form of middlemen that get between Medicare and the doctor and those middlemen, yes, can be private equity firms, venture capital firms, Medicare Advantage plans, and so forth. Any company can apply to be an ACO Reach middleman.

Q: So essentially you're not safe is what I'm hearing is even if you avoid the pitfalls of Medicare Advantage, which you know is narrow networks, pre-authorizations – all the problems that come with Medicare Advantage – just because you're in traditional Medicare doesn't mean you're not going to be privatized.

Malinow: Exactly. That's exactly right. You're not safe. That's really, really true and then one other thing that is really, really important is how do these seniors find themselves in an ACO? They didn't sign up for one. Well, they are what is called in CMS language “aligned” through their primary care doctors into an ACO. So for example, with ACO Reach, if your doctor has been recruited by one of these ACO Reach middlemen into an ACO Reach, then all the patients from that doctor's panel become aligned into that ACO Reach without the knowledge or consent of the seniors and the exact same thing happens with ACOs. Seniors are not aware

that they are now in an ACO, they're not. Even though these hospital systems have to put up some sort of notice on the bulletin board that now we're part of an ACO, Well, good luck, you know, <laugh>. So basically seniors are being assigned into an ACO without their knowledge or consent through their primary-care provider for the most part, or whatever health system they are part of. If the health system is now an ACO, they become entangled into that ACO as well.

Q: So why would a physician or a health group join an ACO?

Malinow: Well, physicians are, for the most part, not making these decisions. I will tell you. Physicians now belong to larger groups. They belong to health systems, and it's the leadership of the health system that is making these decisions for physicians for the most part. So why would a health system want to be part of an ACO? It's because what is happening is that they are being promised the possibility of sharing any savings that they have for their beneficiaries so that they're going to be reimbursed for their services.

Plus, they get to take home whatever they save. You know, under fee for service, that isn't happening at all because Medicare reimburses the doctor, but now they have, you know, these ACOs have these spending targets that are basically like capitations, right? Monthly per member per fee. Although it's much more complicated than that because that would be too simple. But at any rate, just sort of think of it as a spending target that you get to keep for, you know, Mr. Smith, you know, for the thousand dollars that you get for Mr. Smith, you get to keep whatever you don't spend on health care. And if you only spend $500 on Mr. Smith, then you get to keep a share of the $500.

Q: So do you think this whole system is corrupting health groups?

Malinow: Absolutely. Our healthcare system by definition corrupts because it's a profit seeking healthcare system. It's a market-based healthcare system that promotes consolidation, that increases costs, and it lowers quality of care.

Q: So yes, let's talk about how this is affecting patients who maybe have been co opted, their health group was assigned to an ACO or co-opted into an ACO, and now what does that mean for these seniors?

Malinow: What Medicare will tell these seniors is that because you're on traditional Medicare, you still have the right to choose any doctor or provider or hospital that accepts Medicare. They are told that. This is true. But think about this. If you are a doctor in an ACO and you know that your salary depends on the savings that you make on this patient, and your ACO is a network that has decided that, you know, this is where you go to the hospital, this is where you go to get your X-rays, this is where you go to get your labs, this is where you go get your cancer care. This is where you go see your specialist. Then that doctor is incentivized to use that network because they know that any patient that goes outside of the network will cost them money because then CMS reimburses that other doctor outside of the system.

Q; Okay, so why is that so bad though, if they use one network of doctors?

Malinow: Well, exactly. Why is prior authorization bad? Why are narrow networks bad? Because what it does is it will incentivize these networks to have contracts with providers that possibly are lower quality, and that's how they're going to get better lower costs, right? It's because when, for example, Medicare Advantage has contracts with certain providers and certain hospitals that are possibly not the best in quality, but they give them a really good rate and so that's why they have networks. It's because they're getting good rates. And with ACOs, you can say the same thing. Yes, you have to get your, not you have to, but we're going to be encouraging you to get your care here.

Now think of it as a beneficiary. Say you're a senior and you've been going to this doctor forever, and suddenly you're diagnosed with cancer, say, and your doctor says, 'okay, well I think you should go to this center to get your cancer care.' Now, the patient doesn't know from ACO, right? <Laugh> has no idea that that, that they're actually possibly being sent to a cancer center that is possibly not going to be giving them the best care possible. Right? And once the patient understands that this is what is going on, then the patient is going to think to him or herself, you know, whose best interest does my doctor have – mine or the ACOs?

Q: Wow. It's disheartening to know that doctors could fall into this trap, but it's almost like they're being forced in a way, like to choose between the care of their patient and their own salary.

Malinow: Absolutely. Absolutely. Yes. It creates perverse incentives for doctors. Exactly and it directly threatens their agency, their care and who it is that they really should be looking out for and I think that also drives physician burnout as well, because I believe being a pediatrician and being a physician, that most doctors go into the practice of medicine because they want to serve their patients and now they're being put in this position that that's not going to be the case, that that's being threatened because if you put your patient first and foremost, then you might end up cutting your salary.

Thank you Dr. Ana Malinow.

Stay tuned for next time when we delve further into the privatization of traditional medicare through ACO Reach, and what we can do about it.

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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