ACO Kickbacks in the News and Gatekeeping in the Courts

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In 2018, Administrator Seema Verma of the Center for Medicare and Medicaid Services (CMS) wrote that she was disappointed that 82 percent of Accountable Care Organizations (ACOs) lacked "savings,"[1] i.e., profits, to share with CMS. She anticipated that the new CMS "Pathways to Success" program would furnish ACOs the "opportunity" of greater "shared savings" through "waivers of specific fraud and abuse laws, including the physician self-referral law and the federal Anti-Kickback Statute."[1,2]

ACO: an Insurance Corporation Practicing Medicine

ACOs require waivers of patient protection laws because ACOs are profit-driven mini-insurance corporations without a license, practicing medicine without a license.

The ACO insurance corporation covets the professional appearance and legal attributes of large integrated clinics, which earn, and split monies paid, for delivering services. In contrast, an ACO insurance corporation needs a waiver "license" to split premium profits earned from clinicians rationing services.

Federal Trade Commission (FTC) waivers of anti-trust laws[3] established as policy in 2011 allow creation of government-protected (i.e., crony) corporate cartels through mergers of competitors including hospital and staff (aka ACOs), as well as HMOs and ACOs. Merger mania has followed.

CMS waivers of anti-fee-splitting kickbacks and Stark anti-self-referral (Anti-Kickback) laws[4] published in 2011 legalize transfer of insurance corporation financial risk to mini-ACO corporations and their gatekeepers. These players split insurance premium (capitation fee) profits to fund kickbacks (return of part of a sum received often because of a confidential agreement or coercion),[5] so that all players, including CMS, may share the profits of corporate rationing of care ("gainsharing"). Rep. Pete Stark's 2005 efforts to stop gainsharing proved futile.[6] The ACO business model[2-4] permits profiteering contingent on the volume of referrals (i.e., an "unfair profit, generated often through…abuse of dominant position."

How did an intended cure for cost inflation end up as an insurance game of profiteering through gainsharing kickbacks at the bedside?

The Origin of Unrelenting Cost Inflation

Unrelenting U.S. cost-price inflation began abruptly after 1965 for the first time in nearly 90 years,[8] following passage of the Medicare and Medicaid laws.[9; 10, pp 48-57; 11, p 1] This was a turning point when 85 percent of the populace suddenly had inexpensive tax-subsidized insurance (employed workers and, since 1965, official old, poor, and disabled)—a piecemeal U.S. version of National Health Insurance.

The "unplanned" good intentions behind using tax subsidies[12] to artificially decrease the price of insurance meant that non-taxed, apparently inexpensive insurance dollars were used to pre-pay even affordable and expected medical care: the "moral hazard" of insurance.[10, p 325] When care appeared "free"[13] (the boss or government pays for it), sudden demand inflation followed.

Managed Care 1.0 and 2.0 Rationing Failure

Cost control failed during nearly four decades of Managed Care 1.0,[10, pp 48-57] including 1973 HMO profit-driven access barriers, numerous other rationing panaceas,[11] and decades of illness-prevention promises.[14]

All organizations that give the appearance of free care, whether they are HMOs or ACOs in the U.S. or a National Health Service abroad, have an economic fatal flaw. Paraphrasing the economist John Cassidy: no central authority, however brilliant the managers, can accomplish the functions of freely determined prices for the allocation of labor, capital, and human ingenuity.[15]

Managed Care 2.0 (the Patient Protection and Affordable Care Act, PPACA, ACA, or "Obamacare[16]) replicated many experimental panaceas for controlling costs,[10, pp 498-521; 11] which failed from 1965 to 2003. This time, they were to be implemented[1, 17-19] by a more powerful, but still fatally flawed government-protected (i.e., crony) corporate cartel-like system created and legalized through waived patient-protection laws.[2-4]

It is fantasy to expect that medical cartel regulations can have an effect on population health equivalent to the remarkable effect of public health measures on mortality,[20] such as clean water, good sewage disposal, vaccination, and prenatal care, as well as modern highways, food inspection, and basic academic research.

Further, the absurdity of a cost-control fix based on bedside rationing of care should be obvious. Clinicians have no control over such factors as poverty and social and cultural status[21,22] and no control over ACO rationing barriers and aging. This transfer of conditional power to ACO clinicians (who furnish a professional façade) obscures "a clever (but unscrupulous) business model that seeks to husband business profits while pushing off business risk to others" (R.B. Walsh, personal communication).

Kickbacks and System Gaming in the News

In a commentary about a CMS promotional of its Pathways to Success program, *New York Times* reporter Robert Pear[23] wrote that the "kickbacks" or "value-based" care are what one lawyer said was "the administration…inviting companies in the health care industry to write a 'get out of jail free card' for themselves."

Gregg Bloche[24] noted: "Medicare's Shared Savings Program, which rewards ACO physicians financially for restraining spending, doesn't let clinicians off the hook for dishonesty or neglect…. [C]aregivers will move from frustration to insensitivity to corruption when put in an impossible bind between demands for frugality and demands for excellence." Bloche wrote that impossible demands can multiply the possibilities for gamesmanship scenarios. These have led to institutional scandals at Veterans Administration health centers and the British National Health Service.[24,25]

Gatekeeping in the Court Room

In 2019 the Minnesota Supreme Court in the case of *Warren v. Dinter* ruled that an ACO hospitalist "gatekeeper," who had never

seen the patient, was culpable for not "opening the gate," when a result was "reasonably foreseeable."[26, p 14] The patient was sent home, where she died from "sepsis caused by untreated staph infection."[26, p 5] The family sued both clinicians (nurse practitioner Sherry Simon and Dr. Richard Dinter) for medical malpractice.

By extension this ruling could make every ACO and ACO clinician a gatekeeper culpable for lawsuit allegations of harmful delay and/or denial of care.[27] Allegations of such abuse may loom, when *Warren v. Dinter* is deliberated by a jury.

Nonetheless, the conventional wisdom is that rationing access is necessary. For example, political-corporate policymakers have successfully imbued many clinicians and others with evidence-free, grandiose, and vague hopes that restricting care is necessary,[1,2,17,18] will improve health,[28] or is an ethical duty.[29] The AMA Code of Ethics "requires physicians to be prudent stewards of the shared societal resources with which they are entrusted."

When ACOs walk the "precarious line between cost savings and patient care," there is real danger to the corporation.[27] It is a great danger to patients if it includes a virtuous (or duplicitous) belief that rationing is the proper (or only) means to control cost inflation. This belief is a serious threat to the professional covenant of a moral and exclusive fiduciary loyalty to the patient.[30]

Most patients are safe today, because the vast majority of medical workers honor their patient loyalty covenant.[30] This can change tomorrow, as collusive corporations financially coerce corporate loyalty.[1-4]

Gatekeeping Responses

The Minnesota Supreme Court's *Warren* decision may help to protect patients from gatekeepers denying care for a patient who was not been seen by a physician.

Further legislative remedies are appropriate when waivers negate patient protection laws. For example: (1) Where clinician pay is contingent on the volume of referrals ordered, malpractice culpability at minimum ought to be shared lest the ACO abandon clinicians in court. (2) Clinician pay contingent on rationing of care metrics ought to be subject to full disclosure for every ACO enrollee or patient. (3) Federal waivers of laws legalizing kickbacks to corporate clinicians ought to be reversed.

Conclusion

ACO mercenary budget-balancing through profiteering kickbacks to clinicians incentivized to ration care is protected by federal waivers of patient-protection laws. These potentially corrupt means to achieve the "golden goal" of medical-sector cost control jeopardize the integrity of patient care, the medical profession, and the nation's medical sector. Further remedies would be wise.

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