Episode 143.

As the number of patients getting value-based healthcare doubles, many more high-risk patients are excluded. EMMT is a potential bipartisan solution.

Value-based care has emerged as an alternative and potential replacement for traditional fee-for-service reimbursement, centering quality and outcomes rather than quantity. That is the theory. In practice, value-based care has been shown to exacerbate some disparities in the healthcare system by making it harder for those patients with complex conditions, or being impacted by social determinants of health, to access care. Put simply, if some categories of patient are more financially risky than others to treat, providers may find ways to exclude them – unless checks and balances are put in place to help manage risks associated with SDOH and comorbid conditions.

Health policy expert Matt Reiter hosts a discussion featuring Bill Finerfrock from Capitol Associates, and Tom Dorney from The Root Cause Coaltion. Together they discuss the very real danger of widening health disparities resulting from the expansion of value-based care, and the legislative solution proposed by the John Lewis EMMT Act (Equality in Medicare and Medicaid Treatment) which has been reintroduced in 2023 by Rep. Teri Sewell and Sen. Cory Booker.

Excerpt: “But when you actually get down to the implementation (of value-based care), that's where people are really potentially going to be harmed. And one of the sad facts is they're going to be harmed without even realizing it.”

Excerpt: “You know, when he was growing up on the farm there was no such thing as health insurance for them. And the fact that they were born in the South, and they were very poor, and they were African American, and they had a really a difficult life on the farm. You know, that was their preexisting condition.”

Excerpt: “Social determinants of health, the fact that the woman is perhaps overweight, the fact that she's on her feet all day, the fact that she lives in a building without an elevator and maybe in a neighborhood that's not particularly safe, means that she's not necessarily going to be able to do all the postoperative things that you might otherwise do. And so, as a consequence, the risk is that it is not going to be what someone defines as a valued outcome. Now, the fact that the woman has much improved mobility can now, you know, far reduced pain that doesn't seem to get factored in because the value-based payment system created a disincentive on the part of the orthopedic surgeon to take that case on.”

Excerpt: “Really making sure that quality in healthcare includes equity, not just cost savings is a big part of the EMMT Act. And it's something that I think that everyone can and should get behind.”

Excerpt: “Elected officials, regardless of their party affiliation really do worry and care about their constituents having access to healthcare.”

Matt Reiter (Host): Hello and welcome. You are listening to the Health Disparities Podcast. A program of Movement Is Life. Movement Is Life is a nonprofit organization which advocates for the provision of more equitable care of common comorbid

conditions in underserved populations, in tandem with championing the essential role of lifelong physical activity or movement in improving health.

I'm Matt Reiter, your host for this episode. I'm a federal health policy specialist in principle at Capital Associates. I also serve on the Leadership Committee for Movement Is Life.

Value-based care has emerged as an alternative and potential replacement for traditional fee for service reimbursement, centering, quality and outcomes rather than quantity. That is the theory. In practice, value-based care has been shown to exacerbate some inequities in the healthcare system by making it harder for those patients with complex conditions or being impacted by social determinants of health to access care. Often these patients represent racial and ethnic minorities, women, or are from rural areas. Put simply, if some categories of patient are more financially risky than others to treat within the value-based framework, providers may find ways to exclude them unless there are checks and balances in place to help manage that risk. For several years now, Movement Is Life has been championing legislation that would introduce some of the necessary checks and balances and provide safeguards to protect patients receiving value-based care, particularly Medicare and Medicaid patients. These efforts have culminated with Representative Terry Sewell and Senator Cory Booker reintroducing the John Lewis Equality in Medicare and Medicaid Treatment Act, or EMMT Act for short.

This bill would require all new payment models to take into account how the model impacts social determinants of health. I'm joined today on the podcast by two people who have been very close to assessing these issues and championing the EMMT Act as a legislative solution. Tom Dorney is Vice President of the Root Cause Coalition, whose mission is to reverse and end the systemic root causes of health inequities for individuals and communities through cross sector partnerships. In his prior role, Tom served as senior policy advisor to Congressman John Lewis, who first introduced the EMMT legislation prior to his passing in 2020 at the age of 80. Welcome, Tom. Thanks for joining us today.

Tom Dorney: Thank you. It's good to be with you.

Matt Reiter: Bill Finerfrock was the president of Capital Associates until his recent retirement. Bill is a specialist in healthcare financing, health systems reform, health workforce, and rural health. In addition to numerous successes in the legislative arena, he has successfully worked on public policy and regulatory issues before the Department of Health and Human Services, the Centers for Medicare and Medicaid Services, and the Health Resources and Services Administration among others. He worked closely with Tom and Congressman Lewis to advance the EMMT legislation. Thanks for joining us today, Bill.

Bill Finerfrock: Thanks for having me.

Matt Reiter: From the perspective of movement, his life, who instigated advocacy on this issue, can you share with us some of movement is life's concerns about the potential negative effects of value-based care on particular populations?

Bill Finerfrock: I think you kind of touched on it in your introductory remarks, which is that as we move into what they are calling a value-based payment system, that the way that people are defining value will be done in a manner that will have the effect of either excluding or creating a disadvantageous environment for individuals who come from minority, low income, rural, women, folks who have historically been disenfranchised from the healthcare delivery system, unless we really take a deeper dive on these models and build in some cushion to make sure that those disadvantageous outcomes don't occur. So, should a physician be only held accountable for those things over which he or she has some control, what they're doing as a clinician, and can we make sure that those factors that may affect the outcome don't adversely affect their quality score, their financial incentives, that type of thing.

Matt Reiter: Tom, can you share with us how and why Congressman John Lewis took on a leadership role in championing legislation that would offer solutions to the side effects of value-based care?

Tom Dorney: Absolutely. Let me just say again, I really appreciate being with you guys to talk about this issue. John Lewis kind of came of age during the Civil Rights Movement and was the leader of the Student Nonviolent Coordinating Committee and was a protestor, sit-ins, Freedom Rides, spoke sixth at the March on Washington in 1963 and was generally known for his life's work of, you know, justice and freedom and civil rights. And when I had the huge honor of like, joining his team, joining his staff, and doing healthcare for him, he was on the Ways and Means Committee in the House of Representatives and had some jurisdiction over health. And at that time in the House and on the Ways and Means, this was very much, you know, the topic we're talking about today was really what was going on. And the house was in the, the middle of passing a legislation called MACRA to do away with an older reimbursement law called the Sustainable Growth Rate, which I will not talk about at all because it's got talked about a lot in its time. But so, you know, this movement from volume to value really had a good portion of its roots there. And at that time, you know, Mr. Lewis, I will say you know, he had been on the oversight subcommittee of that committee. But he put himself on the healthcare subcommittee during those days when this legislation was introduced because, you know, he recognized pretty quickly that this transition from volume to value and how do we make sure that we're incentivizing the right types of services, and how do we really make sure that we're meeting patients and Medicare beneficiaries where they are, that we could exacerbate minority health disparities pretty easily if you change how hundreds of billions of dollars leave the Treasury. So, as we were considering MACRA and as we were really trying to change the way that Medicare is reimbursed, that became sort of the issue for him was like, how do we make sure that Medicare and Medicaid are going to work for people who are not as healthy and not as wealthy? And I have to say how grateful I am and how grateful he was to Movement Is Life and to Bill, and to you, Matt, also as well for your work in those early days to really come together and brainstorm and think about like, what would addressing this issue really mean in legislative terms? And so, you know, Mr. Lewis had a lot of his healthcare priorities for his district, and this became, you know, this became one of them a way for him to fully address health disparities, you know, from the position that he was in as a senior member of the Democratic Party and the Ways and Means Committee. We're so grateful

to Movement Is Life and to also to Terry Sewell and to Congressman Booker for really taking that mantle up and running with it. And, you know, we think it's a really important part of the future of these vital programs.

Matt Reiter: Thanks, Tom, I appreciate that, and we really enjoyed the opportunity to work with you and with Congressman Lewis, who is such an inspiration to us all. And like you said, to look at these issues and identify what does a legislative solution look like? And it sounds to me like it's just even more encouraging that Congressman Lewis never stopped looking at issues through the same lens of equality and equity and trying to improve life for people and in this context, it seems something wonky like Medicare payment policy, but ultimately something that's intended to have a similar effect as some of his other work.

Tom Dorney: Let me share one more thing. If it's all right, and you can cut this out of the podcast if it's not, if it doesn't, you can leave it on the editing room floor, but after Mr. Lewis joined the health subcommittee, we found him getting a lot more invitations to speak about health and to speak about the Affordable Care Act and to speak about health disparities and health equity. And so, I was writing a lot of remarks for him, and he told me a story that I'll never forget. He called me up and he was telling me that he had to deliver remarks for this event, and it was about health equity. And he told me a story about growing up in rural Alabama, just outside of Troy. And he told me a story about how you know, when he was growing up on the farm there was no such thing as health insurance for them. And the fact that they were born in the South, and they were very poor, and they were African American, and they, you know, they had a really a difficult life on the farm. You know, that was their preexisting condition. So, they didn't have health insurance, but they did have death insurance. And that was somebody who came through the town and sold, you know, the promise of a dignified burial. And people would just, you know, go through their house and rummage and find all their pennies and nickels to give to this man to buy funeral insurance, you know, so that they could have a, so they could, they could be remembered well. And he said to me on that call, and he said, Tom, this is what I want you to write. He said, it never occurred to us to think about how we lived. We could only prepare to die. And so really making sure that quality in healthcare includes equity, not just cost savings is a big part of the EMMT Act. And it's, you know, it's something that I think that everyone can and should get behind.

Matt Reiter: Thanks for sharing that powerful story. I think that segues into, you know, a question I have for Bill. According to a recent report by McKinsey, value-based care as a proportion of the healthcare landscape has been growing steadily and capital investment in value-based care quadrupled during the pandemic. Value-based care growth is now predicted to accelerate and is set to be the framework for double the number of patients in the next five years. How might more patients than ever be at risk?

Bill Finerfrock: Great question. And I, and I think it absolutely does lead to the, to the potential and what I think is going to be the reality of more patients being at risk, unless we do the kind of things that we call for in the EMMT Act. One of the problems you have here, and I think it's, you know, people say, oh, we've doubled the number of people in value-based care. Well, you know, what is value-based care, number one? And number two, who's defining value? And I think the second question is

almost the more important one, how do we define value? Typically, those who develop the value-based payment models define value in an economic context. You know, what is, is it cost effective care? And they do throw in quality measures to say, well, we don't want it to just be about, you know, economics. We want to make sure that in, in achieving value, we don't in any way diminish value. Great sounding words, but when you actually get down to the implementation of that, that's where people are really potentially going to be harmed. And one of the sad facts is they're going to be harmed without even realizing it, because in many cases, they're going to be denied care by simply not being recommended for certain care. So, for example you have you know, a 40-year-old woman who is perhaps overweight, borderline obese, lives in an apartment on the third floor where there is no elevator, has a job where she is on her feet all day. And as a consequence of all that, she has significant knee pain, and she needs really a knee operation. She needs a knee replacement. The doctor who she may get referred to is going to look at that, and this doctor is, let's say now in a value-based system. And that value-based system is going to look and say, well, did the patient fully recover from the knee where they restored to full mobility? Did they have to go into long-term care or some kind of post-surgical treatment? Did they have an infection as a consequence of the surgery? Well, many of those evaluations are going to be affected by what we talked about earlier, which are these social determinants of health. The fact that the woman is perhaps overweight, the fact that she's on her feet all day, the fact that she lives in a building without an elevator and maybe in a neighborhood that's not particularly safe, means that she's not necessarily going to be able to do all the postoperative things that you might otherwise do. And so, as a consequence, the risk is that it is not going to be what someone defines as a valued outcome. Now, the fact that the woman has much improved mobility, can now, you know, far reduced pain that doesn't seem to get factored in. And so, the doctor is going to look at that, the orthopedic surgeon is going to look at that and say, gee, you know, Mrs. X or Ms. Y, you're not a very good candidate for knee replacement surgery. And so, the patient goes away going, oh, okay, I guess I just don't get knee surgery. Well, the reason she's not a good candidate is not because of anything that, you know, they could easily replace her knee, but it's because the value-based payment system created a disincentive on the part of the orthopedic surgeon to take that case on.

Matt Reiter: Let me follow up on that. How would the EMMT act fix these issues?

Bill Finerfrock: So, in essence, what the EMMT Act says that in developing models that are value-based care models, you have to develop it in a way that does not result in a reduction in access to care, which is not part of the underlying requirements, nor that in any way discriminates or makes it harder for individuals based on their race, ethnicity, gender, or geography to access the system. And so, they have to go in and when they're developing the model, they have to build in these safeguards to ensure, and it's not really that difficult and it's not unusual. As an example, when the government contracts with a health plan, you know, a managed care plan, a private commercial insurer under various programs what they often do is they build in what are called risk adjusters. So that if the health plan gets an adverse or high percentage of high-risk patients, the plan comes in and adjusts for that and says, okay, that's not your fault. We're going to pay you more. The same thing can be done now at a provider level. And that's kind of

what we're hoping this would lead to, where you can build in various criteria factors in essence, risk adjusters that say, okay, if you have a patient that is overweight, if you have a patient that has chronic conditions, if you have a patient that has other factors that are outside the control of the provider or the hospital, we're not going to hold that against the provider. We're going to, in essence, risk adjust this payment and this evaluation in order to normalize. So, there is no incentive or disincentive on the part of the surgeon to skew their patient population to those who are upper income, healthy, you know, et cetera, versus patients. You normalize that you level that playing field, so it's a clinical decision, not one that's based on this arbitrary definition of value.

Matt Reiter: Thomas, did you have anything you wanted to add to that?

Tom Dorney: During the reintroduction phase of this bill last year, we had an opportunity to talk with CMS and the Innovation Center, and they made a really interesting point, which was that, you know, you should be correct to think that equity is a part of quality, but you'd be wrong. And right now, this part of the statute really lifts up cost and quality in as what the primary purposes of the, of developing new payment models is. And the EMMT bill, it does place equity alongside quality and cost considerations where it should be.

Matt Reiter: Can you tell us to what extent organizations in the coalition share these concerns for vulnerable patients with regard to value-based care? What are some of the solutions you were seeing being put in place?

Tom Dorney: Absolutely. You know the Root Cause Coalition, which is about a hundred organizations all, all united around achieving health equity through cross-sector collaborations. So, you know, our organization really is, it's sort of a Rorschach test. If you look at our membership page, you can sort of, you can see community-based organizations, food banks, but also payers, hospitals, health systems. And so, everyone is united on really just this aim about, you know, making healthcare work for people who are not as healthy and not as wealthy. You know, for us, our sort of spiritual founding is around nutrition and hunger as a health issue, and food is medicine. And recently you saw the White House Conference on Hunger, Nutrition and Health, and it was a bipartisan event. And the Root Cause Coalition is presently going around the country holding events in each of the USDA regions just building off the momentum of that event. And people may not realize that the last White House conference on nutrition was held in 1969 by President Richard Nixon, and it created a lot of the, you know, food stamps, SNAP, TFAP, WIC, all of those programs come from that effort. And so, there's a lot of conversation momentum around having nutrition be something that is really considered in Medicare and Medicaid reimbursement, specifically in Medicaid, and in 1115 waivers. I'm up here in Massachusetts right now, and there's a lot of work being done in Medicaid to make medically tailored meals a part of a covered benefit in Medicaid. And so, that's sort of where our head is right now. But across the country, there's, you know, in each area, in each community, folks are really having to reinvent the wheel to think about, you know, how their community is going to pay for addressing social determinants of health. And really, you know, where is that, where does that money come from? And so, the EMMT bill is just the, a really crucial part of getting that step forward, the Root Cause Coalition believe, and we are circulating a letter of support for

that bill right now. So, you know, again, I'm kind of biased about it, but I love it. I love the bill, and I think it's going to be a really important part of the conversation moving forward.

Matt Reiter: Thanks, Tom. Bill, can you explain why you think the policy solutions in the EMMT Act can appeal to both Democrats and Republicans?

Bill Finerfrock: Sure. I think first and foremost, it's, you know, and I've been involved in politics and advocacy and congressional staff for over 40 years. Universally, whether it was Republicans or Democrats, everyone cared about access to care. So, I think you start from that premise that elected officials, regardless of their party affiliation, really do worry and care about their constituents having access to healthcare. Now, some of them represent urban populations, some of them represent rural populations, some of them represent areas that are more well off than other areas. But you know, at the end of the day, there are things that restrict or limit access to care, whether you're in a rural underserved area or an urban underserved area, as an example. And so, what you find politically is that many rural areas are represented by Republicans. Many of your inner-city urban areas are represented by Democrats. Those aren't universal. But, you know, as a general proposition, the EMMT Act says if we're looking at this based on race, ethnicity, gender, and geography. And I think the geography part really creates the opportunity for this bipartisan consensus because although individuals in rural areas, they have access to care problems, but the underlying reasons for that may be different than someone who lives in an urban area. In rural communities, it's very often a function of geography. Literally, the ability to have a hospital, a doctor, a PA, a nurse practitioner in close geographic proximity or reasonable, not even close, reasonable proximity to where you live. In urban underserved areas, you may very well have, you know, providers who are in close geographic proximity to the patient, but for various reasons could be language, could be financial it could be transportation, they don't necessarily have access. And so, by focusing on access to care and how this ensures access to care, I think creates that synergy that allows us to attract individuals from both sides of the aisle.

Matt Reiter: Tom, what is our call to action to listeners wishing to support its passage and honor the memory of John Lewis at the same time?

Tom Dorney: Oh, well, that's an easy one. Get into some good trouble and keep your eyes on the prize and don't give up and don't give in. I'm just using all of his turns of phrase. Yeah, it, you know, this is the sort of thing where it really comes down to spending the shoe leather. And I would just say to any of your listeners who are thinking about being more involved, getting more engaged, where do I start? What do I do? You know, knowing who your elected representatives are, staying in contact with them. There's a term for the type of engagement where you contact your member of Congress or your local representative only once. And that term is tourism. You have to stay engaged, you have to keep poking them, get involved but the most important thing is to stay involved.

Bill Finerfrock: You know, Tom, that use of the term tourism, I think is a great way to phrase it because we would often talk about that to people that we worked with. And this idea that, you know, you need to not be a pen pal. You don't want to be so writing

so often so frequently that it's like, oh, here's, you know, Bill, again, but enough that they know that you care. Persistence is really an important part of this. So, you know, yes, you write the letter, you reach out, you communicate, and don't allow your presumption of where you think that member is coming from is, oh, well, because they're this, they're automatically going to support the EMMT Act or because they're, that they're automatically going to oppose the EMMT Act. Absolutely, throw that up, throw away whatever assumptions, presumptions you have. You have to ask number one, you know, you have to, I remember Tip O'Neill was at a dinner one time, and Tip O'Neill was the keynote speaker, and it was one of the first times he was running for office. I think he was running for the state legislature up in Massachusetts. And you know, he was going around and he ended up, he didn't win, and he went to one of his neighbors that had known him since he was a young boy and you know, he was talking about, you know, the woman said you know, gee, I'm sorry about your loss. And he goes, oh, it's great. He goes, you know, I really appreciate the support. I appreciate the fact that you voted for me. And she said, well, well Tip. She said, I didn't vote for you. And he was like, what do you mean you didn't vote for me? You've known me my whole life. You know, we've been up the street your, you know, our friends or families. Why didn't you vote for me? And she said, well, you never asked. And he presumed that because she knew him, he didn't need to ask her.

Matt Reiter: That's a great story to end on. Thank you, Tom and Bill for this important background information that illustrates why we need the John Lewis EMMT Act to receive bipartisan support and to be successful. Our listeners can find everything they need to support the legislation by following the link we have provided in the summary. Until next time, I'm Matt Ryder saying thank you for listening and for supporting Movement Is Life, be safe and be well.

(End of recording)

LETTER OF SUPPORT TEMPLATE
Dear Representative Sewell & Senator Booker,
I am writing in support of S.1296/H.R.3069, the John Lewis Equality in Medicare and Medicaid Treatment (EMMT) Act of 2023.
The EMMT Act would require the Center for Medicare and Medicaid Innovation (CMMI) to include experts in health disparities and social determinants of health as part of the evaluation and review process for new payment models. If enacted, this bill would also require fairness of these new payment methods for women, high-risk patients, patients from racial or ethnic minorities, or patients from rural communities. Lastly, it directs CMMI to develop and test a payment model that is tailored to addressing social determinants of health.
While quality and cost are important considerations, equal consideration should be given to the impact a proposed model may have on access to care for women, minorities and beneficiaries residing in rural areas. CMMI is under no statutory obligation to account for social determinants of health when considering new payment models. Indeed, the only factors CMMI must consider when determining whether to approve a new payment model are quality and cost.
Because Medicare is the single largest health care payer in the country, and many commercial insurance plans will adopt policies based on Medicare, Congress must ensure that the models approved by CMMI incentivize reductions in minority and rural health disparities and not create barriers to care. We appreciate all that this CMS Administration has done to advance health equity. Passing the EMMT Act will ensure that all new models account for social determinants of health and how the models impact minority and rural populations.

Your leadership on eliminating health disparities for women, minorities and beneficiaries residing in rural areas is deeply appreciated.
I applaud your leadership on this important bill. The EMMT Act will go a long way towards improving access to quality healthcare for Medicare and Medicaid beneficiaries.
On behalf or our organization:
Sincerely,

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