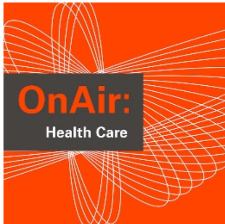

Ep. 3: Health Equity – Two Perspectives

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Dr. Mario Ramirez: Hi everyone, and welcome to this week's edition of *OnAir: Health Care*, Akin Gump's health care podcast. I'm Dr. Mario Ramirez, a consultant here at Akin Gump.

Matt Hittle: And I am Matt Hittle, a senior policy advisor here at Akin Gump. Mario, today we are talking about the thing everybody is talking about. The hottest word in D.C. is "equity" and that's what we're discussing here today.

Dr. Mario Ramirez: That's right, Matt, and we've got two fascinating guests who are going to be joining us for a great discussion. We're first joined by Orriel Richardson. She's a health counsel on the House Ways and Means Committee. She's going to be followed by Gary Puckrein, who's the CEO at the National Minority Quality Forum.

Matt Hittle: Yeah, these are some fantastic conversations. I think our listeners are really going to get a lot out of them. We really tried to plumb the depths into what equity really means. It's kind of become a buzz word and I think a lot of people are just kind of going with the flow, not quite understanding what folks who have been working in this field for quite some time actually mean when they say equity.

Dr. Mario Ramirez: I think you're right, Matt. We're going to hear from two of the experts today. So let's jump right into the discussion.

Matt Hittle: We're turning first today to Orriel Richardson, who is professional staff and health counsel with the Ways and Means Committee in the House. Orriel has a JD from The George Washington University, an MPH [*Master of Public Health*] from Tulane, and a certificate in human rights law from the University of Oxford. Orriel, thank you for joining us today.

Orriel Richardson: Thank you for having me.

Matt Hittle: Before we get started here, tell us a little bit about yourself beyond the vital statistics. Tell us about your work with the Committee and how you got there.

Orriel Richardson: I always like to joke with younger people—particularly when I speak with some of my students, because I teach in the MPH program at GW—that it isn't like I was a little girl and said, "I'm going to do Medicare policy when I grow up." But I came to the Committee after having worked at the CMS Innovation Center, helping them to add program integrity and legal analyses to the front door of the model portfolio, for all of the fun things they were testing to innovate the health system after the Affordable Care Act instituted the Center. I went to CMMI after having started my career post law school, working for the District of Columbia Department of Health Care Finance. Both there and before in the Department of Health Policy at GW, my focus was Medicaid. So, it really was fortuitous that when I got to the Committee, the Chairman was looking into some of the works that we'll talk about a little bit later in the podcast.

Matt Hittle: That's great, thank you.

Dr. Mario Ramirez: Orriel, I was going to see if maybe I could jump in first, and I think we're going to start with the same question that we're going to ask a few of our guests today. But one of the terms that really everyone is talking about right now is equity. Certainly equity in health care delivery, equity in the pandemic sense. Can you explain to us a little bit the lens through which the Committee sees equity and maybe how that's different from equality?

Orriel Richardson: So, I always love this conversation, and one of the best analogies that I've seen to date, from all of the many experts in this field, came courtesy of the dean of my alma mater, the dean of GW Law School and the first woman to be dean of GW Law School, Dean Dayna Bowen Matthew. She uses a photograph of the plane that went down in the Hudson. I'm not from New York, I'm very Louisiana when it comes to geography, but it was Sully's plane. When you think about that plane, you're like, "Well, goodness, that must have been terrifying." But she takes this shot that's zoomed in, and it shows lots and lots and lots of people on the wing of the plane. Then it shows a few people scattered about in various life rafts, and those people also have on life jackets, and they were toward the front of the plane. So, those were the individuals clearly in first class, and they were provisioned even in an emergency to give them a better set of circumstances by which they might survive versus the majority of folks on that plane who were fighting for a non-slippery part of the wing and trying to stay on and stay balanced.

In a sense, people would look at that, and people who've traveled by air would consider that to be a form of equality, right? Everybody can survive; there's a wing for them to stand on. But equity is making sure, at minimum, that everyone had a life vest. Equity is making sure that it's not just that you have people doubled up on flotation devices while you have a majority, two-thirds or more, that don't have any flotation device—they just have the wing. So, that's one example that I like to use, to now articulate the difference. It used to be the little photograph of the very short person on three boxes in order to see the football game, whereas they were standing beside a taller person who didn't need a box at all, or another person who just needed one box. And as someone who's five feet tall, that one used to resonate a little more loudly, but I like the plane example now.

Matt Hittle: I love that plane example; it's really illustrative. So, I appreciate that. I know you've got to give your congressional staff disclaimer here with this question, but

how has Chairman Neal at the Ways and Means Committee incorporated this concept of equity into his approach to legislating?

Orriel Richardson: So I'll just say that I am happy to speak to you about health equity from my perspective as a staffer, but I am not speaking as an official spokesperson for either the Committee or the Chairman. But having worked closely with a team that's dubbed the "Health Equity Avengers" on the Committee, it has been a 360-degree approach, to contemplating, reflecting upon and trying to act, based on the awareness of equity issues wherever they may reside in the Committee's jurisdiction. This really started in earnest in the 116th Congress, when Chairman Neal started the Rural and Underserved Communities Health Task Force.

Now, that's a bipartisan creature, and I won't steal my answer to some probably later questions, but the idea behind that task force, was to look at this issue of the glaring disparities that are being reported out of rural America. But also recognizing that if you just do a little bit of digging in the literature, they coincide with issues that have been cited in urban and underserved areas across the country for years now. It's just the lack of vernacular to relate the two settings, with the same concept and the same need, that really resulted in the co-chairs of that effort asking the staff to help them uncover and do some fact finding: What are these issues, and, if they are the same, what are the things that allow them to manifest a bit differently and are determined based on setting?

So, we undertook this exercise to solicit information from the public, and after receiving about 200 responses, the Chairman felt that there was really no solution except to really synthesize those responses and then try to put some public-facing context out to kind of educate and share the things that the Committee and the task force had learned from engaging the public in that way. So, it was really bipartisan that we released the findings and the RFI responses, and being faithful of saying what the issues were, but then the Democrats took it a step further and commissioned a full summary report, to put all of the issues that actually serve as barriers to health equity into context.

So, that left out reports that happened in July 2020, and since then, Chairman Neal commissioned a second Committee report that wasn't just the health equity report. It looked across all of the areas in the Committee's jurisdiction, which includes Social Security, tax, retirement, working family support, oversight and trade, and talking about health and economic equity in the vantage point of all of those levers. And also, it really did something, I think, which is very uncharacteristic for most politicians and policymakers and put in black and white a pathway and a framework to help achieve a society that has equity at the center of its policymaking.

And, so, that work and those reports then resulted in Chairman Neal going even a step further and instituting the Racial Equity Initiative to contemplate the impact of inequities in all of the facets of the Committee's policymaking. So, I would venture to say that, by virtue of the National Minority Quality Forum recognizing Chairman Neal early this year and even myself, largely because of this body of work, he's been very committed, and continues to be so, to equity in a 360-degree sort of way.

Dr. Mario Ramirez: Interesting. So that's a great segue for our next question. As you know, and our listeners probably know, your Committee has oversight of CMS, and one of the

things that Matt and I noticed in one of the recent press releases was a comment—and I'm going to paraphrase, rather than read the whole statement—but they said, "Consistent with Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities, CMS is seeking stakeholder feedback on ways to attain health equity for all patients through policy solutions."

Then they went on to sort of identify a couple of areas such as social risk factors, a way to improve demographic data collection, possibly developing a hospital equity score. From your perch, what do you make of this language, and what do you think CMS is trying to elicit and do these sorts of requests go far enough?

Orriel Richardson: This is certainly, in my mind, a direct response to the President's executive order, to kind of order this self-assessment within all of the executive agencies, to examine the issues and barriers to equity. I think that when you consider the difference between an executive order and a regulation—the force of law, that kind of teeth that you have in the regulatory process—it does signal that there is a level of commitment to the issues, by soliciting this information and doing so within each of the distinct areas that they have purview over, in terms of the payment rules. It seems to also offer, in some sense, a little bit more of a streamlined way to get at some of the more practical and operationally feasible solutions to doing things that may be on the easier side of things, in terms of a scale of effort here needed to progress towards a society that has equity at the center of its work.

And the Chairman sent a letter to the Center for Clinical Standards and Quality within CMS, largely as a part of his concern around the findings in a *New England Journal of Medicine* article that came out, I think it was maybe around October of last year, maybe September. But that article really talked about, for example, tools that are used to make clinical decision supports easier. So, the tools that help health systems and doctors and nurses more efficiently take in a bunch of information about a patient and co-occurring conditions and all of these things and really funnel it into a manageable tool that allows them to make these diagnostic and treatment decisions on behalf of patients.

What the *New England Journal of Medicine* piece found was that, in certain tools, when race is included as a factor, the tool adjusts, usually to the detriment of outcomes or treatment options for patients who are Black and Brown. One of the interesting things coming out of that work was that all of the organizations that the Chairman ended up sending a letter to provided responses. Also, the Chairman penned an opinion piece in a kidney journal [“Racial Health Inequities and Clinical Algorithms - A Time for Action,” *Clinical Journal of the American Society of Nephrology*] talking about the issue as well.

But also, it just really spoke to the intersection right now of data, health, technology and our ability to really more efficiently move forward in this post-COVID, or pre-post-COVID space that we find ourselves in. So, in those payment rules that the Centers for Medicare and Medicaid Services issued recently, even that issue of those tools and those decision support tools, those algorithms, those artificial intelligence-based kind of schematics that help to make these decisions easier, those things even came within the scope of some of the payment rules.

I think, from the vantage point of the Committee on Ways and Means, Chairman Neal would be very pleased with seeing this quick uptake of this cause and these issues in terms of the first rules out of the gate for the administration. I believe also, generally, never let the perfect be the enemy of the good, and it's also recognizing that there are easy wins here, and there are going to be some long and long-sought wins that are necessary to actually get where we need to be.

Matt Hittle: You're really good at segues—that's a perfect segue into the next question. It's kind of more of a political question than anything. Back when I worked at Ways and Means several years ago, there was an old joke we would tell, and it was that, as House Republicans, our Democratic counterparts in the House weren't our opposition, it was the Senate Republicans who were the opposition. Does that joke still hold true, with the relationship that you have with your counterparts in the Senate Democratic Conference? Or do you think there's strong agreement between the two sides and kind of the approach, especially regarding the pillars of equity that the Committee has laid out?

Orriel Richardson: I'll take an easy swipe at the political piece and just note that, on the side of the aisle that I work for, the Democrats definitely focused on equity from the vantage point of keeping people first, keeping our people, our children and families and communities, our elders, keeping people at the center of the analysis. Generally, I have started to become very familiar as of late, particularly since January and the change in the Senate, with their approach to things, but I'll now switch over a little bit more to my professorial perspective and just note that it is a different perspective when you have a statewide office. And I think that oftentimes when there are issues of inequity, it is very easy to see them manifest in a smaller swath of geography.

So, inasmuch as Chairman Neal, for example, on the Ways and Means Committee recognized the importance of having some creature that kind of continued to provide opportunities for members, to hear from experts, learn and even amplify within the groups themselves their concerns and hear plans to mitigate racial inequity, but also provide the opportunity to expand their view of what these issues do.

Those undertakings are not just things that are happening and need to happen in Congress; it's happening all across the country in various levels—to consternation and controversy—but these are the growing pains that happen when you really try to break through systemic barriers, to make sure that the country can be as great as it can be and as "e pluribus unum" as we expect it to be.

Dr. Mario Ramirez: Interesting. Orriel, obviously, we've gone through a change in presidential administration, and it's always interesting to draw a contrast between the working relationships and sort of the method of doing business, and I think Matt and I have been interested to see that we're still waiting for some major confirmations and some appointments at CMS. So, of course, it's a question still how CMS will work with Congress. But we were wondering if you could take us inside the relationship between CMS and Congress as it stands now. Who's doing the talking? What are we hearing? How is the relationship shaping up?

Orriel Richardson: I'll go back to the days when I was a career staffer at CMS during a presidential transition, and I'll note that, from personal experience, the work certainly

continues, and it continues with a group of very committed patriots, for lack of a better word, because there's a lot of shifting, and there are a lot of transitions that go on top of people moving up and moving out and all of those sorts of things.

So, I'll just note that the lights are on, people are answering the phones, and they're working very hard to both be responsive to a very ambitious set of priorities and also still recognize that there are lawmakers on the Hill who have been around for longer than a few months, like this administration, and have had priorities. And that's part of kind of their joint mission is to work in collaboration with the legislature to make sure that the things that Congress dreams and the flights of fancy that happen on the Hill trickle down to things that can actually be implemented.

So, I do know that there are certainly people there. There are certainly, in a sense, big decisions that any person very familiar with how government decision-making goes, understands won't be made any time soon because the political appointees are not necessarily all in place. But we anticipate seeing movement on that and hoping that particularly, Chiquita Brooks-LaSure is quickly confirmed as the Administrator for CMS, so she can start to tackle the challenges that face the Medicare and Medicaid programs moving into the future, and the marketplace as well.

Matt Hittle: Moving back up the Hill, I guess, from the Humphrey Building, and taking a look at House Democrats in a vacuum here: What's the number one policy you think House Democrats could move this Congress, just in the House, that you think would move the ball farthest with respect to health equity and putting the marker out there—politics aside, whether it passes the Senate aside? What is that policy that you think would really move the ball forward and put a stake in the ground for years to come?

Orriel Richardson: I really grapple with trying to come down with one, because I could probably make rational arguments for a number of them. But I will go back to kind of this first issue that I covered when I arrived on the Hill, and that was doing a hearing that focused on the racial disparities in maternal health outcomes. And I did that hearing under the leadership of then-Chairman of the Oversight Committee, the late John Lewis. That is the issue that seems to have gotten real traction on both sides of Congress. It is a type of issue that just bears out to be absolutely egregious, simply unacceptable, and for better or worse, the perfect type of example of how an equity issue can be something that exists dependent on your ability to pay.

Most people are familiar with Serena Williams, most people are familiar with Beyoncé. We had Allyson Felix, the Olympian, at the hearing that we did. But just seeing the fact that everyone would suggest that whether you're pro-life, whether you're pro-choice, whether you're rich or you're poor, you would like to be able to know that you can give birth in a country as rich as the United States and not fear for your very life. I think even when you amplify this issue against the reports that the Government Accountability Office released, after Chairman Neal and Ranking Member Brady asked for this report, after the hearing I referenced. That report basically attributes exponentially greater risks of severe maternal outcomes for Black women, for women who are indigenous, if they live in rural areas.

So, one of the most important markers I think that could happen is taking that legislation seriously, recognizing the sweat of the Black women, the Black lawmakers, the advocates who put so much strategy and effort into amplifying this issue and to letting the world recognize that these outcomes in this country are embarrassing, unacceptable, and we can do better and we need to use all hands on deck to make sure that that's a reality. So with a lot of different second places and alternates, I would say that that's the biggest policy I think that could make the impact.

Dr. Mario Ramirez: Yeah, and maybe on that point, Orriel, do you think that there are opportunities to partner with Republicans on some of those issues, or is Congress just too divided to work on that meaningfully?

Orriel Richardson: You'll probably remember this, I hope, but I often have come to realize that Ways and Means is a little different, and I would hope certainly that we could continue the good rapport that we have with our colleagues on these issues. But that said, I think there is just a real—and this is citizen Orriel—there's a very marked difference in being able to have a conversation when you start from different places. Even on one side, on the Democrat or the liberal side, I think that you could certainly even think about ways to incorporate more analogies and parallels and kind of bring it home for people who may not live that experience, or see it, or even understand it.

On the other side, I think it's just understanding that if you see this in the data, there's no point in trying to wish it away or change it to something else. Let's just acknowledge the data and try to figure out how to do something about it. It doesn't require everyone to reprogram themselves or to reveal their deepest, darkest thoughts, but it does require coming to the policy table with an earnest effort and intent to do what's best by the people who rely on Congress to make laws that will improve the lives that we live in this country.

Matt Hittle: You've established you're not an official spokesperson for the committee, which we totally appreciate and understand, but can you give us a sneak peek of the health care agenda at the Ways and Means Committee for the rest of the Congress?

Orriel Richardson: This is actually really an easy question for me, because as I alluded to in my first comment, the Committee released the framework, a "Legislative Path Toward Health and Economic Equity," and the health and economic equity pillars and priorities in that report are the priorities for the Ways and Means Committee for the 117th Congress. A lot of the things that are there, some are short-term, some are medium-term, some are long-term and will require negotiations far past this term of Congress, and implementation of all things may require even more time.

But the idea was to put into writing the Chairman's and the Committee's commitment to looking at economic policy, looking at worker policy, and worker and family support policy, child leave policies, retirement policies. Looking at the policies for not just health care coverage—and we're right into the Medicare for All and those conversations again—not just covering people, but making sure they actually have access to providers that they need and that those providers have the structural competency to deliver high-quality care, regardless of who and where they are serving their patients.

I would just invite anyone who's listening, to certainly give a Web search to "Something Must Change," that's the name of the report, and the legislative framework is called "A Bold Vision for a Legislative Path Toward Health and Economic Equity." Between those two documents, it gives a pretty faithful account of where Chairman Neal has directed the Committee staff to deploy our efforts for the near term.

Matt Hittle: I found it pretty easily. I went to www.waysandmeans.house.gov, and I just searched for equity framework, and it popped right up as the first search result. So, I think our listeners will be really interested to dive into that. Orriel Richardson, thank you so much for joining us today. Ways and Means health counsel, professional staff member of, in my opinion, the best committee in Congress. Thanks for joining us.

Orriel Richardson: Thank you.

[*transition music*]

Matt Hittle: We're joined today by Dr. Gary Puckrein of the National Minority Quality Forum. Dr. Puckrein is president and CEO of NMQF. He graduated Phi Beta Kappa from Brown University, where he received both his master's degree and doctorate. He's lectured, taught and been a visiting fellow at several institutions, including Roger Williams College, Brown University, Connecticut College, Rutgers University and Princeton University. Dr. Puckrein, we are so pleased to have you here today. Why don't you tell us a little bit more about yourself and the NMQF and its work?

Dr. Gary Puckrein: Great, so thank you so much. As you said, my doctorate is actually in history. So, I sort of maraud around in the space of health care. I got into health care when I was a fellow at Smithsonian, where I ended up publishing a magazine for Smithsonian for about 10 years, and when I left that, I decided I wanted to work with minority organizations that had publications, but they were not really getting value out of it, because they were not publishers, and that led me to doing some work with the National Medical Association.

That brought me into the health care space, and what I knew from my publishing at the Smithsonian was that there are about 38,000 ZIP codes around the country where people live. Seventy percent of African Americans live in 2,500 ZIP codes, 70 percent of Hispanics live in 2,500 ZIP codes, and about 50 percent of Asians are in 1,500 ZIP codes. So roughly 8,000 ZIP codes around the country is where the minority population resides. Back in the 1970s and '80s, they did a lot of target marketing into those ZIP codes, because we could predict—as people do today—what kind of car people would buy, magazines, would they take a trip, insurance, all those sorts of things.

When I came into health care, I found out that they were not using target marketing. They were not really understanding health care from the lens of where populations were and how they were consuming health care. So, I decided that what I wanted to do was collect health data. This was in the 1990s when nobody's talking about big data analytics, and our abilities to store big databases were really quite limited. But we decided to do it anyway. We decided not just to store data on those 8,000 minority ZIP codes around the country, but we wanted to do it for the whole country.

So, we've been collecting health data now for about 20 years. The National Minority Quality Forum is the organization I founded, and it's been collecting that data. It has a database of over 5 billion patient records. We collect data on about 160 million lives per year, covering about 72,000 different conditions. This gives us a lot of insight on where health patterns are, on who's treating patients, what do their outcomes look like. So, we understand disparities geographically, by condition, etc. At the National Minority Quality Forum, we've been using that data to partner with patient advocacy groups, organized medicine, industry, to really help eliminate those health disparities.

Dr. Mario Ramirez: Dr. Puckrein, you bring up a lot of interesting topics there. I think one of the things that is most interesting—and maybe there's no word that we've heard more often, particularly over the last four months of the Biden-Harris administration—is the word “equity.” Certainly equity in health care, as a whole, but also I think maybe cast into a stronger light because of the pandemic. Could you maybe tell us and our listeners, exactly what does “equity” mean in a health care space and how does that differ from equality, which I think is another term that viewers hear quite often?

Dr. Gary Puckrein: Often when we use the word “equity” these days, certainly it has a sort of racial connotation to it. What it's talking about is the history of American health care, at least the health care system that we live with today that was built during an era of segregation and the inequalities associated with that segregation. So, both by law and by practice, America provisioned health care along racial and ethnic lines, and obviously minority populations tended to get the short end of the stick. It really wasn't until, as a result of the Medicare and Medicaid programs, when the government began to step into the health care market space, that the walls of segregation came down. Hospitals became desegregated, pressure was put on medical societies to become diverse, even single practitioners found pressure to diversify their offices. So, a lot of that legal segregation, formal segregation, came down. But the inequalities that were in that system, they remained. They took on different names, but the inequalities remained the same. So, when people are talking about “equity,” they're really talking about addressing those inequalities that existed out of that era of formal segregation that was so much a part of early American history.

They use the word “equity” because it's not that we want equality, meaning we want everybody to get the same thing. Because what we understand in clinical medicine is that people are different. They need different things. The whole idea is to make sure that when patients come into the American health care system--by race, by color, by gender, by age, it doesn't matter—that they get optimal care. That the system performs well for them, to essentially manage their risk and give them a better outcome.

Dr. Mario Ramirez: That's a really interesting point that you make, Dr. Puckrein. I think it's certainly something that I've experienced in my clinical practice. The question I think we're frequently asking ourselves in the health care system when we see patients is: How do we make sure that we're taking care of everybody equally and paying attention to equity issues? But maybe the follow-up question I'll ask, I think our listeners are wondering how you and your colleagues and NMQF think about the best way that we can actually achieve equity in practice in the health care system today.

Dr. Gary Puckrein: We've been thinking about and working at this dialog about eliminating disparities and new language, making sure that we have equity in our health care system. And what we realized really came down to a very simple formulation: The health care system has to be built around eliminating patient risk, mitigating patient risk. It doesn't matter what your skin color is, your religion, your age. When you come into the health care system, the expectation is that the system is going to mitigate your risk for hospitalization, for an ER visit, for a disability, for mortality, while improving the quality of your life.

That's a very, very basic metric and actually in the short-hand, says exactly what health care is about: do no harm. “Do no harm” means not just that you actively don't do any harm, but if you omit care, if you prioritize policies in a way that elevates a patient risk, that is the same thing as doing harm. It's quite a problem. We can run numbers and we can see where the system is underperforming for certain groups of patients and we think basically that's the metric. It's all about mitigating patient risk.

Matt Hittle: Dr. Puckrein, CMS recently released several payment rules that I think echo a lot of the verbiage you're using with respect to risk. I will just paraphrase the agency's press release on, for example, the Inpatient Prospective Payment System proposed rule.

It said that, consistent with the President's executive order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government, CMS is seeking stakeholder feedback—so a Request for Information—on ways to "attain health equity for all patients” and this includes: enhancing hospital-specific reports that stratify measure results by Medicare-Medicaid dual eligibility and other social risk factors; improving demographic data collection; and the potential creation of a hospital equity score to synthesize results across multiple measures and social risk factors. Now, obviously, you've been working in this space for a long time, since your ZIP code project. So I'm curious: In light of your thoughts on equity, what do you make of this language and what kinds of information is CMS trying to elicit?

Dr. Gary Puckrein: In a word, CMS needs to be really reimagined. It's old school. It focuses mostly on financial risk. When you dig deep into what is happening with CMS, it's always about managing financial risk, and patient risk is subordinate to financial risk. So, you can find policies that come out of CMS that actually elevate patient risk and, at least in our understanding, ought not to be there. CMS is always measuring everybody else, but it's not measuring itself and it has to be measured against elevation of patient risk.

CMS has always got some new payment model, some new thing that it's creating, but it's always the same thing. It's always financial risk; it's not looking at how we make sure that we are keeping people out of the hospital, that we're keeping them out of the emergency room, that we're keeping them from disability, that we're improving mortality and the other side of it, improving longevity?

That's the goal, that's the purpose. That's what you should be doing. But too often, the conversation sits firmly around financial risk. And when you dig into it, what you see is that patients get lost and subordinate in that conversation. Even

in this equity conversation, when you take a deep look at it, what you see is they're sort of layering things on top of a system that actually needs to be reimagined and thought through carefully about how we go about the real business of health care, which is to help patients lower their risk. That would be my basic feel of it.

Dr. Mario Ramirez: It sounds like this rule doesn't adequately capture the concerns that you and your team at NMQF have. Is there a way to write rules in the existing structure that can adequately capture that? Or, as you said, is it really just a fundamental restructuring and reimagination of how the agency should operate?

Dr. Gary Puckrein: Certainly I think you can begin to do that by introducing patient risk scores, and you're actually looking at patient outcomes. Think about it for a second: Every American, when they come into the health care system, they expect that system to be performing to lower their risk. Nobody goes into the health care system expecting it to be elevating their risk. But in order to manage financial risk, we do all kinds of things, unbeknownst to the patient, that are elevating their risk and even hamstringing the provider because we are spending so much of our attention and energy—inappropriately, I would argue—around financial risk.

So, the answer is yes, we could begin to add algorithms into present formulations that would make change. But I would argue that what we're also talking about is a culture change, a deep cultural change in which the mission becomes around the patient. And what we're saying is to help us all. We don't want the next generation to have to deal with diabetes. We don't want the next generation to have to deal with heart failure in the way in which we deal with it, or cancer, or any of those things.

The way in which we get there is by understanding that from the very outset, we have to focus on patient risk. I would just add quickly, that's what happened with COVID. Look what we did—that's an amazing story, and the way in which we did it is we focused on getting that risk down: We got the vaccines. We organized ourselves to make sure that the manufacturers could get the product out there. We set up systems so that people could get vaccinated. We spoke to the American public about why they needed to get vaccinated. You could do that in a number of therapeutic areas, with the same results.

Matt Hittle: That's a really interesting perspective, Dr. Puckrein. Coming from CMS myself, relatively recently, you're really echoing a topic of conversation that's pretty hot inside the agency, which is that tension between, "we're a big insurance company" versus "we want to morph a little into being a public health entity." And where is the line and how do we use the levers we have under the law to achieve these goals? So, this is a fantastic discussion. I want to move from the executive branch to the legislative branch in our remaining time here. There are razor-thin margins in Congress. With very delicate vote proportions in the balance, where do you see health care equity efforts shaping up? What kinds of policies can we expect to see for the remainder of the 117th Congress?

Dr. Gary Puckrein: I just want to make a quick comment on the dichotomy you mentioned at CMS. The thing I would say is that essential insurance is a very, very different thing. No American who's working has an "out," in terms of their participation in the Medicare program. We all have to sign up for it, and that makes it public health, because you can't pick winners and losers in that system. You have to make sure

that everyone gets treated not only equitably, but optimally, to make sure that they get the best possible outcome. That's the bet that was made back in 1965, and I think that's what the system has to own up to.

On the legislative side, you know, we are in a deep transition and obviously, the back and forth about what to do and the thin margins that you speak of are reflective of the fact that we are in this moment of transition, and everyone is trying to find a pathway forward. I think, for those who are thinking about it in terms of the 21st century, that health care is probably right there at the top of the list, and this is what I would say the administration is talking about when they're talking about infrastructure. Because health care is infrastructure, and the infrastructure that we're trying to build is to make sure that the generations that follow us are not fighting the same doggone war that we're fighting now. And it becomes a conversation that we have to have, because that's what democracies do. They have very messy conversations about the future.

I think that's the game here, on all of us—to educate ourselves about what does that future look like, and I think it's really quite powerful. If you look at the medical revolution that we're in the middle of, the capacity that we have that generations before us did not have, and our failure to use it, that really just means that we're just maintaining old cultures and old systems where we don't have to. I think if we talk frankly to the American public, they'll get it, because they're the ones in the hospital, in the emergency room, suffering from disabilities that they don't really have to have.

Dr. Mario Ramirez: Interesting. On that point, I think you're right in that we are sort of in the midst of a health care revolution. One of the things that I think is interesting that, as part of this revolution, health care costs have continued to go up, rather than us truly finding efficiencies in the system sometimes. I think you referenced this a bit before. Is there a way for us to tackle these issues of rising health care costs and equity at the same time? Are these really two separate issues, and how should we address these things?

Dr. Gary Puckrein: I look at health care costs as really infrastructure costs—we're investing in infrastructure. I liken it a lot to when Eisenhower first took command of his first duty in Africa, and the U.S. was not really prepared for the war. It was all new. He got into a battle that didn't go very well, but he had the financial capacity to learn. He had that capability. That's what we're talking about here. Yes, we're going to spend money, but at the end of the day, if we're spending the money wisely, what we're going to see is we're going to get rid of those diabetes hospitalizations. We're going to really control cancer. We're going to make investments in the technologies and the medicines that we need, so that the next generation does not have to deal with what we did. If you look back at the past, we didn't have that technology capability. We weren't operating at the genome level. We didn't have the technologies that were needed to really tackle these diseases.

That's not the situation now. We have that capacity—we just don't want to use it. We want to use it on other things. I'm making the case that those are really smart investments. Now, I'm not saying we should be wasteful about it, but the point is we need to think about it a lot differently because that's our future. That's the next generation that we're working for. We don't want to come out of the 21st century like we came into it, worried about the same illnesses that we can now gain control over.

Matt Hittle: Dr. Puckrein, that was a fantastic insight. Thank you so much for joining us today. If folks want to learn more about what you do, they can visit NMQF.org. Again, that's the National Minority Quality Forum. Dr. Gary Puckrein, president and CEO, has been our guest. Thank you very much, Dr. Puckrein, for being with us.

Dr. Gary Puckrein: Thank you for taking the time.

Matt Hittle: That does it for this week of Akin Gump's *OnAir: Health Care*—what a fascinating topic of discussion today about health equity. I have a feeling, Mario, that this is not going to be the last time we talk about this issue.

Dr. Mario Ramirez: I think you're right, Matt. This is a hot topic in D.C. right now, and I'm sure our listeners enjoyed the discussion. I'm looking forward to discussing it in the weeks ahead.

Matt Hittle: Absolutely. Well, thanks again for joining us today. If you like this podcast, let us know. Shoot us a line if you have any ideas for the podcast or, of course, if you'd like to compliment us on our radio voices. This has been Akin Gump's *OnAir: Health Care* podcast. My name is Matt Hittle.

Dr. Mario Ramirez: And I'm Dr. Mario Ramirez.

Matt Hittle: Join us next time on *OnAir: Health Care*.

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