Can the "Equality in Medicare and Medicaid Treatment Act" protect human dignity?

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Law Professor and bioethics expert Frank McClellan's new book focuses on the importance of human dignity in healthcare. In this podcast he explores how the evolution of health systems has driven an agenda of cost-containment and shifted the burden of financial accountability, often compromising care management and widening disparities for the most vulnerable groups of patients. A new act aims to protect patients by requiring that the consequences of new payment models are researched and adjusted for by CMS, helping to build health equality across race, ethnicity, gender and geography. With policy expert Bill Finerfrock.

Bill Finerfrock: Hi, you're listening to the Health Disparities Podcast for Movement is Life. Conversations about health disparities, with people who are working to eliminate them. I'm Bill Finnerfrock. And today I'm discussing health disparities and health policy issues related to disparities with Frank McClellan, from Movement Is Life. He's on the executive committee of Movement Is Life. Frank, tell our folks a little bit about yourself and how you came about to be involved with, health disparities and Movement is Life.

Frank McClellan: Bill, I'm a Law Professor at Temple Universities, where I've taught for a number of years since 1981 and the areas that I concentrate on are

healthcare law. And I teach courses on bioethics and healthcare financing and medical malpractice. I've done that for years. I've also been involved in representing individuals who have had bad results in the health system. And, thereby explored on an individual basis some of the harms that occurred. About 10 years ago, I was discussing some of these issues with a social friend, Dr. Jimmy Wood, about healthcare and my perceptions of how people of color and women have been the height of the wrongdoings that I had seen in practice and also, that I'd identified and studying the history of bioethics things like the Tuskegee Study, etc. So, he, as an orthopedic surgeon, offered some defenses and some corrections to my view from his perspective and we got into an argument and then we became great friends. And so, finally, one day he said, "I think it would be good for you and good for the organization for you to come and work with me with this group called Movement Is Life. That is really working to do something positive to resolve these problems of disparities. And it's a multidisciplinary group. And I think that adding a perspective like yours of a legally trained person would be useful." So, that's how I got involved thinking it was only going to be a year and here we are almost 10 years later, I'm still involved.

Bill Finerfrock: That's great. Now, you talked about being a college professor, but you've also written some books. I think you have a new book coming out here soon. Tell us a little bit about that.

Frank McClellan: So, I'm writing a book. It's going to be published this year by Rutgers University Press. And the title is, "*Healthcare and Human Dignity,"* subtitled, "*Law Matters".* And what I'm doing in the book is a reflection of a lifetime of work in both legal representation as well as study is that I'm looking at individual stories and cases of people and families that I think really need to be viewed as human dignity problems, not simply medical malpractice or problems of finance, but really presenting themselves to the healthcare system or being denied access to the healthcare system in a way that really goes to the core of dignity of who they are and through this book I'm expanding from the individual story to the broader policy issues that I think really impact. I'll give you just one quick example.

I start out with these young women in my first chapter, who were abused by the Olympic doctor. And so, I used that case as a way of drawing out the fundamental themes that I'm going to discuss in the book like the use and misuse of power and the relationship. So that here we have a situation where young women, young girls are dependent upon a doctor who is supposedly looking out for their best interests, and this doctor proceeds according to the court filings and the findings to abuse them sexually and otherwise, and they feel powerless to do something about it. And it's the way that a lot of people I've seen have felt when they have to enter into and depend upon the healthcare system. And so, that's just

giving you a sense of the kinds of relationships that I'm concerned about and I'm trying to look at how do we control and advance equity on the part of individuals as well as communities of people. Here, they were women. Obviously, there are situations where there are other groups that tend to be abused more frequently than the other or tend to be more powerless. And I think those individual stories end up being reflected in the broad statistics that we draw when we talk about health disparities. So, if we look at women's health, if we look at another chapter I'm talking about people with HIV and AIDS and how they were treated in the beginning when they first tried to come and get healthcare and access to the healthcare system. So that a person could be sick totally in need of help and they would be denied admission to a hospital or denied admission to a dentist for reasons that may be reasonable from the perspective of that practitioner but if you look at what their profession is supposed to be doing and the dependency of people for care, it's horrendous. So, if, for example, you, as a person who's ill and you're dying and the hospital administrator turns around to the other person and says, "You're not married to them. Are you?" And you say, "No, this is my partner." I've been there with them for 20 years. And they say, "You can't go visit them. We're restricting visits to people who are immediate family. You're not immediate family." Again, I'm trying to give you a sense of dignity in terms of the use of power that invades dignity.

Bill Finerfrock: Well, one of the things that, Movement Is Life has been involved in and one of the things that you and I've worked together on is, some of the policy issues and how policies whether consciously or unconsciously, create disparate outcomes in the health disparities. One of the things that, some of us have talked about is the idea that, payment policy isn't necessarily colorblind, for example, if you look in the CPT manual, it'll give you a code for an office visit. And it doesn't say it's an office visit for a white person or an office visit for an African American or Hispanic or office visit for a man or woman. It just says it's an office visit. So, in that sense, you could look at it and say, well, it's colorblind.

Frank McClellan: Well, Bill, I think that since you're so steeped in this, why don't you explain to the listeners what a CPT code is?

Bill Finerfrock: A CPT code, refers to as a common procedural terminology and everything that happens in a doctor's office has a code. It's either a numeric or an alphanumeric code that basically says what happened. So, you'll have an office visit. Maybe it's a brief visit, a moderate visit with a new patient established. Each one of those has a separate code. And it's just intended to describe, what happens. So that when an insurance company, for example, sees that they know when that number is there, what happened, and then they'll assign a payment to it. What we find is that on the payment side of it, the outcomes, even though ostensibly, the

payment is color neutral or colorblind or gender neutral, we get these disparate outcomes. And one of the concerns is that's going to get worse because of some potential changes in how physicians are paid. So, they're going to move to, what we call bundled payments and, potentially create some risks situations where we think that health disparities are going to get worse. And so, we've been working on that. Have you looked at any of that in terms of the payment policy and has that been part of your work and, as a lawyer and some of the work that you're doing?

Frank McClellan: Primarily, and then in the context of teaching and researching, I've looked at the issue of payments. Although, I have some cases that I'll talk to you about that were direct reflection of payment policies. But let's start with the notion that in healthcare, most people to get access to care, depend upon what we call a third-party payer or insurer. It's one of the unique areas in our economy where people don't go with their own checkbook and try to purchase the services that they need. So, they rely upon third-party payers. And so, in this area, in order to get access to care and for the provider or seller of the service to get paid, they have to comply with the standards and guidelines of the third-party payer. A third-party payer could be a private insurer. It could be a government insurer. And so, the dominant ones in our society, in our country are Medicare, which covers people primarily over 65, although some with disability and Medicaid, which covers people who meet a certain poverty level. So, both

of those large insurers, government insurers have to determine how they're going to pay for the service and what service they're going to pay for. So, in the good old days, from the perspective of both physician and patient, they would provide the service and they would submit the bill and they would be paid. It was called fee-for-service. And so, over a period of time, the third-party payer might say, you're doing too many bowel surgeries. You're doing too many, knee replacements.

Bill Finerfrock: Or ordering too many x-rays.

Frank McClellan: Or ordering too many x-rays, etc. So, we'll put you off our list or we'll control you. But that was where they tried to control the costs. Well, the government in the ‘60's decided that wasn't working. We need to have somebody in the middle of the decision-making process that would concern him or herself with costs because the hospitals weren't concerned with costs, the doctors weren't concerned with costs because they were looking at giving the best care they could to their patients. Certainly, the patients wanted the Mercedes instead of the Ford of healthcare, if they could get it, and if they had insurance, that's what they did. So, they started out by saying, to managed care companies, why don't you step in the middle here? And you determine whether or not something's going to be covered prospectively before it happens, or maybe even while it's happening and therefore, we'll keep our costs down that way. Then, we

had that experience for a period of time, and it became, unsustainable, from a human dignity point of view and from a social welfare point of view. Because insurance companies looking primarily at costs started to infringe both upon medical decision-making at the bedside. In other words, the doctor would say, I want you to get Vioxx. And they would say, "No, get the generic one, or get this alternative drug because it's cheaper." Or they might say, "You don't need a CAT scan. You can take an x-ray." And their primary focus was on costs, but when they're doing it, they were doing it in a way that impends directly upon the doctor's decision and medical standards. So, we evolved from that to the point where CMS.

Bill Finerfrock: The Centers for Medicare and Medicaid services.

Frank McClellan: That administers the Medicare program on a national basis said, we've got to come up with another system that would make costs be more controlled. And one way we can do that is to place the burden and responsibility more on the doctors and hospitals. So, that they have an incentive, to limit the cost of care if they can. And instead of making the mistakes that we made during the managed care era of having somebody directly review what they're deciding and say, no, do it this way, do the x-ray instead of this, let's just do it financially through our payment.
And so, they came up with this concept of bundled payments, which meant that if you're going in, for example, we're talking about orthopedic disparities, if you're going in for a knee replacement, let's find out what the

standard charge should be. How much time should it take to do this? How much time should you be in the hospital? How much time do you need for physical therapy? And let's give this bundle of money to the hospital's doctor and say to them that you're going to be penalized, or you're going to be rewarded for staying within the boundaries of these payments.

Bill Finerfrock: But, to that point, I think if you look back at those managed care companies, that over time, what the criticism became was that they only wanted to kind of recruit in the healthier patients. So, if you looked at their advertising, for example, it would always be an elderly couple that was out walking or exercising, or they'd put their office on the second floor of a building that didn't have an elevator. So, if you had mobility issues, you couldn't get there. And so, as a consequence, they were effectively cherry picking, the patients. They were being paid an average amount, but the patient populations that they were caring for, historically, had below average costs. Aren't we concerned that same thing, if we're going to, in some ways almost replicate that? We're going to pay an average cost for a patient now for orthopedic surgery, for example, that same thing will occur with physicians that we saw occur with managed care companies, where they're going to only look to take care of those patients who are lower cost. And so, they're going to look, and the term that we hear used here is cherry picking or lemon dropping. Do you have that concern?

Frank McClellan: Would you explain what those terms mean to you?

Bill Finerfrock: Cherry picking or lemon dropping, it's kind of the flipside of a coin, either way you look at it. Let's say they come in and say, on average, we're going to pay a thousand dollars for this procedure and that's going to cover a period of time, pre-operatively inter-operatively and post-operatively, and that thousand dollars has to cover all the care.
And then I look, and I have two patients come in my door. One is a healthy 50-year-old male, in good shape, no medical conditions, Caucasian, lives in a suburban community and in need of that service. And then I have another patient who comes in who's perhaps African American, overweight, maybe has diabetes. And I'm thinking, well, if I do the procedure on the patient who is African American and diabetic, they may have to stay in the hospital longer. They may require additional post-operative services, and I only got a thousand dollars to pay for that. So, I'm probably going to lose money on that patient. But if I take care of the other patient, they're going to be in and out, maybe I can do it as outpatient surgery. It's not even going to require a day in the hospital and I'm going to get that thousand dollars and I'm going to make money. So, I'm going to tell the patient, "I'm sorry, you're not a good candidate for this procedure." So, you don't even get the procedure and that over time, I'm only going to care for those who are healthy, that I know I can bring in under the cost. So, the government comes in and looks at my quality data

and says, "Gee, you're doing a great job. All your patients, you're getting them out of the hospital quickly. Great outcomes, great quality. We're going to give you a bonus." Meanwhile, there's a whole community over here that we're not even looking at because they're not getting into the front door because they have either social determinant of health or comorbid, medical conditions that cause them to be a less attractive financial patient. And so, I think that's the real, almost insidious part of what's happening is we're shifting this financial incentive to the clinician, and we're not even going to know about some of these things that are happening because simply people aren't going to get access to healthcare.

Frank McClellan: I absolutely agree with that. And I think it's important to point out the difference between, even from an ethical, point of view of what's going on now, from what went on with the managed care companies, because the managed care companies were doing the selecting. They were deciding who they would insure, and they were going after them. And so, if a physician provided care under that insurance policy, they had to comply with that. What's going on now with the CMS model of payment is that they are making the physicians and the hospitals make the decisions about how to comply with the best profit approach to the problem. So, it's even more insidious because what we rely on in society in America for care and quality care, when we go to the doctor, is that unlike the ordinary

seller of goods and services, we expect that doctor to have our best interests in mind. So, that when they make a recommendation of stay in the hospital or don't stay in the hospital, there are different from the car salesperson because we know the car salesman is only looking at the product and making a profit, but the fiduciary duty and the nature of trust that comes into play with doctors is that we want to believe as patients that cost may be a consideration, but it's not the driving consideration. So, that when an insurance company says, here's a pot of money and you get to keep more of this pot of money, if you keep the cost down, the risk is that they begin to pervert or impinge on that ordinary professional duty. Yes. That's what most of them went to the medical school for, in the first place, and in that regard, I think we have to also look at hospitals. Although hospitals are institutions, they don't have that direct human connection, making that decision. So, they're more like the profit making or surviving entity, but they still have to make the same decisions because they're incurring the costs. So that when you use a system like that, what you're saying is costs have to be taken into account. We're not going to make the decisions about who you treat or how you treat, unlike the private insurers, or with managed care, Medicare has to take everybody over 65. Their eligibility is determined by law. Same thing with Medicaid. So, they're not going to limit costs by saying, you're not going to give care. What they're going to say is physician, you decide who you give care to. So, that then shifts the burden to the doctor.

And I'll tell you an interesting case, which I think is very important to think about. It wasn't under Medicare, it was under managed care, but it was a case called Wickline where a woman went into the hospital, had vascular surgery and the doctor who was treating her decided after three days that unlike the ordinary three-day stay, she needed to stay there for another five, six days. Managed care company reviewed and refused said, no, she can go home. They did what was called a concurrent review. She went home and she and her husband are at home watching her leg turn blue, not understanding what's going on until finally after four or five days, they decided we better get back to the hospital. And they go back to the hospital. And by that time, it's too late to save her leg. Now, why do I bring this up? And then, more importantly, in terms of the law case, the court ended upholding the case, a California case that was a medical malpractice case that the doctor still remained responsible for making a medical decision notwithstanding the financial pressures and rejection, the insurance company had made. They said, however, that if the insurance company's policies corrupted medical judgment, that would be going too far. So, that potentially insurance company could be held liable. But think of yourself as a doctor in that situation. You've already made your medical determination. And then you decide that you're going to try to get payment for the patient. You find out you can't and then you decide, well, they're the boss. I'm going to send this back and think about it from the

perspective of the patient. My doctor told me he wanted me to stay, but then he told me to go home. Now, I don't have a leg. I'm making it very crude because that's the bottom line. So, that's the danger. If I know, for example, that keeping this patient in the hospital an extra four days is going to result in more costs, then my incentive is to get them out. Just like the insurance company had that incentive in managed care and just like the hospitals, the hospital says "Who's going to pay for this? You don't have a justification?"

Now, here's the thing I think Bill. We used to refer to socioeconomic factors, so that we all know that patients aren't cookie cutters. And so, they come from communities, they come from environments, they come in with histories that make them different. And so that care has to be tailored toward them. So, what we started talking about in the beginning is suppose we'd get the data, and we find out that high percentage of the people who are going home early or not even being treated now fall into various groups, African American, Latino, women, rural whatever group it is that we're using, and we say, something's wrong here. This payment system seems to be one of the factors if it's not the sole factor, but a significant determinant of what's going on here whereby the bad outcomes or the denials of care are accumulating in certain communities. Now we've identified what we would consider the socioeconomic factors that are influencing the outcome and they’re factors that the provider has no

control over. If housing is the problem, if not having a job is a problem, if not having transportation is a problem, and that's what causes the person to be more costly or more risky, the healthcare provider doesn't have any control over that, and yet you're penalizing them for it.

Bill Finerfrock: And that's one of the things that a number of people are writing about now is that we are shifting this risk to the provider, but we're holding them accountable for things over which they have no control. And so that is what partly contributes to this, lemon dropping, cherry picking, situation. So, Movement Is Life has been working on this and, has some legislation that they've been promoting called the Equality in Medicare and Medicaid Treatment Act. Are you familiar with that and can you talk about that a little bit and what you think that might be able to try and do?

Frank McClellan: Yes that’s, I think a very important proposed bill that hopefully will get serious consideration and passage because all it's really doing at its core is asking the CMS when it looks at what's happening with the provision of care to take into account whether or not there is a disparity, an impact in terms of certain groups. So that information will be available so that when one begins to make payment policy decisions, you can take that into account. To ignore it is to continue a financial system that perpetuates disparate outcomes. To ignore it means that either it's not important to you or that it doesn't have enough importance to warrant the

kind of effort that it takes to come up with strategies to address it. So, I think it's a very balanced and fair bill proposal because it's saying let's do this transparently.

Bill Finerfrock: Yes, I think so often, in the health policy arena, we discover problems after the fact. A researcher goes in, somebody goes in and analyzes and says, "Hey, did you realize that we can identify that, from point A to point B, this adverse outcome occurred. And so, we can identify that that occurred here." I think what, the equality of Medicare and Medicaid Services Act is saying is, let's try to prevent that from happening. When, we're designing these models, when we're looking at whether it's a bundled payment or some type of value-based payment, let's consider the possibility that this could have an adverse impact on individuals, based on gender, race, ethnicity, geography, whatever and, maybe we can build something into the model to prevent that from happening. We've just seen so many examples. We were talking earlier today; they changed the way we were going to pay hospitals back in the mid-1980s. And suddenly they discovered that rural hospitals, because they were low volume for a variety of different reasons, couldn't fare well, and those were all based on average payments. And so, what did we see? We saw the closure of rural hospitals all around the country, and then we had to scramble to try and put Humpty-Dumpty back together again. And I think what we're saying here is let's not replicate those. In the design phase, in the evaluation

phase, let's consider the possibility that these things are going to happen. We already see it, now. We have no reason to believe that this is suddenly going to solve health disparities. So, maybe we can design and build things in.

Frank McClellan: I want to ask a question because I know you're an expert on rural community and healthcare. How do you see this proposal benefiting or helping at all with disparities that might exist between rural and urban?

Bill Finerfrock: As I mentioned, when you move to average payments for hospitals, we saw that rural hospitals, did not fare well. And I think the same reasons that rural hospitals didn't fare well is why some rural providers would be challenged here. And it really is a function of volume. Very often, if you have enough people, you can make a lot of things work because it's going to balance out actuarily. I'm going to have enough winners to offset whatever losers I might have financially. In rural communities, you don't necessarily have that nice little bell curve of patients of, unhealthy and healthy and so forth. And so, you can have that situation. And so, we already know that surgical, specialty care is a challenge. We've worked hard as a country to try and get primary care. This is going to make specialty care even more difficult, and the individuals are going to have to travel. They may have great insurance, but they need to go three hours to the nearest hospital. You're in Philadelphia and maybe I'm up, in North

Central Pennsylvania, and I had to go to Philadelphia. One of the great teaching hospitals in Philly is, three and a half, four hours. Well, okay, I get the surgery now, what? Well now, where do I get discharged to? So, it's like, “I'm not going to go, I won't have the surgery.” And, so, you see that same phenomena of people not getting access to care. It may not be because of economics may not be because of the color of their skin or their gender, but simply the geography says, “I'm sorry, you just don't have it.” And so, what can we do to try and address some of those things to make those services more accessible?

One of the things that a lot of folks are looking at, I think as great promise is, telehealth as an example to say, okay, we're going to discharge you back home, but now you're going to be able to talk to the surgeon in Philadelphia and have a communication. We'll give you a camera. You can show them how the wound is healing and answer questions. So, even though you're four hours away drive time, you're immediately available because now we can have a telecommunication consult, that we weren't able to have. So, how do we use technology to say, that's going to cost something. So, if you've got a patient who's in a rural area and we go back to that early example of a $1000, okay, we're going to pay you $1,200, because you're going to have to take advantage of technology, but it's going to be better. And then you're not going to have the disincentive to see that patient. And that patient is not going to have the disincentive. So

how do we adjust the payment model to take into account that, okay, you may not be able to go home. We're going to have to put you in a skilled nursing facility. You don't have a SNF close by or a home health agency close by. So, we'll adjust the payment model to take that into account. Instead of just paying everybody a flat rate $1,000, we're going to adjust that based on those factors over which you have no control.

Frank McClellan: It's interesting that you point out the problems with post hospital care, because I saw a two-year study of the mandatory, bundled payments for total knee replacements was in *New England Journal of Medicine, 2019*, and the first part of the conclusions they offered were that it did not show evidence of more bad outcomes or lower quality of care, but they focused on things like deaths and other kinds of serious adverse reactions.

And then, they noted that the way in which the hospitals responding to this bundled payment had saved money was to count or cutdown on, physical therapy in house or other kinds of post-surgical treatments. So again, I think looking at the consequences one has to say, given socioeconomic factors that there may be some serious disparity. So, if, for example, you say to a person who just had a knee replacement, we can't give you rehab here. We're going to send you to another place. You have to be concerned about the quality or that you're not entitled to rehab at all. So, I was talking to a physical therapist who said that she had seen a marked increase of

people coming to her three months later, as a result of having surgery and not having physical therapy. And they're coming in on crutches and other things that in her experience they would not have had, had they had the physical therapy right away. So that raises some important questions.

One, if we're talking about cost control, are we really doing a fair job because we're not looking at the costs associated with not having care afterwards. So, for example, if it's socioeconomic factors, if you live in a house where you don't have someone who lives with you, or if you have someone who doesn't have the capacity to take off from work, there's a cost to that. If that person is there for two weeks at home and needs to be cared for, and they're not having physical therapy. So, I think that, again, we're talking about transparency, looking at what are the intended consequences, what are the actual consequences and do those consequences that are real, are they justified, are they good policy? And we won't know that if we don't get the information.

Bill Finerfrock: Yeah. I think one of the things that's interesting in this whole discussion is it's pretty well recognized that, this idea of comorbid conditions and how that can contribute to added costs.

Frank McClellan: Comorbid, what does that mean?

Bill Finerfrock: That means, you have other things that are wrong with you. So, for example, you may be obese or have diabetes or arthritis or high blood pressure. And so, all those factors could affect the outcome of surgery. So, if you're going to go in for knee surgery, if you're obese, if you have high blood pressure that may affect certain things. And so, that's pretty well recognized, that can add cost. And so, a lot of the payment policy, if you look at how an insurance company, if you have a high number of diabetes, patients who have diabetes, who enroll in your plan will pay you a little bit more because we know. But one of the things that's not as well recognized is this idea of social determinants of health. These non-health factors necessarily that are also impacting on the cost of that patient and saying, we need to think about those as part of the payment policy. Not just those measurable or diagnostic components, but to your point, is there a support system at home? Is there a spouse who's able to help provide care or children who can come, or does that mean we're going to have to have a home health agency? Or you're on the third floor of an apartment building and you don't have an elevator. And so, you're not going to be able to get up and down or do the exercise or get to the PT, or you're relying on public transportation or you live in a neighborhood where it's a high crime neighborhood and going out and doing an evening walk to get some exercise is not realistic because of safety reasons. All those non-health factors impact on the outcome and to the extent that we're now going to hold the physician or the hospital financially accountable for the

outcome and say, well, wait a minute. So, I think part of the challenge is how do we build that into the payment model to create a more level playing field? So, the doctor says, okay, I don't care whether you're a Caucasian male from suburban Philadelphia or you're a Hispanic woman who's obese from inner city, Philadelphia, economically, there's no incentive or disincentive either way. I'm going to now go back to the point you made earlier is making a clinical decision based on this procedure and whether it's a good procedure and I'm not going to be influenced by the financial ramifications of that decision.

Frank McClellan: And yet you could understand why CMS is concerned about costs and building a sustainable system would say, “Okay, let's make sure that we don't have people being out of the hospital then being readmitted unnecessarily. So, let's penalize the hospitals that have higher readmissions.” And so, there's been a study done that shows that if you ignore socioeconomic factors, then you see that they're imposing penalties on hospitals with more costs because of readmissions. But if you factor in those socioeconomic factors, then you would not see this as something that's penalized. I like to think about this analogy as the schools, so that if you're going to penalize a teacher or a school system, because they're taking care of the neediest kind of students, then what you're doing is you're discouraging them from doing that. Whereas, really, the opposite should be true. If we're looking at making the analogy, you may be able to

punch a hole in my analogy. But if you really wanted to build a payment system for improving the overall education, as well as health system, you would say, let's give the most money to the people who take on the most challenging students and produce the best result. So, I don't know how we get there, but I know that we need information about the consequences in order to make a rational, fair policy.

Bill Finerfrock: As you're telling that, and making that analogy, I'm smiling here because, my daughter is a schoolteacher, and she teaches in a Title 1 school.

Frank McClellan: What's Title 1 school?

Bill Finerfrock: Title 1, it's large population, low-income children who are on school lunch programs. And it's a school that had actually lost its accreditation and they were recruiting teachers, to come in and try and help turn that school around. And so, she took that opportunity. And we've had this very conversation, I've talked to her about some of the challenges in healthcare and these social determinants of health and how it's impacting. And she said that's exactly what she deals with as a teacher. She sits there in the classroom and she has kids from different backgrounds. Some whose parents are supportive and helpful, some kids are coming to school hungry and, did they even get a good night's sleep and she as a teacher is

being evaluated and they have to take tests. And, if a certain percentage of the kids in that class don't pass, then she gets a bad score and is evaluated as a bad teacher. But how much of that is due to factors that are beyond her control as a teacher and how do you build that in? So, I think your analogy is spot on. I think that these areas where all of these factors can impact outcomes, and to the extent that we're evaluating people and saying you're good or bad, or your quality's good, or quality's bad without taking all those things into consideration, we're doing a disservice to teachers and to health professionals.

Frank McClellan: And we call those safety net hospitals. They're safety net, because we're saying you're the ones who have to stop them from hitting the ground and dying. And so, if people are in those areas, they're in an urban area like I teach at Temple University. Temple Hospital is in North Philadelphia, which has a really, large population of people who are poor and don't have jobs and have all the other kinds of problems. So, the issue is if you have a payment policy that penalizes readmissions, and doesn't take into account, I'm not saying you reward low quality, if they're not doing a good job, then we should make sure that they don't get paid, but if they're doing a good job, you should take into account that they unlike the hospital, that's in another community like sometimes I'll go to a hospital out in the, in the suburbs, and I'll be into the treatment room before they even ask about insurance. So, that hospital is used to having a patient

population where they know they're ultimately going to be paid, they can develop policies, but on the other hand, Temple is treating a high percentage of people who don't have insurance, and if they do have insurance, it's going to be with Medicaid, which pays less as a rate than, do some of the other insurance. And so, you don't want to compound the lack of access of people to healthcare by saying, we're going to penalize you because these folks aren't doing as well.

Bill Finerfrock: Well, this has been a great conversation and I really appreciate you taking the time, to be with us today. Again, it's been Frank McClellan and Frank is a professor emeritus at Temple University Law School. He's written a couple of books that I would encourage you to track down and look at and the title of your new book again?

Frank McClellan: "*Healthcare and Human Dignity: Law Matters."*

Bill Finerfrock: And check it out. So, thanks Frank for spending time with us today. We really appreciate it.

Frank McClellan: Thank you. I enjoyed it, Bill.

(End of recording)