Value-based payments: a health economics perspective.

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Dr. Mary O'Connor hosts a discussion about the potentially detrimental impact of value-based care models on vulnerable populations, and how the safety-net hospitals that serve these patients are further strained, particularly in rural and inner-city areas. Featuring cardiologist and leading health economist Dr. Karen Joynt Maddox, M.D., co-director of the Center for Health Economics and Policy at Washington University in St. Louis. All views expressed are the participants own.

Dr. O'Connor: Welcome to one of our first Movement is Life Health Disparities Podcasts of 2021. We're all praying for this to be a better year than 2020. I am Dr. Mary O'Connor chair of Movement is Life. In our podcast series, we focus on topics related to health disparities with our goal of improving health for all people. I hope that one of the lessons we learned from 2020 is that we're all connected and that differences related to income, education, gender, race, or ethnicity, do not and have not protected us in this pandemic. So, the healthier we are as a society, the healthier our communities are, the better each of us will be as individuals. We also saw in 2020, how access to healthcare dramatically influences health outcomes. We know that communities of black and brown individuals have suffered more in this pandemic for many reasons, including access to healthcare. Our guest today is Dr. Karen Joynt Maddox, an expert on how we pay doctors and hospitals and how those payment models can impact

health access and health disparities. To me, this is one of the dirty little secrets that we have in medicine that are well-intentioned so-called value-based payment models. Models designed to improve healthcare can actually hurt certain populations of patients, particularly brown and black people, and those living in poverty in rural America, those with disabilities, and even our frail elderly. Dr. Joynt Maddox is an assistant professor and co-director of the Center for Health, Economics and Policy at Washington University in St. Louis. She's extremely accomplished with numerous high-quality, published research in the areas of health disparities and value-based alternative payment models. I am a big fan of Dr. Joynt Maddox and excited to have her join us on the health disparities podcast. Welcome, Dr. Joynt Maddox.

Dr. Joynt Maddox: Thank you so much for having me. I'm honored to be here. I'm a big fan of your organization and all of its work as well. So, thrilled to get to spend some time with you.

Dr. O'Connor: Let's start by helping our listeners understand what we mean when we say value-based payment models and alternative payment models for hospitals and doctors. How do you explain these terms to the average nonmedical person?

Dr. Joynt Maddox: That's a great question. So, when we think about the old way of paying, we'll start there, a physician or a hospital would submit a bill for a chest x-ray or a flu shot or whatever we want to get paid for and then you'd be reimbursed by the payer, by Medicare, by United, by Humana, whoever. And when we talk about value-based care, we talk about changing that payment based on whether or not you're providing high-quality care. So, instead of just paying everybody the same thing, we're going to pay you a little bit more for everything that you do if you can demonstrate to us that you're providing high quality, and maybe we measure that by the proportion of your heart attack patients that are getting the right treatment. Maybe we measure it by some other process of care for pediatrics in your hospital. Whatever it is, we're going to pay a little bit more to places that provide care that we think is a little bit better. So, that's the value-based piece.

Moving to alternative payment models goes one step farther. It says, let's shake up the whole system of how we pay for care and let's actually give you say a chunk of money to take care of a bunch of people for a month or something like that. So, value-based care is typically just kind of nudging things up or down based on quality or outcomes or whatever the measures are, and alternative payment model starts to really sort of shake up the payment system a little bit.

Dr. O'Connor: So, I think intuitively we all embrace that basing payment on value rather than volume makes sense and supports better quality healthcare, but your research shows that these models can also impact not only what care people receive, but who receives care. Can you elaborate on this for our audience?

Dr. Joynt Maddox: Sure. And I'll start by absolutely agreeing with you. These seem like such a good idea. Of course, we should pay more for hospitals that are delivering better care. The problem is that we don't actually know how to measure who's delivering better care. So, if we don't have good measures of how that's happening, we may not be rewarding the right people. And I'll give you an example. I'll actually start with education because I think that's a simple place to start. Say that you were trying to compare two schools and you wanted to compare them on whether or not their first graders were meeting reading metrics or whatever standardized state test they take. You found that a school located in an impoverished area where kids hadn't had access to preschool and may be living in challenging circumstances had worse reading scores compared to a wealthy, likely whiter suburb. Would the fix then be to take money away from that school that serving the children who are not at first grade reading level? Of course not, that's crazy. That's what value-based payment does for hospitals. It says we're going to take hospitals that are serving very sick, very challenging patients or patients who may face a number of

social challenges in their lives or patients who may have the most complicated of medical illnesses and we're going to try to compare those hospitals on things like readmission rates to a hospital that may be located in a wealthy suburb and care for a very sort of uncomplicated patient population. We just don't do that very well and so we end up unfairly making comparisons between those two hospitals when they're really not comparable. Then, what we do is we've put now into place incentives for hospitals to avoid sick patients. So, if you told a school we're going to have a bunch of kids come to your school who don't know how to read and then we're going to judge you on reading. They would be appropriately concerned that their scores might fall. Same thing for a hospital. If a hospital is going to take care of more complicated patients, they might have higher readmission rates. And because we don't do a good job of comparing these hospitals, we can put hospitals in a situation of having incentives to avoid really sick or complex patients be that medically or socially.

Dr. O'Connor: So, I can imagine a listener right now saying, but doesn't the hospital have to take me? I mean, if I'm a patient and I show up in the emergency room and I'm sick, don't they have to see me and take care of me?

Dr. Joynt Maddox: Yes and no. So EMTALA is an act that requires that hospitals stabilize people. So yes, people will absolutely be stabilized in emergency rooms. But the hospital is actually not required to then continue to deliver care. So, we tend to have hospitals in most, certainly in big cities and most medium-sized cities, hospitals that are sort of either officially or unofficially designated the safety net. And those hospitals are the ones that are willing to accept patients who can't pay, patients who may have Medicaid insurance which doesn't pay nearly as well as some private insurance. So there tends to be hospitals that will then provide care to those patients regardless of their ability to pay, but most hospitals don't actually, are not required to provide full services to people who may be more complicated or who may not be able to pay. So, it's concentrated in a smaller group of hospitals than you might think.

Dr. O'Connor: And these safety net hospitals, which is the term that we use as you said tend to be in larger, either medium or larger sized cities and they tend to be teaching hospitals and they basically will provide care to the underserved.

Dr. Joynt Maddox: Yes.

Dr. O'Connor: So, I just want you to elaborate a little bit more on how you see these value payment models impacting the safety net hospitals, because if

they're the safety net literally, for any patient to be able to receive care, whether they have good insurance or bad insurance, because most of these hospitals are also the hospitals where you will find higher levels of complex care, right? So, somebody that really has a very serious problem may need to go to that safety net hospital just because that's where the medical expertise is to deal with their problem. So how is our movement towards value-based care impacting these critical hospitals?

Dr. Joynt Maddox: They're getting sort of a double whammy, because as you mentioned, many safety net hospitals are also the hospitals that provide the highest level of trauma care, that do organ transplants, that care for the folks who need advanced cancer care, things that just aren't available in most places. So, you have a combination of very medically complex individuals and very socially complex individuals and consequently tend to have things like higher readmission rates, sometimes higher mortality rates, worse outcomes in general because the patients are much, much different. So, when these payment programs then penalize those hospitals, those hospitals are getting 1 to 3% of their revenue taken away because of performance, it threatens their financial bottom line. And in some cases that can be a real problem.

You know, safety net hospitals that don't also have a big private payer component really do struggle to stay open. We saw that with Hahnemann.

We see it with public hospitals all over the country that really do struggle. And so, taking away one, two, or 3% of payments is significant and that's more than most hospitals margins. So, we worry, I think that as these programs proliferate, as they get more and more common, that is putting more financial pressure on the places that can sustain it the least. In my opinion, we need to be trying to help these hospitals and give them more resources to provide this more complex care, to provide more supports to patients, and just taking money away doesn't really accomplish that.

Dr. O'Connor: Let's go back for a moment to your comment about margins. In other words, the amount of so-called profit that a hospital makes because I'm not sure that many of our listeners appreciate how small the margins are for most hospitals across the country? And where would you estimate those margins to be in general for rural or safety net hospitals, et cetera? So, I just want you to educate our listeners on margins.

Dr. Joynt Maddox: Hospitals on average run slightly negative operating margins. So, they are dependent on other sources of revenue to even break even in many cases. So sometimes that's charity. Sometimes it's state funding. Whatever it is, but hospitals typically are not a very high-margin industry. There are some big systems that do quite well in margins. Typically, the biggest sort of best-funded places have figured this out and have pretty healthy margins. But there are a lot of hospitals that run quite

negative, and we see that with safety nets, and we see it with rural hospitals. Smaller rural hospitals that serve an increasingly aging and poor population are the ones in the most trouble right now. The combination of being in a rural area where the population is getting older and sicker and jobs are being lost, so insurance coverage is lower. And being in areas where you're sort of serving that dual purpose of needing to provide everything, but in an area that may be losing resources. That's where we see a huge threat to hospitals in rural poor areas, particularly where there's a high proportion of minority patients.

Dr. O'Connor: When hospitals close, how do you see that impacting the patients that previously were served by that hospital? And how does it impact the surrounding hospitals? Because some people might think, well, you know, let's take Philadelphia and Hahnemann for example, right. There are lots of hospitals in Philadelphia. I trained in Philadelphia. So, there is a lot of opportunities that patients could say, well, I'm going to go to another hospital instead of Hahnemann, and Hahnemann is closed now. So, what's the big deal that Hahnemann closed?

Dr. Joynt Maddox: There are a few things. In most places, the sort of excess hospital capacity in one place is not that great. So, there are other hospitals around. But for example, when Hahnemann closed, one of the first things people had to figure out is where all the babies are going to go. You know

people don't stop having babies. People don't stop having heart attacks. And so, absorbing all of that volume into the surrounding hospitals was no small feat. Certainly, you can imagine that it can separate people from their clinicians. It can create a lack of continuity. For sure there's a lot of disruption that happens around it. It is true that over the past couple of decades, some hospital closures have actually been sort of appropriate, right? There are maybe too many hospitals for a town that is now smaller and so economically, it just doesn't make sense to have two. Sometimes one hospital has bought another. There's been consolidation. So, it's not to say that all hospital closures are necessarily damaging. But in some urban areas and in many rural areas, a hospital is really a hub. It's where people's physicians might be employed. So, it can take away not only hospital care, but also outpatient care. It can be a big economic driver for a community, a huge employer, a place where people can sort of connect around, you know, around a community, right. Sort of a positive community spot. So, we see that the effects can be not only on patients, who again in rural areas may then lack care entirely. In urban areas may even be more of a disruption issue. But it can really have an impact on communities as well as on people.

Dr. O'Connor: I think that's so true. And I think for Americans living in rural areas the times are even more challenging because with these hospital closures, this increased distance that they have to travel to go to a hospital,

particularly if they have an emergency can make a big difference in terms of their clinical outcome. So, it's not just an economic issue, it's really a clinical outcome issue.

Dr. Joynt Maddox: Absolutely.

Dr. O'Connor: And, you know, kind of the concept of, should we have for any given geography, a facility where emergency services can be provided at least to stabilize the patient, to get them to a higher-level facility would be something that would make sense. I mean, if we were starting all over again, right, and we could design a whole new system, wouldn't that be a nice way to do it?

Dr. Joynt Maddox: Yeah. Absolutely. Because of the way that our health system is set up, it's a series of accidents, sort of economic experiments. It's not a system in any sort of meaningful sense of the word. And so, there are areas where there are inadequate care and the places that are clearly at risk of having the least access are rural areas, particularly those with a high minority population, and then urban areas, particularly those with a high minority population. We have plenty of hospital supply in the wealthy suburbs and then, you know, wealthier parts of cities. But if you look at where hospitals have closed in Philadelphia, in Washington DC, in Detroit, in New York City, it's the hospitals in predominantly black or Hispanic

parts of town in lower-income areas that are closing and that's true in rural areas too. So, we are widening disparities. We are worsening inequity because we're sort of allowing this economic accident to happen where we just take access away from people. And to the point that you made at the beginning of this, which I really appreciate, we are all better when we are all healthy. This is not a question of just, you know, can someone drive 40 more miles to get to the hospital? It's about making sure that we, as a country, as a community, are ensuring that people have basic access to healthcare, and we haven't purposefully done that. And we haven't examined our programs in a way that at the center. If you wanted equity at the center of value-based payment, you would have done it very differently. It can't be an afterthought. It really needs to be central. And so, you know, I hope in 2021 that maybe some of our policymaking will hold equity at the center. Maybe lift it up a little bit in terms of saying, how can we rethink some of what we've been doing, recognizing that we are all better off if we can improve the equity of our healthcare system.

Dr. O'Connor: And I just want to mention for our listeners that we are actually going to have a specific podcast dedicated to talking about Hahnemann with some of our Movement is Life experts and some local Philadelphia people. So, for those of you that are interested, just stay tuned because that will be upcoming in the near future. But I just want to go back to one point. These hospitals that are closing, in general, are closing

predominantly in black and brown dominated communities and rural communities, communities where the individuals are typically lower-income communities and they're closing because the hospital is not making money. I mean, I just want to be very explicit about it. It's not that they're closing because they're not needed in terms of providing care to members of those communities. They're closing because they're not making money.

Dr. Joynt Maddox: Correct. And I'm sure that will be part of the discussion around Hahnemann is the difficulties of keeping hospitals afloat when you're dealing with a lot of uninsured patients and a lot of Medicaid patients, which has lower payment rates. And, you know, I think it's, I'm not quite sure what the appropriate word is shameful perhaps that we still have so many uninsured patients in this country. I just find it completely unacceptable that we have not found a way to ensure that everyone has basic coverage and access to care. And it creates then the problem, not only for those individuals but because then there's not money flowing into the hospital, the hospital closes. Because there has not been a local employer the community can sort of have even less economic engine. It really is a vicious cycle, and it needs to be intentionally stopped. It's not going to accidentally go away. We need to think differently about how we value these things.

Dr. O’Connor: So, let me probe just a little bit deeper because let's just take an example of a hospital that is serving predominantly a less affluent community. And let's just say that those patients have Medicaid, or they have some type of insurance through the Affordable Care Act, and let's theorize that most of those patients have some type of insurance. Why are those hospitals still closing? Why are they still struggling financially if a lot of their patients have some type of insurance?

Dr. Joynt Maddox: That's a great question. So, the legend, maybe I don't know what to call it, the assumption is that Medicare pays roughly the cost of providing care. So, if that's our set point that Medicare rates are roughly the cost of providing care, not the cost of also having pretty buildings and fountains and doing capital upgrades, all those sorts of things, but like the basic sort of you could cover your costs with current Medicare rates. Private payers can pay 200%, 400% Medicare. Medicaid can pay 80%, 60%, 40%, 20% of Medicare costs. And there's plenty of, you know, you can imagine sort of a wide range of options in there. And then adding to that, things like high deductible plans, where even if patients have some insurance, they really aren't first dollar covered for what they need. And so, a patient has to be able to pay $10,000 before insurance kicks in. Well, a patient may not have $10,000 to pay for an unexpected car accident or a cancer diagnosis. If you think about hospitals well then, we know that the costs are more than they are reimbursed. It's really a losing financial

proposition. We can't look at that and think that "Oh gee, if the hospital were just managed better, it could survive." That's not a survivable business model. We need to think differently about how Medicaid reimburses and when Medicaid is not reimbursing at a high enough level for hospitals to cover their costs, what is our responsibility as a community, as a country, as a state, you know, whatever to sort of step in and say, "This access site, this high-quality care provision is important to us collectively and so we are going to support it financially." And we have not decided, as a country, that that's the business that we want to be in. Not totally right. There are public hospitals. There are, you know, you see a role for publicly funded institutions who pick up a lot of this care because it's just not sustainable as a business model, but that's not as intentional and as accessible for many people as it is for others.

Dr. O'Connor: Yes. I know. It's very complicated. It's really, in my opinion, you know, we have a lot of misalignment because we're really not focused on what patients and individuals and communities need. And the focus is on whether you can make a margin to keep your doors open.

Dr. Joynt Maddox: The Affordable Care Act had two really big buckets for healthcare, right. It had a bucket around access. So, Medicaid expansion and the establishment of these insurance exchanges, where people could buy affordable insurance to get some coverage. By and large, the studies

over the last decade would show that those have had a very positive impact. States that have expanded Medicaid and improved access to at least insurance, which then improves access to care, see better use of preventive therapies, higher rates of diagnosis and treatment for things like diabetes, and high blood pressure. Earlier diagnosis of cancer, better cardiovascular outcomes, better mental health, better financial health, hospitals staying open. So that piece, there is now not only a sort of moral argument to support people having access to care, but there are hard data arguments to saying, "States are better off, hospitals are better off, and people are better off if we do this." So that is someplace where I hope that we can continue to encourage the remaining states to come on board with that because it is good for the economy. It's good for people. There's a wide range of arguments like getting people covered is important. The other half of the ACA again, oversimplifying, is all this value stuff. Now, if we do give people access, how are we going to try to make what they're accessing the highest quality, highest value piece possible? And that's where we really haven't seen the improvements we want. We've seen it have negative consequences for the safety net and we haven't really seen it drive improvements. And so, we need to build on the part that works, build on access and we need to, I think, think differently about how we do quality.

Dr. O'Connor: Just for clarity for our listeners because they may not understand some of the nuances of Medicaid, which is again the insurance typically for non-seniors, those that are under 65 that have you know, very little income or have disabilities, et cetera. And why does the reimbursement vary so much from state to state?

Dr. Joynt Maddox: So, Medicaid is sort of a funny program. It's very state-run. So, states decide a lot of how they're going to do things, but the federal government actually funds a large chunk of it. So, the federal government gives a lot of money to the states. The states put in some money of their own, and then they administer the program. So, states can decide sort of how they do it. There are some guidelines around what states have to provide and what they don't. But many of these guidelines are pretty old and haven't been updated and only apply to, you know, certain groups and lots of States have waivers. So, it's a very, very, it's 51 individual experiments when it comes to how Medicaid is set up. So, some states pay reasonably generously. Some really don't. Some pay more for some things and less for others. It's really quite variable how it sort of plays out across the country.

Dr. O'Connor: So, you mentioned that the kind of second over-simplification, but kind of categorization of the Affordable Care Act was driving value-based payment models. And we spoke a little bit earlier about alternative

payment models, where groups of patients are bundled together and a doctor group, or even a hospital, some kind of medical group is paid a certain amount of money to provide care for that population over certain period of time. How do you think those alternative payment models are understood by the average person in this country?

Dr. Joynt Maddox: That's an interesting question. I think in some ways they're extremely intuitive because what you'd want as a patient is to think that your care provider, your primary care physician, maybe the system with which they're affiliated is caring for you as a whole person. That they're thinking not am I going to get $50 when they come in this week and a hundred dollars when they come in for a test, that they're thinking, what do I need to do to keep this person healthy this year? If I look at my panel of a thousand patients, who on this list needs an extra phone call? Who on this list needs to meet with a social worker? Who do I need to make sure have transportation to get here? Who do I need to check in on because their heart failure has been difficult to manage? That's what you would kind of hope that your primary doctor would be doing. And so, in some ways, I think moving towards these sorts of medical home accountable care, the more sort of holistic approach to providing care actually feels really intuitive. But it's so not how things are done for the most part that it actually represents just a, you know, Titanic level shift to think about moving our payment system in that way. So, I guess to me, it feels when

I've talked to friends and family members about it, people sort of think, isn't that how we should be doing things? Like to your point, if we were starting over wouldn't you want to sort of join an organization that would help you stay healthy and out of the hospital? That's not how our healthcare system is set up.

Dr. O'Connor: So, if I had an elderly parent who's ill and who has some chronic medical conditions, would that doctor perhaps not want to accept my mom in their panel because they know she's sicker and more complicated, and she's going to require more healthcare resources when they're getting paid X amount to provide care for her for a year, let's say. Maybe they say, well, we don't really want you to join our practice because we know that you're going to cost more. And of course, we've used the terms and I mean many of us have heard these terms of lemon dropping and cherry-picking. So, in that scenario, she's perceived as a lemon, right? Not a favorable patient. Whereas somebody could be her same age, but who's healthy would be perceived as a favorable patient into the practice in terms of the financial impact in that payment model, where that group is paid a set amount to provide care to that patient regardless of what they need.

Dr. Joynt Maddox: Right. That's a great question. It's all about how you do the payment. So, if we were to accurately account for the costs that someone

might be expected to incur with their particular mix of frailty or post-acute care needs or whatever it is, in some ways, those are the people who stand to benefit from the most, from a system like this, right? Those are the people in whom we say, gosh, speak from my own experience, you know, a family member has been admitted to the hospital three times this year for heart failure. Wouldn't it be great if they got the kind of personal, directed, focused care that could keep them out of the hospital? That's where the opportunity is. Not in the healthy, you know, 40-year-old who doesn't need much care, but in order to make that worth someone's time and not make that person just seen as a risk, you have to pay enough. You have to say we're going to take into account the fact that someone who has many more of these needs is going to cost much, much more. But we also think that that's where this type of approach, this sort of the more holistic sort of centered approach, that's where we think the benefit is. And so, it's really a Catch 22. The devil is in the details to sort of borrow a probably overused phrase that we want to incent clinicians to provide what patients need. If that's a social worker, if it's a community health worker, if it's a wheelchair, if it's a home health nurse, you know, we want to put the incentives in place to try to direct resources to people where we think that we can prevent some of these really adverse events. We don't want people to fall and break their hip. And right now, we only pay if they fall and break their hip. We don't pay to prevent them from falling and breaking their hip. So, we need to shift towards putting adequate money in

the outpatient setting to focus on keeping people healthy and functional to the degree that's right for them.

Dr. O'Connor: And so, how well do you think we're doing with our current, I'll use, we use the term alternative payment models. I mean, I think people understand.

Dr. Joynt Maddox: Medium.

Dr. O'Connor: Medium. Okay. So, maybe we're doing a C that's better than a D or an E. But certainly not A or B.

Dr. Joynt Maddox: Yeah. I think that the studies so far would suggest that some of those payment models have led to some reductions in payments and some very innovative programs around trying to find high-risk patients and get them these extra services. It really does free up innovation, right. Then you can decide, okay, it is now worth it to do a fall prevention physical therapy class for our group of folks at highest risk of falls, because we know that's cost-effective if it prevents them from going to the hospital. And now, we're kind of on the hook for whether or not they go to the hospital as opposed to getting rewarded if they go to the hospital. So, it really has the potential to drive a very different kind of innovation than we've previously seen. For the most part, the data that we have don't

show that there's been very much adverse selection in those programs. I shouldn't use adverse selections, a little jargony. The data don't suggest that patients are getting kicked out of these programs if they become high cost. For the most part, it seems like organizations are really trying to proactively identify people, but it is always a risk. And it is certainly where we need to do a much better job of measurement and of understanding and of really incenting the things that we want people to do around positive interventions for high-risk patients, as opposed to avoiding them. We should be bonusing the heck out of programs that want to take care of our sickest patients. We should make it financially attractive for them to care for people because it's a win-win right. Go care for people who need to be cared for. Like that's what our health care system should be about. So, we need to be shifting more toward thinking about that as value, as opposed to just like a little checklist of how many dollars someone spends. That's not value. Value is providing value how the patient wants it provided and most people would like to be healthy and happy and at home.

Dr. O'Connor: Absolutely. What advice would you have for a patient who feels that they might be negatively impacted by these alternative payment models?

Dr. Joynt Maddox: I think it starts with trying to understand how a primary care clinician may be thinking about this because there are so many different ways in primary care that this is being done, that it would be difficult to

assume that your clinician was under any given model. Oftentimes, there's a different model for Blue Cross and a different model for Humana and a different model for Medicaid and so clinicians are really stuck in the bunch of the middle. And so, it probably starts with a conversation with a clinician around, you know, are you a medical home? How do you think about taking a sort of holistic care of your patients, understanding their values? And if you feel comfortable that your primary care clinician and their team is really representing your values, I think you can feel pretty confident that they are sort of operating within all of these crazy payment models to the best of their ability.

It's trickier on the hospital side because all hospitals are under these programs. They're mandatory. Typically, the way that we see these have negative effects is not that the clinicians in the hospitals are doing bad things, it's that the payments are being cut to the hospitals. And so, there are tough decisions to be made around hiring more nurses or social workers or whatever it is. So, it's much more opaque at the hospital level, and it can be much harder to figure out sort of even who you would talk to about that. So, I would say that the most important thing is just to understand that philosophically you are with a primary care provider that has your entire needs and sort of best interests at heart.

Dr. O'Connor: So now that we're past the election, what would you say are the top two priorities that you would want the Biden Administration to tackle relative to value-based and alternative payment models because of the impact on patients? These issues that we've talked about, if you had your wish list and I had President Biden on the other line, what would you tell him we need him to do?

Dr. Joynt Maddox: I think the first thing, the top thing on my wish list is to prioritize equity. We have not made that an official piece of how these programs are designed, and so, not surprisingly, they've had if anything, a negative effect. And so, when we think about how to do these better, and by better, I mean, not just better for vulnerable populations, certainly that's important, but better for society as a whole. For us all, to be sort of moving in the right direction, we need to have equity just at the center of what we do. It can't be an afterthought because it won't ever get done. And we need to be very intentional about how we do that. So, thinking about are the payments adequate for caring for high-risk patients, including high social risk patients? How are we measuring social risk? How are we making sure that patients have access to care? How are we making sure they have access to the social services they need? Really starting a discussion around value with what the patients need as opposed to sort of the bean-counting of the dollar spent. Some of our patients need more money spent on them, frankly. And so, we need to rethink value around

how do we get people what they need and not sort of the simplistic starting point. We started where we started because that's where you start, right. But we now need to move into, I think, sort of a different focus of value which starts with equity and which really focuses on meeting patients' needs, whatever they are. Again, with the idea that people want to be healthy and out of the hospital and independent to the degree that they can and those should be our driving principles.

Dr. O'Connor: You do, but I'm going to comment on this first because you just flowed into my next comment so beautifully, I have to take advantage of it. And that was, as you know, Movement is life, we worked with the late great Congressman John Lewis on legislation entitled the Equality in Medicare and Medicaid Treatment Act and this legislation would direct the Center for Medicare and Medicaid Innovation to actually consider the impact of access to care on patients based on race, ethnicity, geography, et cetera, when creating these alternative payment models. So, it was really to address that gap, that unintentional gap created by value-based payment models and alternative based models, where we were seeing concern regarding cherry-picking and lemon dropping. Then, of course, we lost Congressman Lewis, but I'm pleased to announce and share with our audience, the Congresswoman Terri Sewell from Alabama and Senator Cory Booker from New Jersey have agreed to introduce the EMMTA act in the new Congress. So, we're really excited about this

legislation now being reintroduced and working with the Congresswoman and Senator on moving this forward to try and get this into law.

Dr. Joynt Maddox: Yeah, because it's crucial legislation.

Dr. O'Connor: It is crucial.

Dr. Joynt Maddox: And what a way to honor one of the great Americans of all time, right. To just sort of say, we are going to put this into law that we care about equity. That this has to be the center of what we do. It has to be measured. It has to be considered. It can't be an afterthought. I think it's extremely important. I'm thrilled to hear that there's a mechanism to move it forward.

Dr. O'Connor: Well, just for clarity for our listeners, what the legislation would do, would be require CMMI, which is the group at Medicare that creates these other payment models to include the lens of access to care and equity to care. And the legislation says you cannot create new payment models, CMMI if they're going to increase health disparities or decrease access. And that is a fundamental piece that we missed in the Affordable Care Act. And so, it's really a way of addressing one of those gaps that were created, I think, unintentionally, but nonetheless was created for driving health equity. So, yes, we're very excited about that.

I want to comment on an opinion piece that you published in the "*New England Journal of Medicine",* in 2018 and you wrote about the idea of risk adjusting payments for social factors, such as poverty as a way of avoiding cherry-picking and lemon dropping. And what you wrote war was the following, "Hospitals or clinics with the high proportion of poor payments may lose money under alternative payment models through no fault of their own, particularly in programs with a high level of downside financial risk. There's a powerful incentive for clinicians to avoid providing care for high-risk patients, which could have meaningful consequences for access to care." So again, that is exactly what we are hoping the Equality in Medicare and Medicaid Treatment Act is going to prevent. But there are those who would argue that risk adjusting for social risk factors protects poor-performing hospitals and poor-performing providers. So, could you speak to this criticism?

Dr. Joynt Maddox: Yeah. And I think it's actually entirely consistent to say that we're going to recognize that social risk is associated with bad outcomes and so we need to take that into account when we're judging hospitals. And at the same time, we are going to work our tails off to try to make sure that quality and access can improve for those same patients. But right now, what happens is that if someone comes into the hospital who is at very, high social risks, say someone who lacks stable housing who might not

have a job who might not have access to medications. If that person is readmitted within 30 days your hospital could be penalized, and those factors are not taken into account. It's taken into account whether that person has diabetes or high blood pressure, but it's not taken into account whether any of those social factors are present. And obviously, those are hugely powerful.

Now I would love it if, in a four-day hospitalization, I could fix someone's lack of housing, lack of employment, lifetime of exposure to interpersonal and structural racism that has led to terrible damage to their body. I would love it if I could get rid of those things in four days. I cannot. And so, expecting that a hospital can achieve the same outcomes with people who face all of these challenges is just unreasonable. But you can both want to appropriately credit the hospital, so say, okay, this person is more likely to be readmitted. So, let's make them less likely to be readmitted than they would have otherwise. And, at the same time say, "And we think it is crucially important that we work to improve housing, job access, poverty, stress, racism. So, I think it is entirely consistent to say both that we need to recognize the hard work that hospitals are doing, who care for patients who have all of these other challenges and also say, and we want those hospitals to work to make those better. I think only if we do both of those things, can we make value-based care have a positive effect on equity, as

opposed to both create a disincentive to caring for people and put hospitals at a financial risk for doing it.

Dr. O'Connor: Well, I couldn't agree with you more because we have to address all of these issues in a more holistic and intentional way. Dr. Joynt Maddox, unfortunately, our time is coming to a close, and I know we could talk about this topic for hours. I want to thank you for the generosity of your time and expertise and I know our listeners have found your insights to be most valuable. You've been a fabulous guest, and we look forward to having you on the Health Disparities Podcast again in the future. I'd like to close with any final comments you have for our listeners.

Dr. Joynt Maddox: I'd just like to thank you and thank everyone for listening. I think we're at a touchpoint in history, and I hope that we look back over this next year, a couple of years, five years, and feel like we really started to move the needle on equity. I think we're at the beginning of a movement and I really hope that we look back and see that things have changed.

Dr. Joynt Maddox: I could not agree more. So, thank you, Dr. Karen Joynt Maddox, from all of us at Movement is Life and our Health Disparities Podcast. We want to wish you and yours all the best in 2021, and really, truly applaud all of the work that you do to promote health equity. Happy 2021.

Dr. Joynt Maddox: Thank you, you, too.

Dr. O'Connor: Thank you. Bye-bye now.

(End of recording)