Proposal for An Accountable Health Care System

Toward a more perfect Union

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Preface

This Document proposes a transformation of the United States Health Care system. It is a long-over-due change with substantial consequences, not only to heath care, but to economic, social and quality of life issues. There are two plans proposed in this document. Plan A and Plan B

Most of this document applies to both Plan A and Plan B. Part 4, The Single Payer System Transformation, details the difference.

Plan A

Most of this document applies to both Plan A and Plan B. Plan A is for a complete transformation of the US health care system. The approach is a strategic solution that fully addresses the needs for the nation to deliver a health care system that addresses the objectives presented in Part 2.

Plan B

Plan B. is a primarily driven by the CMS health care systems. This transforms the systems with the most, low-income and poverty recipients the less-ambitious undertaking, that could be considered a first step, but Plan B transforms only Medicare (routine and acute care), Medicaid (routine and acute care), the Affordable Care Act (routine and acute care), and Medicaid, Long Term Care, into one, unified, government system. This addresses the most egregious failings of the current system, but not all. It will significantly improve the lives of people in poverty, disabled, mentally ill or elderly along with most of those with limited incomes. It still addresses most of the objectives of Part2, but only for the populations served by the transformed system. The primary difference between Plan A, and Plan B, is the limitation of the transformation phases presented in Part 4. Plan B stops after deployment of Phase 4, deployment of Medicaid Long-Term Care, that includes mental health. Phase 3, includes expansion of Medicare lower

age limit and the coverage for spouses and dependent children, along with intervention for children in public schools.

For decades, “Medicare for All” has been proposed as a single payer approach to improvement to our health care system, but it has not captured the interest of our politicians. In the meantime, the system has further deteriorated. Medicare is now a big part of the problem and Medicaid is an even bigger problem.

This proposal specifies a new future for national health care. It is a dramatic change because there is no simple fix. Simple fixes fail to appreciate and fix the real problems, and meeting the needs, just continue to make it worse.

The Congressional Budget Office (CBO) has conducted a number of studies over the years regarding single payer systems. This document has used the May, 2019, report as a reference to consider the “Key Design features,” and “Components and Considerations for Establishing a Single-Payer Health Care System”, for the United States.

https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf

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1 Part 1, A Single Payer System

1.1 Introduction

This introductory section sets the stage for healthcare reform as a single payer system, where the Federal government is primarily responsible for the funding, administration and payments for services of the national health care system.

The Proposal has the following parts

1) Why a single payer system
2) What is the future of Health Care
3) Overview of the Proposed Health Care Organization
4) System Transformation Program

1.2 What is a Sigle Payer Health Care System

A single payer health care system conceptually, is a government organization that manages that manages the funding and payments for health care services. There is not a formal, international definition, but the Congressional Budget Office (CBO)2019 report considers 6 different national single payer systems to provide some characterizations of the similarities and differences. Not all are national system, for example Canada has a different system in each province.

A new, national system is proposed her, that supports an integrated, full range of health care services of health care services, from birth to death, based do a single package of benefits and associated compensation rates. For the most part, the providers are independent companies from doctor's offices and technical medical services, to large hospitals and government services like the Veterans Health Services. The service providers are engaged by contract to perform relevant services and submit claims for compensation based on the national benefits package specifications. The patient records and other systems are integrated so that the whole system is unified with appropriate portals for each different user perspective.

Providers submit claims for payment for services, including medications or other supplies. Providers and others must be qualified and authorized, nationally, to access or update patient records so that patients can obtain services anywhere in the nation, with selected providers and potentially one, primary care physician who may be in the patient's home regioon. Much more will be developed in the objectives defined in Part 2 of this report.

Here, we focus on a government payer for all the citizens. The expectation is that the vast majority of the citizens will receive equitable and affordable health care, for life.

The "Single Payer" is the government health care system, and it should include these other providers so that treatment is consistent and equitable, but yet, somewhat specialized, as appropriate. This will eliminate the multitude of insurance companies that pay these government claims submitted and modify the benefits and claims of providers, to adequately serve their insured members.

1.3 What is the Problem; There Are Many

Currently, the United States has a fragmented non-system of care where benefits are limited, delayed or denied to many. Many are suffering or at risk of suffering and there is gross inequity. The problems are discussed in greater detail in the following sections. Details for a new system are discussed in Part 2 and Part 3.

The current, United States, health care system consists of many hundreds of health care providers and thousands of health are providers with different groups of payers, subscribers as well as state laws and regulation. The varius information systems systems are fragmented and incompatible, and the benefit package are similar but different. The provider compensations for service providers and other expenses vary widely, and many costs are out of reach for most low income or poor The current health care system fails in many ways, described in the following sub-sections.

1.3.1 The US Has a Health-Care ***CASTE*** System

There are multiple levels from wealth to poverty and deprivation: a "caste" system. Consider the following example populations of health care levels of improved quality of services, starting with those who have no healthcare insurance. Consider the number of people who don't even have Medicaid, the lowest level of quality and adequacy of health care "insurance."

- Wealthy People/Families (Who Don't Worry About the Cost of Healthcare)
- People/Families with employer-paid Healthcare Insurance
- People/Families who Pay for Conventional Healthcare insurance
- People/ Families with low income and high deductibles (ACA)
- People on both Medicare and Medicaid

- People on Medicare
- People on Medicaid
- People/Families Laid Off, without Insurance
- People/Families who are currently unemployed without Insurance
- General-Population People in Jails and Prisons
- Families in poverty, without health care insurance
- Elderly Poor People
- Seriously Disabled, Low-Income people
- Moderately Mentally Ill People living with Families
- Mentally Ill People Who are Isolated in Poverty
- Seriously Mentally Ill people on Medicaid
- Seriously mentally Ill people in jails and prisons
- Homeless families
- Homeless mentally Ill people

This caste hierarchy is destroying the country.

- People at the bottom are suffering from poverty and homelessness, along with inadequate or no health care.
- People who are employed may not have health care insurance, they have terrible deductibles that can put them in poverty if they become seriously ill, and then they likely will lose their employment and their and their health care, along with their assets.
- People further up the hierarchy have coverage by Medicare and/or Medicaid that each compensates providers at a fraction of their reasonable fees. They may engage a physician(s) with an ACO (Affordable Care Organization) that is paid a bonus by Medicare to cut costs resulting in inadequate treatment and denials of appropriate coverage. These cuts can spread through peer pressure and treatment planning.
- Rural communities are losing physicians and cannot attract new ones while local hospitals are disappearing due to consolidations (for profit) and financial failure due to a large population of persons that receive inadequate coverage and provider reimbursement by Medicare and Medicaid.
- People with employer-based healthcare insurance are at risk of losing their jobs **AND** their health care coverage, and worse if they have a seriously ill family member, **AND** at risk of health care bankruptcy.
- Seriously mentally ill people have a life expectancy 25 years younger that the general population (primarily due to poor health care). “Life is hell, and then you die.”
- Medicare is responsible for putting families in poverty by being a last resort that is only available to people in poverty. It encourages people anticipating long term care, to

move all assets, years in advance, so they will qualify as impoverished. Further more, it traps people in poverty because they will lose Medicaid coverage if the gain assets or a job with a disqualifying wage (so that they likely lose health care and any associated benefits (housing, medications, residential assistance,…). This is exacerbated by politicians that insist that people on Medicaid get and report sufficient continuation of jobs, likely jobs that they can't keep.

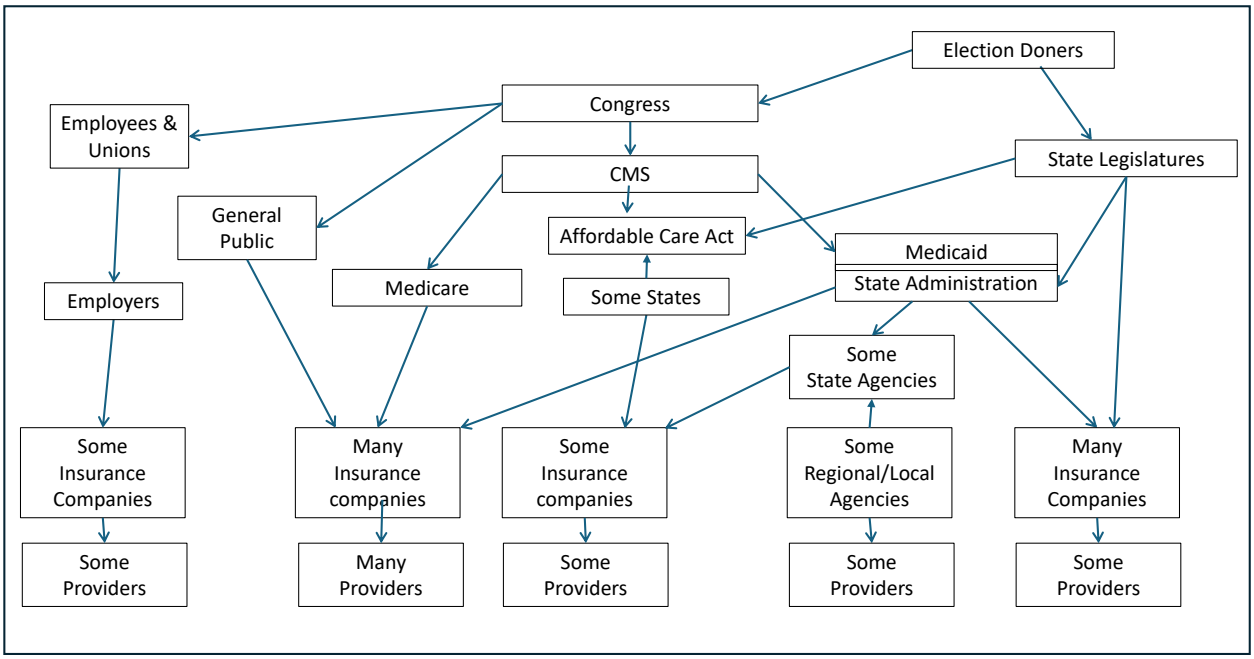
Together, this is a large population of people without much respect for our system of government, elections and capitalism.

See references Section 5

1.3.2 The UN-Accountability Hierarchy

A gross failure of accountability at many levels and branches of the system is a major fault.

The diagram, below depicts components of the system hierarchy in which funds flow from top to bottom, in multiple levels and branches. This should depict the corresponding upward flow of accountability. However, there is no accounting for what should be accomplished in the delivery of good health care services to everybody. No assessment of provider performance, NOR accountability for value delivery.



1.3.2.1 The Flow of Funds

As the arrows indicate, the health care funds flow down the hierarchy. The value-delivery, accountability should flow up the hierarchy, **but it does not**. The following sections describe the many challenges.

1.3.2.2 Election Contributors.

Election funding is primarily driven by big spenders and their interests in big budget issues of corporations and wealthy citizens. Funding for Medicare and Medicaid is not a big spender concern. Large corporations already support employee health care through insurance company group policies. Retirees are covered by Medicare, but that is not an employer concern. So corporate election spending and lobbyists are focused on taxes, and other budget, regulatory and subsidy/investment issues.

Congressional members do not hear from the people who suffer for unaffordable, inadequate or absence of health care. Many of those have lost insurance because they lost or changed their job, some have become bankruptpt by health care bills. Many are victims of economic turmoil: disappearing industries, corporate takeovers of bankruptcies, and suppressions and inflation. Most of them do not appreciate the importance of voting, when the candidates are all listening to the big spenders and corporations.

1.3.2.3 State regulations

States regulate Insurance companies and health care providers. At the bottom of the hierarchy, they don't regulate the fact that health care is under-funded, and unaffordable and unavailable to millions of people. Some exist independent of Federal funding. Insurance companies and health care provides to Congress, CMS, Medicare, the Affordable Care Act nor Medicaid account for the money spent, not the unserved or underserved needs. The insurance companies engaged through Medicare, Medicaid, and the ACA should be accountable for the services they provide through Federal funding, allocated by CMS, and re-allocated by Medicare, Medicaid and ACA to the insurance companies and providers. State regulation should make the insurance companies and providers accountable for the federal funds they receive as well as from other sources.

1.3.2.3.1 Insurance Companies Violate System Accountability, and Much More

Insurance companies dominate the current system. They are integral to health care in the public marketplace (above) they are integral to Medicare, and they have substantial role in the diverse, state implementations of Medicaid health care. They generally raise the same concerns, driven by budget and profits, before quality care.

- Note the Un-Accountability Hierarchy in Section 1.3.2, Cost Sharing in Section 1.3.2.4.1, below., and Equity (2.1.3), Quality (2.1.4), Affordability (2.1.5, and Accessibility (2.1.7).
- Insurance company provider networks have influence over treatment choices to save money. Choice of provider is limited by a penalty for using an "out-ot-network" provider.

- Insurance companies played an important role in bringing widespread health care to the country, but they evolved to a major source of profit at the expense of good health care for most everyone, but that is no excuse for their current role.
- They create risks of losing health care coverage along with medical risks of denials and delays. They take a lot of money, but they deliver no health care, and they abandon people when care is needed the most (see Section 2.1.4.2, Subsidies Are Essential)
- They are barriers to accountability, foster poor care, cutting benefit payments, and delaying or denying appropriate care.
- Advances in health care may increase costs, but advances also reduce or mitigate the consequences of illness or disabilities (including fewer patients, fewer inmates, fewer homeless, fewer shootings)
- Therapy is a new expense requiring more professionals, more benefits, more money, but better health.
- Cost cutting and restrictions drive the workforce out of health care. Inadequate staff means overworked staff with poorer quality of health care and patient quality of life.
- Sustaining good health and economic security require affordable health care, always there.
- Health care debt, inflation, bankruptcy, poverty, are real threats to millions of middle-class and low income Americans.
- Insurance companies have had a major role in creating and sustaining the health care caste system.

1.3.2.3.2 Cost Sharing

The major cost control is "Cost Sharing." The out-of- pocket cost is aggregated from the start of the insurance policy year. When it reaches a threshold amount, that invokes the (ransom) super-cost, deductible, that must be paid in order to continue further coverage. After the penalty, the benefit payments are zero until the end of the budget year, when the out-of-pocket aggregation starts again. A big deductible payment may not be worth the savings before the end of year cut-off year. A serious illness may continue to be costly for years (See Section 2.1.5.2, Subsidies are essential).

This is a major accountability issue. It is not apparent that the impact is reported to any finding source or to Congress. How many people suffer unnecessarily from serious illness, and potentially die from their inability to pay the super-deductible?

We cannot assert that this is practiced in the same way by every insurance company, but it is clearly wrong, and it should be condemned by the insurance companies, and the funding sources ant all levels as a practice and as a failure of accountability.

1.3.2.3.3 Service complaints and appeals

Complaints about services are typically resolved by the treatment provider. If there are Appeals to a higher authority, it becomes a complaint about the provider, and the easiest resolution, is to blame a direct care provider, employee who may be moved to a different location, or fired, but there is seldom a complaint where a systematic problem is recognized for corrective action by the benefit manager or the funding manager, or others up the management, accountability chain. Patients generally accept delays/denials of insurance companies as being the last word. Potential for appeals depends on the funding source accepting some responsibility.

1.3.2.3.4 Limited choice of provider

Insurance companies have the potential to restrict the provider service capacity in their network to reduce costs, and influence the provider treatment decisions to deny or deny treatment choices. Providers also have the option to refuse to accept undesirable.

1.3.2.4 Public-Market Insurance Companies

Below are modes of insurance companies participating as independent providers of services in the consumer marketplace. That includes the types of services described below. that are not funded by federal funds. They are only regulated by states.

1.3.2.4.1 Independent Consumer insurance Companies

Many people just pay an insurance company, directly. They are likely to have minimal leverage to agree on price and terms. They will they will pay more for hospital, price-shifted services. Insurance companies pay billions in advertising to attract customers to their programs, and the customers don't understand or ask why the rates are so good for the Medicare Advantage programs. They are using Cost Sharing (see Section 1.3.2.4.1) to cut off health crises coverage by raising a super-big (ransom) deductible that most people can't afford, so they lose their coverage.

Insurance companies have benefit packages that define what is covered and how much the provider is compensated for a service. These may be very similar to the benefit package defined by the payer/funding source, but they provide opportunities to cut cost. Generally, Each insurance company has a provider network of providers, under contract (in-network), and they impose a premium for the use of out-of-network providers.

Each provider may be a member in multiple, insurance company networks.

1.3.2.4.2 Unions Employees with Company Paid Group Policies

The union may participate in the insurance-company negotiations. Unions members are just happy that their employers are paying the bill, even though, they may be getting bargain-rate coverage, with excessive "Cost Sharing" deductibles that they can't afford if a family member

has a health care crisis**.** (see Section 1.3.2.4.1). These policies are also likely to have big, "ransom" deductibles and recipients lose their coverage.

1.3.2.4.3 Company paid Employee Group Insurance.

These policies are negotiated by the employer, so they are inclined to take a low offer with benefits that look good while the insurance companies find ways to enhance profits.

This category is different only by the intervention of the employer as the payer on a group insurance contract that covers employees of the employer. Of course an employee is no longer covered if they lose their job or they quit.

Employer-paid insurance coverage originated from union demands. This has become a high-budget item for employers. However, it has spread to most larger corporations and employers of high-cost employees due to market competition for employees.

Employers negotiate for employee health care insurance policies. Of course, cost is a priority concern. The insurance company risk and thus costs may vary depending on the nature of the business and the employee population, and some of whuch will be exploited by insurance companies where employees don't necessarily understand the immediate/potential risks to them in the benefit specifications.

1.3.2.4.4 Government Employee Group Insurance Policies (not shown).

This arrangement is little different from the employer paid arrangement, above, except that there may be different group insurance contracts with different insurance companies in different segments of a large government organization and thus different budgets and different benefits, but little accountability for delivery of health care except competition about benefits that consumers have difficulty understanding for risks.

1.3.2.5 Health care providers

State regulations of providers, includes licensed professional, other persons functioning as health care providers that may not be licensed, the residential facilities they operate, as well as the services they deliver through Federal funding. Of course, providers may deliver services, independent of insurance companies, and fewer restrictions and higher compensation.

Typically, each health care insurance company has a provider network under contract. Each provider may be a member of multiple insurance company networks, they must be "enrolled" (under contract by each).

Providers are essentially controlled by the funding of benefits by insurance companies, unless the are operating as an independent provider with direct employment by the

1.3.2.5.1 Insurance Company Provider Networks

Insurance companies are the prevalent intermediaries between the benefit funder and their provider network. An insurance company may be engaged by multiple benefit fund managers, but each insurance company may have different benefit packages and payment controls to save money. each recipient population served, with associated provider compensation rates.

Insurance companies have the same basic roles for different recipient groups and basically the same insurance-company problems. They always find a way to make a profit, and they do that by restricting the provider services through their network management, their benefit packages and their compensation procedures. They may form subsidiaries to restrict their accountability to different funding sources.

For Medicaid and the ACA, their insurance company budgets are capitated. For the Affordable Care Act, there must be information about the services actually delivered and billed, because the subsidy amounts are based on the specific services delivered to each recipient and their income status. It is not clear if the authorization of services is controlled by a formula or a bureaucratic judgement.

The provider networks of insurance companies have contracts with each insurance company (public market customer, CMS Medicare/Medicaid, state Medicaid, local management organization(s), or local health care agency) that authorizes them, so that each payer can define restrictions on the providers and distinguish between providers “in network” or “out of network” (which costs the recipient a penalty).

1.3.2.6 Congress: Government Funding

Congress funds CMS, and CMS allocates the budget to Medicare, the Affordable Care Act and Medicaid. These are all allocated by “capitation.” That means there is some estimate of the number of people to be served, some assessment of how much has been acceptable in the past, and, only in the case of Medicare, there are actual records of what has been spent on real patients, although there is little evidence that this is a recognized fact. However, the Medicare costs per patient are certainly available and might be a consideration if there were details available regarding diagnostic date, but that is scattered over numerous provider records of treatments and tests, and image evaluations and surgical procedures.

1.3.2.7 CMS (Centers for Medicare and Medicaid Services).

CMS is in charge of the policies and budgets of Medicare, Medicaid and the Affordable Care Act, along with associated regulations on services delivered by those programs. CMS takes no responsibility for the quality and equity of the services nor the people that are denied services.

1.3.2.7.1 National health care management problmes

The following are issues that are the responsibility of CMS (or Congress)

1.3.2.7.1.1 No Budget traceability to service delivery

The Medicare budget is national. The rest, Medicaid and the ACAA, are essentially rationed to states, and then, by each state, the state budgets are rationed again, through subsequent delegations until it reaches a provider payer and its provider network. It is never enough funding for quality health care, that means they have a budget that is politically negotiated, at potentially multiple levels, it is rationed, rather informally, to pay for actual delivery of services, not necessarily to specific patients. by various interests, the least of which represent the actual needs of the persons to be served. The primary consideration, is a focus on cost control and profit, not delivery of needed value to the patient citizens.

1.3.2.7.1.2 Intervention Avoided

Many more are excluded because they will not seek treatment, typically because they don't understand the need, or they don't want to be locked up in a hospital. This is a problem that requires new approaches to intervention, including therapy to resolve mental disturbances. Incarceration provides and opportunity for intervention, as well as temporary hospitalization that does not "qualify for Medicaid hospitalization."

Fund managers don't care, they don't have enough, and the don't need more patients.

1.3.2.7.1.3 Poor Continuity Between Acute and Long-Term Care

Many people enter long-term care as a result of a sustained illness or injury. But that does not mean they no longer will require routine or acute care again. There is a disconnect in the transition between acute care and long-term care, in either direction. There is little planning and coordination between the health care providers in the different settings, and different treatment priorities.

1.3.2.7.1.4 No Therapy

Particularly in long-term care, the transition is a major life event. You leave your family and friends behind, you leave you way of life behind, and you need therapy to cope. If you suffer from a mental illness, you already need therapy, but the need is more intense if you have hope of returning to a more normal life with many new challenges due to limits of recovery. The focus is primarily on adapting the mind from physical or mental trauma or other neurological disturbances.

In either case we need to recognize that Maxwell's needs hierarchy still applies, although the needs may need to be adapted to new circumstances, new barriers (see Section 2.1.1 and Reference 5.2).

1.3.2.7.1.5 No belonging

Belonging is a different perspective, but it is related to Maxwell's needs hierarchy. People have meaning to their lives from the environment in which they live, the activities, the relationships, the interests they share, it is who they are. They lose much of this when they go into long-term care, and they left to develop a new belonging, particularly if they are limited by other disabilities or losses (belonging is not currently addressed by health care, see Reference 5.2)

1.3.2.7.1.6 Chronic Illness Becomes, Long-Term Care

- A person with a chronic illness, such as serious mental illness or other disability, may be unable to avoid Medicaid, possibly for life—a life-long debt with inadequate health care. They will likely suffer from continued dependence on medications, treatments and supports, they required from Medicaid.
- If they recover, and are able to obtain a job, they will lose Medicaid if the income disqualifies them, and then they will owe the Medicaid debt. The debt becomes due, and they lose any continuing assistance for medications or other treatment or support. They are at high risk of relapse. This is a deterrent from efforts to obtain work which is likely a very low income. They are trapped.

1.3.2.7.1.7 Fundamental Systemic Problems

1.3.2.7.1.7.1 CMS Does Not Care about Accountability.

Apparently, Congress does not want to hear I, eithert.

- Medicare, Medicaid and Poverty can occur together in large communities, particularly in large cities and rural areas. Doctors and other professionals cannot make a competitive income in these areas, so the professionals may be few and far between. The result is health care deserts.
- In more wealthy areas, people without insurance may get care in emergency rooms for free, thus increasing hospitals costs. Hospitals cover these losses to persons in poverty or covered by Medicare or Medicaid, by shifting these losses to their rates covered by conventional health care insurance, thus increasing the costs to people and insurance companies that will pay their increased rates. Hospitals in low-income and rural areas cannot survive the losses and they are going out of business, they cannot survive on the cut-rate coverage of Medicaid, so People and insurance companies in wealthier areas pay more for insurance.
- Health care professionals are also scarce in these areas, because they are also underpaid and fine better-paying regions.
- Larger hospitals in more affluent areas are doing fine, but they are now shifting the losses from charitable and under-compensated care, to their charges to insurance

companies who pass it on to their members. Then they become opportunities for profits and are being consolidated into larger groups by profit-making national corporations, who don't care about non-profit hospitals, paying for quality health care in their communities. What happened to the tax-free, and community donations that built many of those hospitals?

- No consolidated patient records for analysis, intervention, outcomes, thus no accountability for quality of care.
- No oversight of provider performance and outcomes for ultimately saving cost of care and lives.
- No consideration for the decline in the available, qualified health care workforce due to under payment of claims and thus low income of persons delivering health care services.
- Need appropriate compensation for expertise and commitment
- Downgrading of professional certifications and roles to cut costs
- Need educational input regarding system objectives and recipient rights.
- No assessment of the actual need for health care and the extent to which it is addressed.
- No consideration of the profits the insurance companies have skimmed from the CMS funds.
- No consideration of the significant under-payment of provider claims and their impact on the cost shifted by hospitals to their fees paid by all other payers for hospital services (insurance companies and uninsured individuals).
- All budgets are capitated, (even Medicare): there is a computation based on the number of people to be served but no basis in the actual needs of the people to be served nor the people who are actually served (accountability).
- Politically, the whole hierarchy rationalizes that care is poor because the federal budgets are all we can afford. (of course, we still pay the insurance company their cost of cutting costs, business and their profits). Insurance companies are the primary barrier to accountability. That is the way those who should be accountable like it (including the insurance companies). Without accountability, the system will remain broken, and it may get worse.
- Inefficiency and waste take funding away from appropriate health care for all.
- ACOs (professionals) should save money from economies of scale, but not from incentives to cut costs.
- Efforts focus on cost-cutting without accountability for impact on quality.
- No systematic, actual value-delivery impact analysis for Congressional budget decisions and public transparency.

1.3.2.8 Medicare

Medicare was originally created to serve retired persons. The funding is primarily a payroll tax on all taxpaying citizens with an additional graduated tax on the employer. The tax from an individual contributor is intended to accumulate from an early, taxpayer age so that the federal aggregation fund will aggregate a greater aggregation per contributor

as the contributors get older, and have anticipated, increases in health care costs. Beneficiaries are not eligible until a retirement age, which has been lowered over many years.

Medicare has been expanded to an earlier age, and coverage has been expanded for qualified persons who have disabilities at earlier ages. These extensions have caused an increase in the Medicare budget without an increase in the tax that supports it. Of course, these extensions were incrementally approved by congress without appropriate consideration of the budget implications. Many employed persons have paid for Medicare for life, and many more have been given the inadequate level of coverage, with the help of Medicare and the insurance companies.

Medicare coverage has also been opened up for persons with severe and persistent disabilities, depending on age of onset and other factors.

The Medicare fund has become bloated as Medicare participation has grown. It is not clear if the increase in size aligns with the growth in participation has expanded, but it is clear that the appropriate solution is to reduce the population of people in need, by delivering quality health care so many recover, and move out of poverty.

Medicare delegates all benefit payment management to insurance companies, except for original Medicare that is essentially a single payer system except for supplemental coverage.

1.3.2.8.1 Medicare insurance companies

Those on original Medicare typically happened to join when they first joined Medicare, otherwise it is discouraged unless you have family changes that allow reconsideration.

Original Medicare does not include the Medicare, Supplemental coverage, which requires a separate an insurance policy. Then Medicare Part d (medications) is also separate, and Advantage [;asn are a marketing scam of “more for less” but it is unclear where the “less” comes from.

1.3.2.8.2 Affordable Care Organizations (ACO)

ACOs have been promoted by Medicare. They are essentially organizations of professionals, particularly doctors who join int groups of specialties for economies of scale. However, the real

incentive is that Medicaid will award bonuses to the ACO, and implicitly the members, for cutting costs, effectively raising savings as competing against quality care.

This is not just an incentive for individual doctors, but it creates a community of doctors with a shared financial interest, that depends on them cutting the cost of care. This creates a community of peers with peer pressure to participate in cost cutting. This should be illegal.

1.3.2.9 *Medicaid Budget*

1.3.2.9.1 State Allocation and State Match.

Medicaid allocates the national Medicaid budget to each state based on the state ”need” and state funding match. The state internal budget allocation to its different programs, examples, below, that are defined and organized by the state legislature and the state government administration. From this point forward, each state is different, but, of course, with some similarities.

1.3.2.9.1.1 Optional Affordable Care Act Funding

If the state has adopted the ACA, then the ACA budget must first be separated from from the general Medicare budget.

1.3.2.10 *State Legislatures*

State legislatures have little control over Medicare, except that they have regulatory control over insurance companies and health care providers. The practices of insurance companies to manipulate benefits and members of their provider network could be regulated. For example, denial of a surgery benefit because “the condition is not bad enough yet,” could be regulated as an intentional risk a that the patient will more serious onset, maybe a risk of death.

Nevertheless, legislators do have significant control over the Affordable Care Act and Medicaid which are both funded by the state Medicaid budget. Some states refuse to support the Affordable Care Act.

State legislators are looking at the cost of the State Medicaid match, which is controlled by the Federal Medicaid budget. They have little influence over the state-Medicaid budget unless they want to reduce it, which would mean losing the federal share.

State legislators must match their federal, Medicaid allocation, but they just blame Medicaid for not giving them enough to pay for better health care. Besides they are more concerned about the priorities of local corporations and billionaires, and they are all concerned about other hot budget items and don’t want to get involved in these health care election issues.

State legislators are in charge of the adoption and aspects of the implementation of Medicaid and the Affordable Care Act in each state where it is adopted. They have control over the state

allocation of the budget to the management of various populations based on needs. The extended, state hierarchy, will further allocate budgets to insurance companies and/or directly to the compensation of providers (e.g. Community Mental Health and nursing homes).

1.3.2.11 Affordable Care Act

The ACA (Obamacare), Is designed to provide health care insurance for employed persons. They get graduated subsidies, based on their income, to make the insurance affordable. The program is optional to each state (legislators). With federal funding for the subsidies. It operates under the guidance and some regulation by Medicaid under CMS. It is not clear what happens to their coverage if they quit, or lose their job. They are not necessarily qualified for Medicaid.

The ACA is funded from the national Medicaid budget, but not all states have adopted ACA. Insurance companies are approved to join a "marketplace" in each participating state. Participation is for employed citizens who choose an insurance company from the marketplace. It is not clear when coverage stops if the participant loses or changes their job.

The specific recipient, cost-saving subsidy payments are made to the insurance company to reduce recipient charges before they are billed. However, the subsidy payments are aggregated and reported as tax credits for the participant's subsequent tax return, at the end of the year. That apparently means that if they have any tax to be returned. ., it is reduced by the amount of the subsidies received during the year. If the recipient has any tax to be returned, it may be wiped out by the tax credits and the participant who most needs the subsidies has lost them. See Section 2.1.4.2, Subsidies are Essential.

1.3.2.11.1 Cost Sharing

The major cost control is the out-of- pocket cost that invokes the (ransom) super-cost, deductible, that must be paid in order to continue further coverage. (see Section 1.3.2.4.1). That saves money for the insurance companies, but severely cuts health care for services that need it most. After the penalty is paid, the benefit payments are zero until the end of the policy year, when the out-of-pocket aggregation starts again. A big deductible payment may not be worth the savings before the end of year when the special savings stop. A serious illness may continue to be costly for years (See Section 2.1.5.2, Subsidies are essential).

1.3.2.12 Basic Medicaid

Traditional Medicaid is a national program, but it is essentially delegated to each state for implementation and health care delivery. Medicaid is reputed to be healthcare for the poor and disabled. However, not all poor, disabled or elderly are included because they must first qualify for the financial limit on income and assets. Some people with low incomes will divest their asses to qualify as poor, but in some states, they must divest several years before they can qualify as poor.

1.3.2.12.1 Medicaid Is a National Disgrace.

We define a population that is “not worthy,” of quality health care, and we harass them for being down-trodden. (and worse, because they are in poverty, for various reasons beyond their control (See Reference 5.4). We hold them responsible for the cost services of what they do get, and we expect them to pay it back if they ever get out of poverty (not all states, but acceptable to CMS). Then we find ways to avoid helping many more who are in need.

Clearly, Medicaid is not accountable, nor is any organization down the Medicaid funding chain. Accountability should expose the shame, and motivate major reform. See the Objectives of Section 2.1.

Some more comments. Below regarding how this disgraceful system continues to exist.

1.3.2.12.2 Medicaid Unaccountability’

A root cause of un-accountability is the many layers of delegation and allocation of funds by capitation (irrational rationalization) to where there is nearly nothing left for many who need it and nothing for many that get nothing at all.

Medicaid operates in each state with guidance and regulations from Medicaid under CMS along with the state legislature and administration.

1.3.2.12.3 Medicaid Recipient Debt

Medicaid (in many states) captures the costs of care for each recipient, and aggregates an lifetime dept to be paid if they exceed their income/asset limit, or when they die.

- There are some exceptions for a spouse and a shared home. They are economically trapped and have noting to pass on to their next generation. The health care services are seriously limited, underpaid, and underqualified, so many needs are ignored, and they potentially get worse (or they die). Seriously mentally ill persons die 25 years younger than the general population.
- If the patient recovers or obtains an income, the debt becomes due, and the patient loses any Medicaid benefit, including any continued dependence on medications, rehabilitation, continued treatment or other supports, and they again, do not have health care insurance, and they may still have a large Medicaid debt.
- A Medicaid debt is ultimately-due on death and it may be a debt for a spouse. If the couple has a house, the spouse may be able to continue to live in it, but then the debt becomes due on death of the spouse, and there is likely nothing left for the rest of the family who suffered debt before the person was qualified for Medicaid.

1.3.2.12.4 State Medicaid Budget fragmentation

Every state Medicaid program is different since Medicaid just gives them the money, with some regulations and guidelines for the services they should or should not cover, with Medicaid Regulations (and possible waivers to consider for exceptional coverage). It appears that Medicaid promotes delegation to insurance companies. This eliminates state complaints about lack of adequate funding because few complaints rise up through the insurance companies.

Some states form regional authorities that are governmental, but relatively independent in the management of Medicaid services. They may have separations between different groups of constituents (with different benefits and Medicaid regulations), for example, physical health, intellectual disabilities, children, long-term care (typically elderly patients, and substance abuse, and mental health (including a form of long-term care). Some may manage providers directly, or through non-profit contracts or through insurance companies.

These sub-divisions may group some separate categories, and the budgeted populations, in different ways, using different provider networks and different payment strategies—generally the budgets are capitated (rationed) in some form since they are allocated as, fixed, annual budgets. Some populations may have insurance company benefit packages to manage provider compensation, but there is little accountability regarding the adequacy of the rates of provider compensation, nor the benefits that are actually received by recipients.

Each state has different organization structures. From this point, the allocation of the budget fans-out, based on the state organization structure. Some branches may delegate to insurance companies. Some may delegate to non-profit regional entities, some may delegate to non-profit provider-network contractors, and some may then delegate to insurance companies and their provider network(s)

1.3.2.12.5 Medicaid State Agencies

Each state determines how to manage it Medicaid budget. It may have a hierarchy of state or contract organizations with variations of budget capitations depending on geography, classifications of recipients, classifications of providers or groups of insurance companies. Ultimately, each branch ingages insurance companies or directly with providers of various services. Regardless, they end up with a capitated budget because that is good for the state budgeting process, and the state does not need to suffer over the details and the variability of the actual needs to be addressed.

1.3.2.12.6 Dual Eligible, Medicare and Medicaid Recipients

Dual eligibles are currently treated as a whole different population for some beneficiaries. It is not clear why, but a Medicare payer benefit package that nets- out their benefits should resolve that along with some significant changes that makes the difference (equity?). They have

Medicare, and they may qualify for Medicaid based on their income and assets and the nature of their need. Essentially, they do not lose their Medicare when they join Medicaid. Essentially, this means that their health care "benefits" come from two different funding streams, presumably with Medicare primary. The difference is that Medicare has cheap, but better benefits, but they likely drop out if there is "long-term care." But it is possible to get assistance from both Medicare and Medicaid, and they will bott take it back if there is a relevant award for an injury, law suit award.

1.3.2.12.7 Medicare Savings Program(s) (MSP)

An MSP is a state program for a person with Medicare coverage to obtain complementary(?) Medicaid services if they meet the Medicaid income/assets qualifications. The coverage depends on the state.

1.3.2.12.8 Quality of Care

Medicaid recipients are, for the most part, members of the lowest level of the health-care caste system. Medicaid recipients must be sufficiently poor, or in crisis (e.g., a mental illness) to obtain access to Medicaid, so they are very vulnerable, and they may lose their Medicaid support if they are too difficult to serve, or if they are able to receive some income that exceeds their asset/income limit to qualify. The actual compensation of providers will not engage providers, unless they are doing it for some form of charity, and note, if a family member pays for a preferred doctor, Medicaid will consider that income and the recipient could disqualify for continued services. In addition, doctors are warned not to accept Medicaid patients privately.

1.3.2.12.9 Jails and prisons

In some states, jail and prison inmates are covered by Medicaid. This is beneficial, if that provides some collaboration/coordination with community providers from before and after incarceration. Other states just interrupt the Medicare coverage during incarceration, and that may result in unnecessary gaps and the changes in treatment that result in deterioration of the patient's condition with potentially long recovery. Some states get a waiver to use Medicaid during incarceration.

1.3.2.12.10 Needed Benefits

Many patients are excluded from Medicare because their condition is not severe enough to merit care. This is particularly care for serious mental illness. That is a consequence of closure of state hospitals, many years ago, to exploit Medicaid coverage that was not allowed in "institutes of Mental disease" (including state hospitals and stand-alone psychiatric hospitals. Closures shifted many patients to the criminal justice system. The need for state hospitals is clear for non-acute care (I,e., long-term care). Some states have obtained a waiver to apply Medicaid in state hospitals. Of couse this would likely increase the state, Mental match funding.

Medicare does little to be accountable for delivery of quality care for the benefit payments. Insurance companies create a barrier for oversight and problem resolution, particularly systemic problems. Medicaid does respond to individual complaints that bypass the insurance company. Hospitals are required to advise patients of their right to appeal. Some do, but there is seldom a satisfactory resolution, depending on the state and the service.

Local/state authorities are responsible for provider compliance with regulations, licensing and certifications, including facilities. Medicaid does not appear to provide congress with data regarding provider performance, recipient needs and services delivered and the cost of quality care as well as the damage of denials and delays of services.

1.3.2.13 Medicaid Long-Term Care, Waiting to Die

Long-Term care, is too often a decline into solitary confinement, life without a life, until the end. We need quality life care, quality of life and death with dignity and Maslow's needs hierarchy, as a guide (see Section 2.1).

Long-Term Care has a major impact on the Medicaid budget, but the budget categories(s) may depend on the state. Nevertheless, it has a significantly distinct impact on the persons served, so here it is a major topic.

Long-term care has serious problems with accountability because the funding is typically capitated, so it is not traceable to specific recipients and their needs and outcomes.

1.3.2.13.1 Public Guardians

Many people in long-term care, do not have the mental ability to represent themselves for legal, financiall and medical decisions that might be resolved by a family member, acting as a court-appointed guardian. Some people do not have a willing family guardian, and the court will appoint a public guardian (generally a lawyer, selected from an authorized pool) to make decisions that a health care professional is not allowed to make. Essentially, public guardians are an essential participant in the operation of the health care system.

The status, role and compensation of a public guardian depends upon the state. There is very little oversight and accountability. In some states, there is no government compensation for a public guardian, and apparently no accountability except integrity as a lawyer. A guardian makes decisions, and may take some legal actions, essentially as charity unless the ward has money. Then the guardian is expected to charge that person for the guardian's services (of course the guardian is effectively in charge of the ward's assets) and that becomes compensation for the charity work. The ward may be a person in long-term care who has no active family relationships or a person who is in long-term care as a result of an auto accident and has debilitating injuries and a lawsuit-award for damages.

A guardian, necessarily makes decisions that authorize health care services. The guardian, like a family member, is unlikely to have the expertise to decide if the provider has established the need for a proposed service(s), but the guardian approves the decision. There can be other incentives for the approval. Some wards are persons who have been in long-term care, beginning as disabled children, and may have a guardian approving services that may not be delivered, because there is no accountability for the decision or the actual delivery. Typically the budgets are capitated, so there is not tracking of individual diagnosis, delivery and outcome.

2 Part 2, The Future of Health Care

2.1 Strategic Objectives

The following subsections describe a number of core objectives to guide the future development and subsequent evolution of a health care system that will improve the lifes of every resident of the United States.

2.1.1 Maslow's Needs Hierarchy

This proposal is about health care reform, but at is core is a more fundamental goal of quality of life. Quality of life is best depicted by Maslow's hierarchy of needs (see Reference 5.3). The hierarchy is represented graphically, below.

These needs are reflected in the objectives developed in this section'

2.1.2 Healthcare is a Human Right

Every eligible citizen must have equal access to all the health care benefits that address their need for health care, from birth to death. There may be various factors that affect when, where and how quickly the need is addressed, such as the limits on the availability of relevant providers, the urgency of the need, the circumstances that affect the ability of responder(s) to deliver the needed service(s), and triage.

In addition, this right must be extended, at least conditionally to foreign citizens who happen to be in the United States or its territories, particularly for threats of infectious disease, pandemics or injuries suffered in the US.

Nevertheless, the need for access to appropriate health care is no less than the need for police or fire protection, nor freedom for the rights declared in the Constitution. The right is national, and it must be addressed nationally.

We expect everybody to have police and fire protection without deductibles. We have roads and bridges that gives us freedom to roam around the country without using toll roads. We expect to have access to clean air and water wherever we go, without paying a toll.

Our country, health care capabilities and challenges have changed dramatically, since our country was founded. There has been tremendous research and development of new medications, new surgical procedures, new diagnostic technology most of those advancements had beginnings in Federal research and grants—our tax money. The wealthy have profited from all that, certainly more than those in poverty. They have also profited much more from the infrastructure: roads. water, power, police, fire protection, the military, and they seldom suffer from lack of health care, personal bankruptcies, and poverty from lost jobs. much more, and they seldom suffer from health care denial, but they fight taxes to sustain what they inherited, and cut taxes that should benefit others, less fortunate. Many of them have managed failing companies and put other people into poverty, but they typically survive.

Our government and researchers have spent billions to develop health care technology. We should all have access to that technology.

Ther is a human right, that may not be explicit in the Constitution any less than a right to national defense, protection from infection and pandemics, and rights to police and fire protection, without charge as well as a right to clean air and water.

2.1.3 Health Care Equity

“All persons are created equal.” Equity means that all patients will have the same access to appropriate-quality health care regardless of the patient’s age, sex, race, other suspect categories as well disabilities, mental disorders, illness and injuries with reasonable expectation of achieving satisfaction of multiple levels in Maslow’s needs., living circumstances, rehabilitation, mental state, and **preferences.** Patient preferences must be **respected** with reasonable **accommodation**.

Equity is an objective and a responsibility at all levels of health and wealth. However, the US has a caste system of healthcare that must disappear. Persons who suffer from a serious mental

illness, who are elderly, who are impoverished, or others who are currently at the bottom, must be rescued.

Health Care equity also applies to health care workers. Health care workers (those with direct contact with patients and families) must have appropriate skills, and must have **compensation, workloads, qualifications and discretion** that are appropriate to their qualifications, and the needs of the persons they are expected to serve, as well as the circumstances under which they are required to deliver care. This is a provider leadership, responsibility and must be reflected in the provider benefit compensation,

The current system ignores equity. Equity is impossible when the system is dominated by insurance company cost controls, budgets and profits, that are determined by politicians and bureaucrats who have no accountability for the caste system that they have created and maintain.

The healthcare system must be constantly evaluated and corrected for evidence of funding that results in profits or financial incentives that are inconsistent with the quality and accessibility of equitable health care cost and quality.

2.1.3.1 National Benefits package

The current health care system has hundreds(?) of benefits packages. Every health insurance company has their own package with modifications to restrict, delay, increase the cost or deny coverage in order to cut costs, including “Cost Sharing.” There must be one national benefits package, and no cost sharing (see Section 1.3.2.4.1), Cost sharing is not a violation of equity, it clearly discriminates against economically disadvantaged recipients.

2.1.4 Health Care Quality

Health care quality depends on many factors, but most of all, it depends on the people who do the work that affects individual patients, or people who need care (e.g., intervention, oversight, skills and expertise of many forms, and their dedication to do the right thing).

2.1.4.1 Treatment based on professional judgement

The current system constrains doctors in many ways. They are underpaid, by restrictive benefit compensation, and by Medicare, as a rule, and Medicaid by extremely limited, capitated budgets, and more. The insurance companies ignore the doctor, and delay or outright deny authorizations. They are not expected to look for other symptoms or engage a specialist to look deeper to resolve a persistent or complex problem, in order to consider possible alternative diagnoses, treatments and side effects.

Doctors must have discretion to apply non-standard options that might have some additional cost or risk. These may be subject to review, after the fact, to consider the outcome and justification of continued application. If there is exceptional risk or cost, the doctor would be well-advised to seek the prior support of another doctor with suitable specialty. If there is patient risk, it should be undertaken with the recipient's discretion and informed consent.

This is not like repairing a car—find the problem component, disassemble, replace and re-assemble. Every patient is a different person. They probably have other problems that may be relevant or more serious. This is a particular challenge for primary doctors—treating the whole patient. This is quality care, that might take a little more time and analysis, but it will improve outcomes and may save lives. Saving lives does not necessarily save money, but it is a good outcome.

Benefit specifications are not there to tell doctors what to-do, or not to-do. Benefit specifications are there to compensate the doctor, or any professional, for doing or prescribing appropriate care.

2.1.4.1.1 Limits on discretion

There should be some limits on discretion, particularly high risk or high cost. Some constraints should at least rais an issue for a collaboration consensus or review by professionals.

Individual health conditions vary in severity, in combination with other conditions or circumstances. In addition, the treatment for some individuals may not be most-effective due to their side effects, the personal DNA, or other factors. Physician discretion is essential for quality health care.

Consider the following options:

- Give the doctor a typical compensation, and let the doctor adjust that to reflect the additional care or support required.
- Let the doctor consider that this patient needs something more than a quick fix, but maybe he should (1) consult a specialist, with a phone call? All the patient's records are immediately accessible. Maybe he gets a new idea, or (2) Maybe, with a few questions, the specialist suggests next steps that are clear, and he will expect to see results, or (3) Maybe there is a more-lengthy discussion, leading to some diagnostic tests and follow-up collaboration to discuss the results, or (4) A (referral?). In any case the specialist gets compensation for his time and expertise. The health care session is quickly addressed, without unnecessary delays, and, possibly, a good outcome.
- The doctor knows a quick and inexpensive fix, but this patient is not typical, and he is aware of an alternative procedure that might have a significantly better outcome, with

faster recovery. He discusses this alternative with the patient and, potentially, with a colleague, and he decides to go with this alternative, with an experienced specialist.

- In the patient's record, he reports the proposed/selected alternative plans, his reasoning, and the expected outcome as beneficial to the patient. He includes his additional compensation, if any, and that of the specialist and the recovery. After the outcome is clear, he again reports the actual procedure and the outcome, along with the consulting specialist. It the outcome is of broader interest, it is reported in a social media forum (maybe something like LinkedIn, but possibly more specialized, to reach other physicians of their success, and/or insights. This is traditional medicine with supporting health care infrastructure and compensation.
- This type of practice, and flexible benefit compensation will benefit patients and potentially advance the practice of medicine without major research programs, research grants, clinical studies and delays, but just smart, good practices and some innovation. The doctors get the job satisfaction that they deserve.
- The professional must be clear on the record, when exercising professional judgement, that the exercise may be reviewed, and should provide supporting detail in the patient record, including outcomes, possible collaboration/consultation with other professionals, along with the expected and actual outcome.
- Doctors must be compensated for collaboration with other treating doctors or for consulting with specialists, as well as treatment planning and collaboration with treatment teams. This should be an explicit, billable benefit, or if incorporated in a more complex benefit. It should be noted in the patient's record and the doctors performance record.

2.1.4.1.2 Barriers on discretion

The current system burdens professional judgement with capitated (rationed health care), bureaucratic budget controls, disincentives, low compensation, insurance company delays and denials, and general, poor job satisfaction. As a result, heath care is no longer a high job satisfaction career. Some real-world examples, follow.

- A doctor advises his patient has an aneurism and should have surgery. The Medicare insurance company says "no, it is not big enough yest" regardless that two biological relatives have died from it.
- President Biden has a serious prostate cancer, apparently because there is a commonly accepted policy that there is no need for PSA testing after age 70.
- In mental health under Medicaid, if people go to a crisis unit with serious thoughts and behaviors, they are not accepted for treatment under Medicaid, if they are not currently at risk of serious harm to themselves or others.

- People admitted to a hospital/nursing home/jail or jail, are told that the hospital/nursing home/jail formulary does not have “that medication”, so it is not available.
- People who have displayed or have a reputation of requiring additional staffing or longer length of acute care hospitalization may be banned from hospital admissions and there may be no available referral.
- There may be no available residential placements for seriously ill mental health patients, worse if they have been released from jail or prison.

These are some examples of how insurance companies, hospitals, and some providers deny appropriate care. Generally, these are budget/compensation decisions (not professional).

2.1.4.1.3 Treatment options

A benefit package might identify treatment options for a recipient decision or doctor’s advice. These might provide differences including the type of procedure, the risks, the possible outcomes and rehabilitation. These might be options on one benefit or alternative, linked benefits.

The doctor should document his/her recommendation and the recipient’s choice in the patient’s record.

2.1.4.2 Therapy for a Better Future

Therapy is generally a common benefit in physical health care, but, particularly in mental health it is minimal, and almost ignored in Medicaid, behavioral health care and long-term care. It must be considered to be a legitimate health care treatment for various forms of mental disability or stress, particularly if a recipient does not understand their need. (See Reference 5.1)

Therapy is a part of health care for the whole person, and particularly as a result of a traumatic experience or circumstance. There are many circumstances where therapy can be valuable. Sometimes, the difficulty may be resolved by family or friends. But physicians and others must be sensitive to circumstances suggest that a disturbance may be a physical, medical problem, or a life threat. There is a need for professional judgement judgment to determine there should be a health care intervention.

- Therapy for head injuries
- Therapy for PTSD
- Therapy for stroke
- Therapy for a mental illness
- Therapy for addictive disorder
- Therapy for mental disturbances, particularly thoughts of injury to self or others

- Therapy for poverty (people need help finding their way out, not threats and penalties)
- Therapy for traumatic experiences
- Therapy for children, particularly in school
- Therapy for financial or emotional Distress
- Therapy for major life events

Not all forms of therapy require sessions on a couch. grpup therapy may be helpful, engaging in activites with others may be important, a vacation may be important….

2.1.4.3 Health Care Culture that Cares

Professionals are frustrated. They don't have time to fight battles they can't win, or they are not taken seriously. They can't take it anymore, and they quit. One more member, gone from the work force. Providers and the system must respect professionals for the expertise that they bring.

From a patient's perspective, Providers must respect a person's need for health care, and their suffering, without judgement regarding that person's personality, beliefs, allegiances, morality or their antisocial or criminal behavior. There is a tendency to judge some people as not worthy of quality care or health because they are poor, homeless, disruptive, are a member of a different class, nationality, religion, lifestyle, or are mentally ill or aged.

But people, both providers and patients, need the support of a health-care system, where caring is right, and professionals are respected for their expertise that is more important than budgets or profits. Those who deliver the care and treatment must be an agent of the oversight and accountability organizations to hold the system and the contractor-providers accountable.

The states will not continue to accept inadequate and inappropriate care, the states will no-longer be complicit in the inadequate services and underfunding, and because now they, and their citizens will know what is going wrong and hold the system accountable. Everyone has a right to quality, equitable, appropriate and affordable health care. This is an important state of mind for people who provide health care, and those are responsible for the funding and oversight.

A system that cares will pursue all opportunities to intervene early for people who are recognized by people around them as in need of help. No longer the need to be a danger to self or others, if that is the case, the system has already failed. (See Reference 5.6 and Section 2.1.7.1.1)

- For example, a nursing home has a doctor who is hardly ever there, and a physician's assistant is effectively the doctor for everybody.
- The physician's assistant makes decisions that should be made by the doctor and writes prescriptions. Sometimes the doctor may get a phone call and makes decisions without seeing the patient. This seems to be because Medicaid doesn't care, these are old people who are going to die soon anyway.
- This is much worse for persons suffering from a mental illness. Direct care workers are uncertified, minimum wage workers. The patients may have a doctor that sees them occasionally for symptom management. He relies on assessments of workers or case managers to determine if medications must be changed. The doctor does not look at anything "medical." This is not good. It is a consequence of aggregate settings, insurance companies, along with Medicaid and Medicare cutting costs, using capitation funding (rationing) while escaping accountability for down-graded care-giver qualifications.

We must demand that health care workers are all paid according to their responsibilities, competence and skills, regardless of the presumed "diminished value" of the lives they may serve.

Quality is achieved with qualified and dedicated health care personnel, who have the facilities and support they need and the discretion and time to do it right.

2.1.4.4 Professional Collaboration and Treatment planning

This is a responsibility of a designated, primary care doctor with an associated case manager for support of treatment team collaboration and provider referrals.

2.1.4.5 Quality of Life

Health care must serve the whole person.

Health care can be a major factor in a poor quality of life and the ability to cope or to recover from the trauma of a major illness or traumatic experience.

Individuals must have an opportunity to realize quality of life within the limits of their ability/disability, including long-term disabilities, aging, mental illnesses and lesser disturbances and trauma. See Maslow's Needs Hierarchy (Reference 5.2), and "Belonging," (Reference 5.3) that address not only mental illnesses and other disabilities, but also poverty, treatment of the elderly, homelessness, job loss, and childhood, education and development, enabling children to achieve a quality life. (See References 5.1, 5.2, and 5.3).

2.1.4.6 Maslow's Hierarchy of Needs

In this country, we should expect that the vast majority would realize a life characterized as Level 3 of Maslow's Needs Hierarchy (see Section 2.1, and Reference 5.3):

- (5) Self Actualization
- (4) Esteem
- (3) Love and Belonging
- (2) Safety Needs
- (1) Physiological Needs

Unfortunately, many people in poverty or in long-term care are lucky to reach level 2. Our goal should be to ensure that everybody is above level 1 and the vast majority reach level 3. Good health care is a major factor in reaching level 3, with some aspiration to reach level 4 or 5. (see Section 2.1)

Of course there may be circumstances that would be a problem for some people reaching or maintaining level 2, but everybody should expect to experience minimal risk, in our country, at level 2. Many people at the bottom of our health care, caste system, can't get to level 2. We should strive for most people to achieve level 3 in their lives.

We should aspire for health care to support a majority of people to experience level 4 at some point in their lives.

Routine health care should be free, and acute care should be "tolerable" for most, moderate income families. The challenge is the health condition that exceeds the affordability of families who would experience a financial crisis. We need a formula that mitigates the economic impact At level 3. This is a challenge for the design of the benefits package, the subsidies, and the burden on the more fortunate.

2.1.4.7 Quality Improvement Oversight

Oversight and Accountability agencies must assess the quality of care and quality of life of persons covered by Medicaid before the first deployment and periodically thereafter.

This should include mortalities, disabilities related to poor health care, nutrition, along with related, other factors, such as incarcerations, jail and prison populations, justice system encounters, and many other social, economic and circcumstances that may improve as a result of better health care.

2.1.4.8 Certification and compensation of skilled direct care staff

Particularly in mental health care, direct care, as well as some professionals have been given inappropriate responsibility and authority to save money. This is a trend in cost-cutting and

capitation (rationed) under funding, particularly in care for patients with greater or more complex needs and in contexts where budgets (e.g., capitation) and profits apply pressure to degrade the quality of care. This is a particular problem in Medicaid, but it has become common practice, in different circumstances, throughout the US health care system.

In this proposal, higher standards must be enforced to ensure the quality and integrity of patient health care. The certification of professionals is a responsibility of each state, and it gives states responsibility for enforcing the higher standard for qualification and certification of professionals, and oversight of their roles and responsibilities as health care providers.

2.1.4.9 Legislators must undo inappropriate downgrading of certifications

Legislators must not listen to insurance company cost saving schemes that give profits and budget cuts priority over quality health care. Furthermore, states must transform the health care culture, putting the patient first, before budgets and profits, and respecting that every patient is a distinct individual, and deserves treatment that includes the best judgement of the professionals that serve them. Certification requirements must ensure qualified, quality care.

2.1.5 Affordabability

Coverage must not be interrupted or denied, because that can have serious psychological, personal health, social and economic consequences. The current health care system is a source of many disruptions, losses and psychological disturbances that should be addressed by quality health care. Poverty is a major consequence of these disruptions, but poverty alone is a major contributor to poor health. A single payer system may be able to reduce poverty, or, at least ensure that every citizen has potential intervention and recovery from a serious injury or illness without facing poverty or bankruptcy. Children must have equitable health care from birth through adulthood.

The system must provide adjustments so that equitable health care can be affordable for all.

2.1.5.1 Health Care Affordability for Life

Primary goals of this proposal is to bring Equity, Quality, Affordability and Accountability to the United States health care system. The health care “caste” system is a product of our government neglect of these principles, at the expense of millions of people who do not enjoy the realization of these objectives, particularly those who are or become economically challenged.

See “Subsidies Are Essential,” (Section 2.1.4.2), below.

At the same time, there are many, wealthy people and families that enjoy all of the benefits of our democracy and its unique economy, that is out of reach of poor and low-income people

who are just trying to survive. The American dream is out of reach for then until we aspire to a better future., and they are at constant risk that their lack of health can make their lives much more difficult, and some won't survive as a result.

This objective, to bring make health care affordable to all, is to reduce much of this inequity, and give many people suffering economically and at risk of greater loses, some hope of realizing a piece of the American Dream. This cost of equitable, quality and affordable health care should be a responsibility of our government, to be supported by those who can afford it, and are more than enjoying the American dream.

Affordability is a systemic problem throughout the US health care system, but it is most acute among those who are most vulnerable.

There should also be incentives for investment in research for treatment of expensive afflictions that don't bring pharmaceutical windfalls, with minimal cost of research (i.e., based on other non-proprietary research.

2.1.5.2 Subsidies are Essential

We must have the same benefits package for everyone for equity and quality. Obviously, not everyone can afford all of the potential services that they or their families might need. That goes beyond poor and low-income families, because some benefits or the costs of some illnesses may be devastating to at least middle income families. W should not be driving families into bankruptcy or poverty.

There is not a simple income or asset level that triggers one or more subsidies. We need to decide on a sliding scale that is based on additional factors, including the risk of recovery or less than optimal outcome, or death, as well as the financial risk of long-term care, the probability of a return to a relatively normal or somewhat disabled outcome should be considered. This is not a simple formula, but it must be equitable and objective. This is a decision process is policy issue.

The application of subsidies is much simpler when we don't have insurance companies demanding profits. Subsidies can be applied directly in the benefit compensation process. The provider gets paid, and the recipient pays based on a discount, absorbed by the system as a subsidy. No games with taxes or concerns about insurance company profits, just a properly applied formula, that keeps people from risk of poverty are serious financial losses. This must be resolved as a shift of costs to the taxes of the wealthy, individuals and corporations.

Cost sharing will be gone with the insurance companies that profited from the scheme.

2.1.5.2.1 Who must bear the cost of subsidies?

- Who bears the costs of those who need subsidies?
- The wealthy have had the benefit of exploiting the national infrastructure, the government spending, the low cost of labor, the high standard of health care technology, and many other resources provided by various industries that would not exist without the ecosystem of our country.
- One of those resources is the people who work at lower incomes to serve the wealth of the wealthy. Those who have realized substantial wealth owe it to the less fortunate who have suffered from low income, the crises of economic turmoil, the loss of jobs and their way of live when there are failures of the corporations, built by wealthy people with the efforts of many who worked at the lower levels of the corporations, to make the wealthy rich. Those who suffer the most , are also manu of those who contributed the most to their success in terms of actual work.
- So, we call the wealthy citizens, to bring the less fortunate, into a thriving middle class for a better future for us all—to meet the needs of at least level 3 of Maslow's hierarchy, and potentially some realization of level 5.
- Many are currently suffering at level 1, and more are at risk as we face the many disruptions of our ecosystem in the years ahead. In the meantime, many are trapped by poverty, sustained by inadequate health care, along with many other factors.
- It is time that the disadvantaged have the opportunity to realize the full benefit of US citizenship that the wealthy exploit for free, including employment and election funding dominance over the majority of the population.

2.1.5.3 How to Manage Very, High-Cost Treatment Plans

The first problem is to recognize benefits that trigger high-cost treatment, for consideration possible mitigation since there may be multiple claims required to support the treatment. Maybe a prior authorization flag, but maybe an early warning based on symptoms or test results. It is not practical to automatically provide subsidies for all possible treatment plans, particularly when there could be many claims against multiple benefits for the full course of the treatment.

Given that a high-cost treatment will be under consideration, the anticipated treatment plan cost should be evaluated, and alternative treatment plans should be identified. The fundamental cost issue is, should the cost be subsidized for the potential beneficiary. This is not a routine beneficiary issue, since the beneficiary may not be low-income, but may merit consideration for a subsidy. Then, an independent panel should consider the case, with input from the primary doctor or specialist in charge of the proposed treatment, for further consideration of the beneficiary's circumstances. The panel should have prescribed factors to

consider and a limit of their discretion. An option may be to define an alternative treatment plan, or a deductible to be charged, that may still not cover the full cost of the treatment that then remains the choice of the beneficiary to pay for completion of the treatment.

2.1.5.4 Medicaid poverty trap

There must be no Medicaid poverty trap. We need to health people aspire to a better way of living, they give them therapy, opportunities, collaboration and other assistance to help then achieve growth toward a better life.

2.1.5.5 Un-Affordable Prescription Medications

The national system might negotiate for a low (international?) rate for affordability of low income recipients, but deliver the prescription at regular price for persons not qualified for subsidies.

In an alternative, if the pharmacy is a contracted provider, then the benefit affordability compensation could pay the pharmacy the negotiated rate that applies to the specific recipient.

At the same time, pharmaceutical companies increase costs and market with extraordinary advertising expense with questionable customer value.

Hospitals, nursing homes, jails and prisons, and other direct care or residential providers must be compensated for medication management and administration, however, the medication management should be a billable benefit, but the cost of the prescription medication should be a separate benefit or a separate charge for the benefit claimed. Medication cost must exclude mark-up on the negotiated price.

This may be a different category of subsidy (see, abovre).

2.1.6 Accountability

The unaccountability of the current system has been analyzed in Part 1. (see the Un-Accountability Hierarchy diagram in Section 1.3.2)

2.1.6.1 Government funding

The federally funded services are the most serious offenders, and they serve the largesrpopulation, where the majority of the persons served have significant, unmet needs, and many of those are at the bottom of the ***health care caste system***:

The funding at the Federal level is pure, political capitation. There is no consideration of the need for needs or satisfaction of needs of millions of real people real people. There is no accountability for the services needs of the individuals who are, or should be, in the presumed populations.

At the state there is another level of capitation (rationoing) where funds are typically allocated to populations with specific needs, and to geographical areas of the state. There may then be another level of capitation for provider compensation or for insurance companies as payers of provider claims, that in long-term care, providers may be receive capitated funding for the residents of residential facilities. too many levels of capitated allocation (rationing), without any basis for consideration of the needs of the population to be served. These levels each create barriers to accountability that supports the allocation of funds.

Insurance companies dominate the management of provider-compensation. This gives them the power to decide the controls over the approval, or pre-authorization of provider claims. In some cases, the funding is another level of capitation where provider compensation is for the care of people served in a facility, that may or may not serve the individual needs for health care services.

Accountability can be particularly effective in a single-payer system, because there are records of who has claimed payment for services, who was served, and outcomes, how benefit was realized. Beyond that, further analysis can lead to the factors that led to claims that were delayed, denied or improperly paid-for the patient's condition.

2.1.6.2 Private Funding

States are responsible for regulation of insurance companies and providers and discussed in Section 1.2.2.3.2. Many insurance companies sell health care coverage directly to individuals and families, but the recipients know little about the details of their coverage. States should take responsibility to ensure that the direct recipients have access to the information they need and oversight of the quality of care.

Support from the national system

This should be easy with some participation of the state, Oversight and Accpountability, since they will have access to the information they need from the national patient records system and provider contract information for the providers in their state.

2.1.6.3 Strict Accountability.

Accountability, in this proposal, is driven by oversight that may occur in many forms, but, in this proposal, it is a primary responsibility of the Oversight and Accountability agency in each state. (See Section 3.2.7).

In the proposed, single payer system, there is only governmental funding. If there are private services, outside the single payer system, provider payers should be regulated, using the same Oversight and Accountability agency as the single payer system, in each state. The analyses of

individual and selective summary delivery values for similar diagnoses and outcomes should be reported for meaning assessment of ideal and undesirable practices and benefits.

The Oversight and Accountability agencies in each state must enforce accountability, within each state, with administrative authority to investigate, report and enforce corrective action, and, more importantly, ensure delivery of the values that the people expect, independent of budget priorities, and profits. These assessments must form the basis for objective assessment of timely and appropriate health care and progress toward appropriate conclusions and recommendations, to each state, the national system administration, and Congress, each with appropriate viewpoints and explanations.

This is supported by a unified patient records system that tracks the delivery of services and outcomes for each recipient, alone with a value-delivery analysis system for tracking the values delivered to each recipient (i.e. customer). del

This brings accountability at the level of the people directly to all levels of delegation, for the persons they are actually responsible for serving. That eliminates the politics, those who choose not to care, and the debates among decision makers who actually no nothing about the bases for decisions they are making.

The agency also becomes the system quality control advocate for each and the collective advocates for the nation.

This returns the power to the people that has been lost through elections. This approach should be considered for other governmental systems, such as education, social services, and others.

2.1.6.3.1 Accountability Tools

A Value Delivery system will support a range of analyses value delivery from the flow of benefits and outcomes of individual recipients, comparisons to similar circumstances for evaluation of variations in outcomes.

AI should be considered to analyze patient records and value delivery for

- Fraud detection,
- Outcome evaluations, and exceptions
- Medication conflicts
- Redundant claims, scripts of individual doctors and their patients conflicting

2.1.7 Accessibility

Accessibility addresses possible barriers to recipient timely and convenient access that is accessibly when it is needed with the services that are needed.

Relevant factors:

- Distance
- Transportation
- Professionals and practices needed
- Awareness
- Intervention
- Risks of harem to self or others
- Inappropriate delays or denials

Health care deserts in rural and low income areas are a particular concern.

2.1.7.1 Early Intervention Is Good Health Care

Early intervention is important for any health problem, so you can control or eliminate the problem or, if possible, learn to live with it. People often delay addressing a concern, but they will likely regret it. However, some problems are not apparent, and you should have the check-ups to get care if and when, it is needed.

2.1.7.1.1 Early Intervention for Mental Disturbance

Early intervention means engaging a potential recipient in treatment when their need for treatment becomes evident particularly if they don't recognize or acknowledge their disorder. Early intervention may result in early improvement or recovery, and it may prevent a more severe affliction, or an extended, long-term disability. Stress and situational depression can also create or exacerbate other medical conditions.

This is a concern for all people in long-term care, particularly under Medicaid, because there is minimal contact with any doctor.

Early intervention also is a problem among low-income and impoverished people, who are less-likely to seek medical care, or may fail to follow up on medical diagnoses due to cost or stigma.

Early intervention is a more severe problem for mentally ill people. Adults may not get treatment, because they are distracted tht they are not aware of symptoms. Other adults may simply avoid treatment, because of stigma. However, a large number of seriously mentally ill people are unable to recognize the symptoms of mental illness; they suffer from *Anosognosia*, a neurological syndrome that also affects other seriously ill people such as stroke or amputation. These are people who often have become impoverished, they roam the streets and use public shelters. They also do not get treatment, because they "don't need help because they aren't sick." The public mental health system does not recognize the need until they are legally, a **danger** to themselves or others.

2.1.7.1.2 Intervention for School Children

Of particular concern are school children who are primarily considered the parents' responsibility for dealing with emotional problems. For the most part, parents know nothing about the effects of trauma or difficult relationships, or disordered thinking caused by some relationships, medical problems with their brain, or mental illness, in general. Childhood is when the brain develops in many ways, and it is not just about reading, writing and arithmetic.

Teachers, generally, know little more than parents, but they can observe if a student is not behaving like a well-adjusted student, and they should know more about problems to look for, and have a connection with a mental health professional, to resolve concerns. School is also where students develop social skills and collaboration skills, and self-respect. It is where some learn to be bullies or prejudiced. This all relates to developing a healthy citizen, which is, implicitly, why we have a public education system. This is also a health care responsibility to assist in intervention, to provide help. Some Community Mental Health organizations were there in the past, but that got carelessly eliminated by budget problems.

The mental health professionals need to be engaged with the schools so that teachers can get assistance, and professionals can help the student and the family address concerns before the disturbance becomes more serious and more deeply embedded, or dangerous. The student may not be aware or willing to admit a problem exists, but parents can take control. Later as an adult, the child may be more disturbed, and the still refuse to accept help.

Children's early intervention should be acute care, coordinated with schools by the regional office and school. Mental health professionals, as independent contractors, or as employees, should be assigned to schools but engaged by the regional office. They should collaborate with, and coordinate with other mental health professionals as a child's treatment evolves, over summers and after graduation. Children need school for belonging and other brain development. For severe behavioral problems, some form of long-term care may be necessary.

Particularly in complex or evolving cases, there should be a primary physician, an a team provider and provider liaison and appropriate specialists or direct care personnel. The collaborators will depend on the situation and guidance by the primary physician.

In the current system, collaboration between doctors is primarily though some sharing of medical reports by the laboratories and imaging providers, but the patient appears to be the primary messenger for collaboration.

This informality is primarily a matter of funding. Doctors are not reimbursed for collaboration. And patient records have a variety of sources, depending on where the patient has been for treatments and/or testing. This may not be a problem for a patient that only has one condition of concern, but if there are multiple conditions, the interactions may not be obvious.

The concept of a primary doctor seems to be common, but it is not clear what the primary is expected to do, except maybe an annual physical. The primary doctor should have some role in providing treatment for the whole person, and might look for issues of concern and even consult, ad hoc, with a relevant expert.

For complex cases, there should be case management provided by a professional designated to facilitate collaboration and some form of treatment consensus assessment and planning, dependent on the complexity of the case. It would be beneficial if the case manager is affiliated with the primary doctor. This calls for some sharing of patient information and possibly ad hoc collaboration.

Collaboration, treatment planning and case management will benefit significantly if all of the patient's records are accessible from a single source in standard formats, and arranged chronologically or through various viewpoints. This can also be a valuable tool for analysis of patient history and trends over longer periods, and potential alerts regarding significate changes or AI alerts. Treatment plans and progress can be more easily shared with many different treatment teams, if all doctors have the same source of information for the shared records.

This can also be a basis for patient monitoring—services that actively monitor a patient's condition and events, electronically, with automatic alerts to appropriate doctor(s) or emergency services. This is much more effective than an ad hoc call to 911 to someone with a brief synopsis of a problem of somebody that nobody knows anything about except the current person or crisis observer. They only learn more about the patient's medical conditions when they arrive on the scene.

Physicians, in particular, must be encouraged and compensated, to collaborate, coordinate or consult with other physicians who are treating or familiar with the patient, or are specialized, to ensure that complementary/potentially related treatments and supports are coordinated. Such collaboration actions must be captured in patient records and billable. A primary doctor has responsibility for recording collaborations and consensus in the patient's record.

People often have multiple disorders that require multiple specialists. This is particularly true of elderly people and those with a serious mental illness or other disability. Unfortunately, these are patients served by Medicaid, and such attention is not likely to happen. Too often, they only get attention for one of their conditions. They don't have specialists because that is too expensive and inconvenient. Typically, they don't get enough attention to their special conditions because there are no specialists available. This is a particular problem for Medicare and Medicaid because they pay so poorly. Patients with Medicare and Medicaid are somewhat better served if the condition becomes acute and requires hospitalization.

An equitable health care system will identify a primary care physicians, and, as needed, work with specialists to ensure that together there is a treatment team and team members are aware of the recipient's status, collaborate and contribute their expertise.

This is particularly a problem in long-term care, particularly Medicaid, where patients are more likely to have multiple afflictions that require special expertise, and patients may not be aware of, or cooperative, and they all must get timely attention and contact with their primary care physician, and the occasional attention of a key specialist, as appropriate.

2.1.7.2 Community Health Care

2.1.7.2.1 Hospitals are going out of business

- This single payer system must stop this discrimination and profit taking that has undermined health care in rural and other low-income communities. Compensation must be consistent across the country (possibly some adjustment for regional economies). Wealth must not be a factor in the ability to get accessible and affordable healthcare.
- The poor compensation rates of Medicare and Medicaid that, in particular, have encouraged hospitals to consolidate to offset/cost-shift to profitable insurance rate markets (generally locations with large numbers of persons on employment health care insurance.
- At the same time, rural hospitals are going out of business, because they cannot survive on the low rates, and they cannot attract professionals that will not accept the low rates.
- The system must actively improve the appeal of careers in health care, by enabling professionals to realize the full potential of their education, expertise and experience that are part of their qualifications, receive the respect they deserve and receive appropriate compensation, possibly regional adjustments for exceptional circumstances.

2.1.7.2.2 Recovery of health care in rural and low-income areas

Significant damage has been done, and missing hospitals will not just re-appear, particularly in areas with no higher-income patients. There must be Federal funding to re-establish and encourage the growth of non-profit, low-income-area hospitals and ensure that their care of low-income people does not drive them out of business again.

Professional education might be subsidized for students who will commit to practicing for some period in a "health care desert (see Section 2.1.5.1) but the jobs must be more that a short-term assignment.acxZzcx.gh/

2.1.7.3 Qualified Work Force

The new health care system must have appropriately qualified , compensated and appropriately certified. This has deteriorated for coast savings, in conflict with quality of care.

2.1.7.3.1 New Skills and Expertise

Quality health care requires certified, competent and dedicated employees who are allowed to apply their skills, judgement and dedication and are properly compensated and proud of their jobs. All this cannot be achieved without accountability. The whole system must be accountable, independent of politics, budgets and profits, to serve the people who need health care and health care security. WE CAN DO THAT. But that is fundamental change to the system.

of long-term care will be a significant change. It appears that Transformation of Long-Term Care

Transformation there is little or no foundation for fee-for-service billing, and a variety of methods for managing the operations as billable services. However, insurance companies are making payments, and they likely have some common methods of serving many of the same providers. The first problem is to resolve services that are capitation-funded, and the operating methods and records that support the billing of individual, billable services.

Certainly, it can be done, but it must be done in a standard way so that the national system can interpret and pay the claims properly, and maintain consistent records of the services performed and who was properly paid. The final problem will be to get all the people actually doing the work to properly provide the records needed, to get paid, and be accountable.

2.1.7.3.2 Fee-For Service Transformation

Long-term care tends to be effectively capitated care. Staffing is based on the number of patients and the severity of their disabilities, no specific delivery of health care benefits to the individual (i.e., fee-for-service). This is both a problem of benefit specifications and compensation, but it is a cultural transformation in the management of personnel and accounting for their work, as services to individual patients. This is quite similar in concept, to a hospital, but I expect that the operating discipline and accountability here, is less structured than in hospitals, particularly in mental health care.

(Hypothetical) Employees (providers) might be allowed to continue to employees as apprentices at “old” billable rates, and also have a plan/progressive-steps to reach certification and the new rate. The provider might have a requirement for the rate of reduction of non-certified employees that could include new hire replacements.

Upgrading the staff is a serious problem, particularly for mental illness, since the direct care people are not expected to have any therapeutic skills or even an understanding of the disabilities. These issues must be part of a systematic development, benefit package, that grows the billing rates to create the increasing demand of appropriate wages and job satisfaction to satisfy the expectations of those inspired to join the profession.

2.1.7.3.3 Coordination of Acute Care and Long-Term Care

Persons in long-term care, still need occasional acute care, and health maintenance care (regular health assessment and follow-up on chronic conditions that may require acute attention). This appears to be neglected in the long-term population, particularly under Medicaid. This often requires collaboration of a treatment team and a case manager, not restriction to professionals, in the long-term care staff. Some people should have continued attention of their specialist(s) who cared for them before they moved to long-term care, particularly the long-term care is an extended recovery from a serious acute care treatment.

2.1.7.3.4 Absence of Therapy Professionals

People, not only those with a mental illness, need therapy to re-train their brain, from stroke, from PTSD and from other disturbances. Medication is not the only answer, nor is just getting your head straight on your own. Therapy is seldom even considered in today's health care. There must become an expanded, national market for professional therapists.

Currently, wealthy people may be the only ones who realize that level of quality health care.

The state as well as health care professionals must be concerned about the health of their community, such as infectious disease and people who need intervention when they may not understand their condition or believe they cannot afford treatment. Some attention must be given to the availability of hospitals, of health care providers, to engage potential patients in need, the availability of a hand promote the health-care awareness in their community. This includes intervention of children in schools. This also requires qualified professional care givers, as well.

Many brain illnesses sustain ill effects after the medical treatment (acute care) is completed. A stroke typically has symptoms that remain after the trauma is repaired, but we accept that therapy/rehabilitation is still required to re-retrain the brain.

Therapy is a critical problem for recovery from a mental illness, and other people on long-term care, particularly the elderly. It is also a major problem for people with low incomes and poverty that are often in severe economic and social problems, and they need help.

The public mental health system considers a need for therapy as a personal or social problem. The system treats the acute symptoms of a mental illness with medications, but it leaves the

residual side effects for the patient to retrain the brain on their own—just get it together. The result is, typically, long-term care (a non-life) or discharge to the streets, or worse.

We need to treat mental illnesses as real illnesses, that may need both medical treatment and therapy to retrain the brain. At the same time, the problem has much broader effects, because many people need therapy before everybody knows they are not functioning properly. They need early intervention, maybe starting with therapy, and they may have a totally different future. On the other hand, therapy may be all they need, particularly if the cause of the disturbance does not just go away. More improvement, fewer patients, lower cost (including fewer inmates, fewer Homeless, fewer, domestic violence, fewer unemployed, happier families)

PTSD, is caused by psychological trauma, and requires therapy, although medications may be required to stabilize the brain to accept therapy. Severe mental illnesses have been accepted as biological disorders and are treated with medications, almost exclusively, for many. Medication is not the only answer.

We could save a lot of money and a lot of lives, if we would stop abandoning many persons with mental illness, because they don't heal themselves. But the real problem is that research on mental illness has been focused on the profits of medication, and these "uncooperative and sometimes dangerous" people are just warehoused to keep their symptoms under control and out of trouble. A change is decades overdue. (See References 5.1, 5.2, and 5.3).

2.1.7.4 Long Term Care Is Health Care

Long-term health care applies, in particular, to the elderly, persons who suffer from a mental illness and persons with severe disabilities. Persons who are receiving long-term care are worthy of equitable health care, with a reasonable quality of life within the limits of their disability, not the limits of their economic and social circumstances.

Public mental health care (Medicaid) is difficult to distinguish from acute care, except by the treatment site (e.g., hospital) where hospitalization duration tends to be terminated by subjective discretion, regarding level of recovery and number of days.

In the single-payer system, this may be a distinction without a business, because the is the issue is what services is the recipient qualified to receive. This is no longe a budget stream issue, nor a financial circumstances issue, that is a distinct concern related to qualification for subsidies, rather that treatment planning or benefit needs.

Reform in Long-term care is particularly relevant for persons on Medicaid, who may, already suffer from a mental disability. They are isolated and neglected, with no hope for the future. They have no life.

We need a new model for long-term care that minimizes isolation from family, friends and social activities, and provides support for elderly to live with family or other associates of their choice, potentially in familiar neighborhoods. We need to provide therapy to help people deal with mental disturbances and loss of memory rather jus becoming a non-person. Many people could experience some quality of life, even some recovery, and we might even save money. See references 5.1, 5.2, and 5.3.

There is little health care, only maintenance. A nursing home may have hundreds of residents with only one doctor who is seldom there, represented by a physician's assistant, who is the "medical expert" for all the afflictions of potentially hundreds of residents.

Medicaid is the primary source of funding for long-term care that is typically characterized as nursing home care. Medicare is focused on acute care, theoretically care that restores health from a specific affliction until the damage is recovered. However, it has become rather common for people to have rehabilitative care that occurs in a nursing home, or an illness or injury that has an expectation of an extended period of recovery under Medicare, particularly if they have been discharged from a hospital, but still require rehabilitation.

In addition, there are dual-eligible persons who are on Medicare, but also on Medicaid, because they qualify under the Medicaid income/assets constraint, and Medicaid is a lower standard of care, and not everyone has access t Medicare, only if you (or maybe a parent?) paid for it beginning early in life.

As a result, the boundary between "acute care" classification of hospital care, and Medicare, that is generally characterized and acute care, and Medicaid that is for poor people, but also covers elderly people, is very vague, if not a personal, accident.

Unfortunately, it seems that the distinction is somewhat subjective and may depend on the state, the management of the competing Medicaid budgets, political influence, and the levels of capitation involved. So, in effect, it is unclear what Medicaid should be accountable for. Is there a standard for health care if you can afford it, and another if you can't? Is that the American way? You only get what you can pay for and anything else is charity, no national obligation.

This fuzziness must be resolved in a unified, national system of care that is an equitable standard for all, as proposed in this document.

2.1.7.4.1 Three Major populations

First, we consider 3 important categories: care of the elderly, care of the seriously mentally ill, and care of persons who suffer from severe physical disabilities that have lifetime consequences. These have somewhat distinctive characteristics, but will still be fuzzy around actual practices.

Care for the Elderly

Although the boundary between acute care and long-term care is rather arbitrary, care for the elderly is quite distinct for poor people who are elderly and cannot take care of themselves either physically or mentally. Consequently it must be charity, unless they also have Medicare.

The default is residential care, nursing homes, where there is economy of scale to keep it cheap. There are some standards that are mostly, subjective “medical necessity” (within budget) that includes personal and facility sanitary conditions, and medication management. Generally they have certified nurses and certified nurse assistance qualifications, but not a sufficient number to serve the needs of the more seriously ill or disturbed patients. Some nursing homes are better than others, but many will try to keep you comfortable if it is not too much trouble, until you die, with no life worth living.

There should be supported modes of living with some supports for elderly people to continue to be active members of their families and friends. It should be less expensive to live with family or in the old neighborhood, without making a member of the family the live-in caregiver, particularly when many adult family members, now have jobs or young children.

Maybe we need to promote family living, instead we discourage marriage because that might disqualify support from Medicaid poverty qualifications. Incidentally, we also consider any purchased assistance from other family members that might improve their quality of life or improve their condition as unauthorized income. That includes no paying for a more qualified doctor or some specialized treatment because it is “income.”

Care for the Seriously Mentally Ill

Persons with a serious mental illness are a different category. Most persons with a serious mental illness are afflicted in their teens or twenties—not elderly. They are typically denied treatment if they do not have immediate symptoms of a risk of harm to themselves or others. Their care tends to be custodial, to control their symptoms and manage their medications, due to their behavioral symptoms. Unfortunately, there is little effort to support recovery, particularly therapy to “rehabilitate” the brain. In the meantime, there are at least hundreds of thousands of persons denied care, because they are not dangerous enough. Some of them are well enough to act on their delusions to plot to plan and perform violent behavior. The answer is confinement, but not until it is necessary to spend the money.

Once in the public mental health system (Medicaid in all states), you are stuck, in a local, general hospital (but not for long as acute care, and too expensive), or in a group home, with staff members who may try to make life better and others who do not, or in inxependent living with occasional supports by non-certified personnel, but there is no guarantee. Doctors have too many patients and tend to get their information about the patients from the staff or case manager regarding a need for medication adjustments. Ther is seldom other medical care

unless there is an acute physical problem (assuming it is noticed. The direct care staff members of the group home have some very limited training regarding problem resolution, possibly medication management and home routine responsibilities. They know very little about mental illness or the behavior and ways to deal with delusions or hallucinations, or associated disturbances except from experience. Generally, they are minimum wage, have unpredictable schedules, and are close to poverty-level families.

Their lives care is custodial. No therapy, or other rehabilitation, little if any activities, exercise, social activities, mostly television and meals. Many have potential for recovery, but that is not part of the program. For the most part they are there until they die, with some visits from some family members, mostly parents, but they no longer have anything in common, only their lonely lives with no future. They are prohibited by law, from going into a nursing home, because that is a different funding stream with different care(?).

There must be serious reform in the treatment of persons with a serious mental illness that will ultimately reduce the number of persons with a mental illness who need long-term care, as well as the number of persons incarcerated as a consequence of symptoms of their mental illness.

In particular, this requires a serious reorientation to treatment as a combination of therapy balanced with medications to control the biological disturbance (see Reference 5.1, along with5.2).

Care for the Persons with severe, lifelong disabilities

Medicaid beneficiaries are poor people, with limited incomes, and limited assets, who require substantial assistance for daily living. Although it is treated by Congress, as charity, it should be a right that is being seriously, violated, but assistance and health care are restricted by budget limits that ensure that it functions as a charity. Some states even consider it a loan that should be paid back. Care is generally, more caring and supportive, probably because many families continue to be fairly involved in their lives.

Care for persons who suffer from addiction disorders.

Treatment for addiction disorders may be long-term, but is significantly different from the conventional characterization of long-term care. Residential care is relatively short term, but supports and treatment may be on-going, with relapses, but including appropriate therapy. Much is to be learned regarding the biological disturbance of addiction.

2.1.7.4.2 Public Guardians

Public guardians play a major role in the care of persons in long-term care who are unable to make personal decisions regarding their finances, health care or their living circumstances. See Section 1.3.14.1 for accountability concerns. This requires that the actions by public guardians,

and potentially family-guardians as well should be accountable for their decisions regarding their representation of their ward. This means that, for public guardians, their work must be funded, rather than charity, for those who have no money. They and the health care provider must be accountable for the health care decisions regarding health care services, and the outcomes, like everyone else. That may be a simple matter of an entry in the patients record, identifying a person representing the patient in health care decisions. The health care professional recommending and delivering the service should already be there. Furthermore, these decisions must be subject to review, particularly if anybody expresses concerns for the welfare of the ward.

2.1.7.4.3 Special attention to the Long-Term Care Staff

The same benefits are supported by insurance companies, and they are likely low, but effectively they represent the current, poor-paying market. However, rates will be fee for service, no longer capitated, (rationed care). Hospitals, nursing homes, small direct worker companies, independent professionals or groups, are all providers that may fall short as qualified workers. However, the available work force must qualify. Thus, many may need education and training to qualify or to be interested in employment for a growing number of qualified people attracted to a better paid profession. Current employees should be given opportunities to develop needed skills, and potentially achieve certification. Changes in assignment should not affect quality care, but this might be approached as an apprenticeship or similar development program with proper supervision and apprentice aptitude. It will take some time to build a workforce certifiably capable of providing equitable, quality, long-term health care.

An approach may be to define two classes of benefits: those who are delivered by certified personnel and those that are delivered by personnel who are not certified, but are engaged in a strict improvement program to qualify for certification in a specific period of time. This would require some assessment of each un-certified person to determine if they qualify for the required education and training.

This could be accompanied by individual employment transition benefits (not mental health benefits) somewhat like the GI Bill after WW2, to help those who have lost their jobs to gain skills and/or experience for new job markets, many of which will occur in health care with the increase in certified positions or professions as will as the currently expanding need for climate change industries. (see Section 2.1.8).

2.1.8 Mitigation of health care job losses

This is a national interest/priority. Displaced employees must have an expectation of financial security and employment. See Reference 5.4.

Our country, as well as the leaders of most others, ignore the impact of major economic changes that create new jobless populations, suffering from loss of income and financial security. We don't pay attention to repossessions, homelessness and bankruptcies, and those are the tip of the iceberg. Let's **not** create a new poverty population. **See Reference 5.4.**

2.1.8.1 Employees in care of persons suffering from a mental illness and/or Substance Abuse Disorders

This work force is typically minimum wage employees with minimal training, and only experience for training in the needs of persons suffering from a mental illness nor appropriate ways to work and communicate with people suffering from delusions, hallucinations or paranoid ideations.

T the same time these populations are less stable, and may be in and of treatment with unpredictable consequences, so the direct care may be more challenging less unpredictable demands.

These people need therapy and understanding to manage or improve their symptoms, not just medications. Current direct-care workers have little understanding or commitment to help these patients. They need to be upgraded to appropriate levels of certification and leadership, along with a better appreciation of the needs and disabilities of the persons they serve.

2.1.8.2 Employees in Care for persons in need of Rehabilitation and elderly, long-term care

This may be a relatively stable work force, but they should be appropriately educated and certified in their roles, with proper compensation and staffing levels.

Particularly under Medicaid, in nursing homes, some direct care may be minimum wage employees (Certified Nurse Assistance, may depend on the state) others may be only un-registered care takers. If persons are in a nursing home, they need more professional care, and appropriate levels of staffing that would not be acceptable in non-Medicaid funded facilities. Some may be Employees for Closed Health Insurance Companies, or private pay, but also have Medicaid recipients who were admitted before the qualified for Medicaid.

2.1.8.3 Employees in direct care of persons with life-long, substantial disabilities

This population tends to be more stable because many of the patients had disabilities as children, and are life-long dependents whose parents remain in contact with them. This means

there is also a family relationship with the caregivers. Nevertheless, they deserve the same level of professional car , potentially with participation of families in firs-hand awareness of changing circumstances. So maybe different protocols, but not lesser level of knowledge and skill.

2.1.8.4 Employees discharged by insurance company cuts

This health Car reform will eliminat a large number of jobs in insurance companies. There are likely, few similar jobs to hire these people, and there may be many in associated residential areas in many states. We need to provide assistance to these people to survive this loss without becoming a new generation of neighborhoods in poverty.

Consider how the nation responded to the many thousands of displaced veterans returning from the second-world-war (the GI Bill). They participated in an economic expansion of the middle class and national economic success of their generation.

We should consider similar measures for today's jobs and economic crises of persons displaced by the decline in the fossil fuel industry, and climate chang natural disasters.).

2.1.9 Enhanced, Core Information Systems

Some of the systems described below provide fundamental facilities, today, but must be significantly enhanced as part of a national system. Other are providing new capabilities or economies of scale not achieved before

2.1.9.1.1 One Reliable, Accessible Source of Patient Records

Current systems are fragmented, and the relevant records are held at diverse sources of relevant information. Typically, a patient who has been in different hospitals or testing clinics will have multiple sources over time. Clinics may send results to more than one doctor and update their own records in another system. Records must be properly arranged in chronological order and managed with similar display formats so users don't need to quickly adapt to different systems. This all takes time for which the doctor probably is not paid enough. Quicker to just ask the patient, who probably does not remember, certainly not with details.

2.1.9.1.2 National Benefits Package

The national benefit package is open to all for evaluation and to make suggestions, along with appropriate guidance and interpretations of the technical and not-so-obvious intent and consequences.

Changes must be reviewed by representatives of the Oversight and Accountability agencies of the states, and other representative advocates.

2.1.9.1.3 National Provider Network Records

Provider contracts, performance evaluations and complaints (and findings) are open for patients and families can make informed decisions in selecting a provider.

2.1.9.1.4 National Patient Records

Al patient records systems (hospitals, professional groups, Laboratories, etc., capture patient recordes wherever a patient receives services. Unless a doctor wrote the prescription, other information for a patient may be in multiple systems. . Doctors or other treating professionals must to go multiple places to pull together records for one patient. Some of those systems have some patient history, and othe services and medications they have received.

This system would “federate” these records in one system, in a consistent format. The multiple sources would send their records to the central system instead of the prescribing doctor or service provider, to be available to any authorized doctor or other service provider, wherever the patient is being served, in the country, so the right information is available if the patient is traveling on vacation, a Congress person in Washington, DC, as traveling sales person, a trucker, traveling cross-country, etc it also provides support to identify fraud, or pandemics (with appropriate protections for privacy, of course).

2.1.9.1.5 Value Delivery Analysis

VDML (Value Lelivery Modeling Language) is an industry-standare modeling language based on the analysis of the sequence of vaue added to a flow of work to deliver an end product.

Essentilly a detailed, patient record of the delivery of health care services is such a value-delivery flow. The value delivered is expressed as measured contributions to value types by the services delivered along the way. The value types may be costs, flow time, could be laboratory test measurements (possibly variance or a sequence of measures), patient satisfaction etc..

The value types of interest are measures of interest are predefined for collection.

Analysis could be performed for a specific patient, or the outcome of a sequence of services, for cost of delivery of values or a selected group of patients, or the patents of a selected doctor, or group doctors, or patients with a certain diagnosis, and so on. This provides a number of options for analysis for a variety of reasons, including statistical analysis for accountability for delivery of values.

Care analysis could involve analyses of outcomes, or epidemiology analysis for epidemics, or prevalences of diagnoses that may be quite valuable and easy to perform with geographic breakdowns.

The patient records must be defined to identify and capture the measures of the value types of interest, and the service providers must capture and record the value measurements when thry

submit the claim. Of course, this could be a lot of effort if there are a lot of value types of interest, although lab reports or image reports should necessarily have measures reprted for the patient record, already. The extra value reporting/analysis would be done by computer based on the analist's query.

Of course, there will be some requirement for extension of the standard modelng application for this particular application, but there could be a very large market.

2.1.9.1.6 Shared Provider Systems

Every provider will require certain systems to access the health care system records or submit claims and associated information, to submit other information to the patient records or to obtain system reports, or to track and report on team meetings, and so on. There will be National provider portals for Patients and Provider record-keeping (Patient records and business reporting).

These systems should be developed, with as an integrated set of components to be configured for different types and sizes of provider. It is important that these systems are designed and implemented for the new national system, since they will need to change over time as the business changes and information requirements chang, the system changes must be effective to each of the providers affected.

Teh user interfaces must be appropriate to the various users and the context of their usage and terminology.

2.1.10 Information Systems Technical Requirements

The aspects of information systems, discussed, below, are critical to the health care system: Reliability, Privacy, Standards, Efficiency Models and Insight. These must be considered in the context of the size of the national, the critical dependencies on continuous operation of the system, particularly emergency response to patient records and key providers.

2.1.10.1 Reliability

- Redundancy: no single point of failure, considering catastrophic scenarios.
- Capacity: adequate capacity for the size of the national health care system: file sizes, communication speed and volume, connected devices
- Crisis response: preparation for various forms of major disruptions: power, internet, civil unrest, terrorism, storms, wild-fires, earthquakes, etc.
- Physical vulnerability: Criminal actions,
- System change control: validation, testing, review, authorization, installation procedure, user notice, fault contingencies

2.1.10.2 Absolute Privacy/Confidentiality Protection

A master file of patient records, and certain derivative information can create national risks of identity theft or other criminal activity that enables predators to access or infer private or confidential patient information for illegal purposes.

- Control of individual access authorization requests is just the beginning. Depending on the query request content, multiple queries from the sqme or different person might be used to narrow down the selection of patients that share occurrences of selected elements to those who are of interest or potential targets, and access to their patient records may provide personal information that could give credibility to fraudulent solicitations or other schemes.
- Searches of the national patient records should be highly restricted.
- Searches must be authorized based on the scope, the specific criteria, and the intended use of the resulting data.
- A record of every such querie must be kept to ensure accountability for potential, unauthorized use,.
- Each query authorization request must be compared with prior authorizations to ensure that the new and any prior authorization(s) could not be used to infer private/confidential information about specific patients.
- Certain, high-risk queries must be specifically authorized and conducted by an independent, high security specialist who will also be on record as the submitter of the authorized query. The query result the result must be reviewed by an independent, high security, specialist. Before the result is made available to the original requester.
- Specifications must be formulated to enable relaxed security measures for more routine, properly authorized, queries to be performed for authorized, epidemiological or clinical studies. AI application(s) might be developed to identify potential inferences that might occur in the intersection of query results from independent, authorized query requests.
- Consistent and accurate, nation-wide searches (with appropriate constraints with respect to confidentiality and privacy) could expedite recruiting for clinical studies and record-keeping to draw on Patient records to obtain identify potential participants and coordinate the capture and monitor the statistical data and outcome.
- Queries must be designed to prevent the use of multiple intersecting queries to discover patient identities through intersecting record content and block
- prohibited inferences and access to such conflicting data sources.
- Systems should also keep records of who has accessed individual records of each patient for potential recognition of mistaken authorization and potential identity theft.

- All users should have access to their appropriate user interface to access or input consistent information from/to the systems they use, so there is less training/retraining of personnel for new hires, job changes, also video courses, nation-wide.
- Consolidated patient records should provide one source of patient medical histories.
- Access, privacy controls and record updates control are more likely to be timely, consistent and secure when users are no-longer accessing different systems for related records, for the sane purposes.
- The authorized users of the high rusk query results must be informed of their obligation to protect or properly destroy the

2.1.10.3 Technical Standards

See Reference 5.8 regarding a source of some relevant health card standards and support for new industry standards.

- Interoperability: systems must work together, in harmony
- User interfaces, Portals: portals must prevent unauthorized access, user interfaces must be meaningful and easy to use by the intended users in potentially diverse situations and environments.

2.1.10.4 Operating Efficiency

- Collaboration/coordination for diagnosis, treatment planning, outcomes
- Business Processes: reliable flow of activities/operations
- Automation: computer to replace rote human operations

2.1.10.5 Models

- Various models are used in health care, for planning, diagnosis, surgery, etc. These models may require properly skilled users, and the systems must have integrity due to potential consequences to patients.
- Contract templates: possible application of a business reporting language
- Value Streams
- Business Processes and health care management
- Artificial Intelligence (AI) requires skilled developer(s) and application oversight)
    1.1 Model the domain
    1.2 Define the inputs (context, people, sensors, records,?)
    1.3 Train the model for desired actions
    1.4 Connect to the real world

2.1.10.6 Insight

- Epidemiology: studies of patient records and benefit claims
- Value delivery: studies of treatment flows and values delivered
- Fraud detection: recognition of deviant benefit claims or falsification of records
- Cost control: analysis of diagnoses and claims
- Clinical trials: planning and management of clinical trials
- Treatment planning and collaboration
- Absolute Privacy Protection

Information systems are fundamental to the efficient and effective management of the business of providing health care, and the ability to capture and provide timely and accurate information for the diagnosis, treatment planning, collaboration and practices of delivering health care services,

The following are some more considerations for the design of the required systems.

- Patient records become a lifetime of health conditions, treatments, illnesses, and can become a source of family histories.
- All providers for a patient can achieve better consulting and coordination of care using the same system, including treatment plans, status, event, etc. found in the same place and accessed from the same system
- Epidemiologic studies can query information from national populations, filtered/restricted to prevent unauthorized access/inference to the identity and personal information of selected patients. (security, confidentiality, privacy are a critical issue) (see Section 2.1.17.2)

2.2 Broader National Consequences

There are many aspects of the single payer health care system that will provide savings and other benefits that are beyond the scope of consideration by the CBO, budget-based analysis of the potential impact of single payer health care system.

2.2.1 Improved Individual health care

- Better outcomes through prevention, early intervention, appropriate care and rehabilitation
- Loss of health care coverage is no longer a risk of change in employment
- Doctors are encouraged to use professional judgement for better health care
- Reduction in shootings, domestic abuse and trauma through timely intervention in behavioral health disturbances

- System responsibility, accountability and problem resolution through state oversight, public reporting and corrective action through administrative and legal authority, independent of political or budget priorities.
- Fewer employment absences and losses due to personal and family health problems.
- Health care, when you need it, from birth to death.
- No Health care deserts
- Attractive careers in health care,
- more qualified providers

2.2.2 Improved Economic Welfare

- Uninterrupted health care coverage.
- Fewer people trapped in poverty by health care debt
- Fewer, if any, health care bankruptcies
- Fewer families forced into poverty to gain access to health care
- More sustained family wealth and escape from poverty
- An end to health care as a loan and financial barrier to recovery
- Reduced outsourcing for low wages
- Reduction in jail and prison populations and criminal justice workload related to mental illness.
- An end to insurance company operating costs and profits that inflate health care costs and deny timely and appropriate care.
- An end to hospital cost shifting and health care deserts as a result of inadequate compensation from Medicare and Medicaid
- Continuous health care coverage for working people, in employment-based coverage, seasonal work, small businesses employees, and start-up businesses
- No health care economic risks due to a recession
- Every child will have health care as a citizen

2.2.3 Improved Quality of Life

- Fewer people in long-term care (elderly, mentally ill, disabled) due to better treatment and rehabilitation.
- Better quality of life for the elderly and mentally ill through more appropriate assisted living care.
- Equitable health care, for all. No more caste system. No more gaps in coverage.
- Reduced threats of violence, school and community shootings, domestic violence and childhood- trauma, bullying and suicides of children, and improved quality of life for mentally disturbed people.

- Health care equity across all states, including travel and relocation

2.2.4 Enhanced Epidemiological Analyses

Depersonalized access to, national health records for analyses

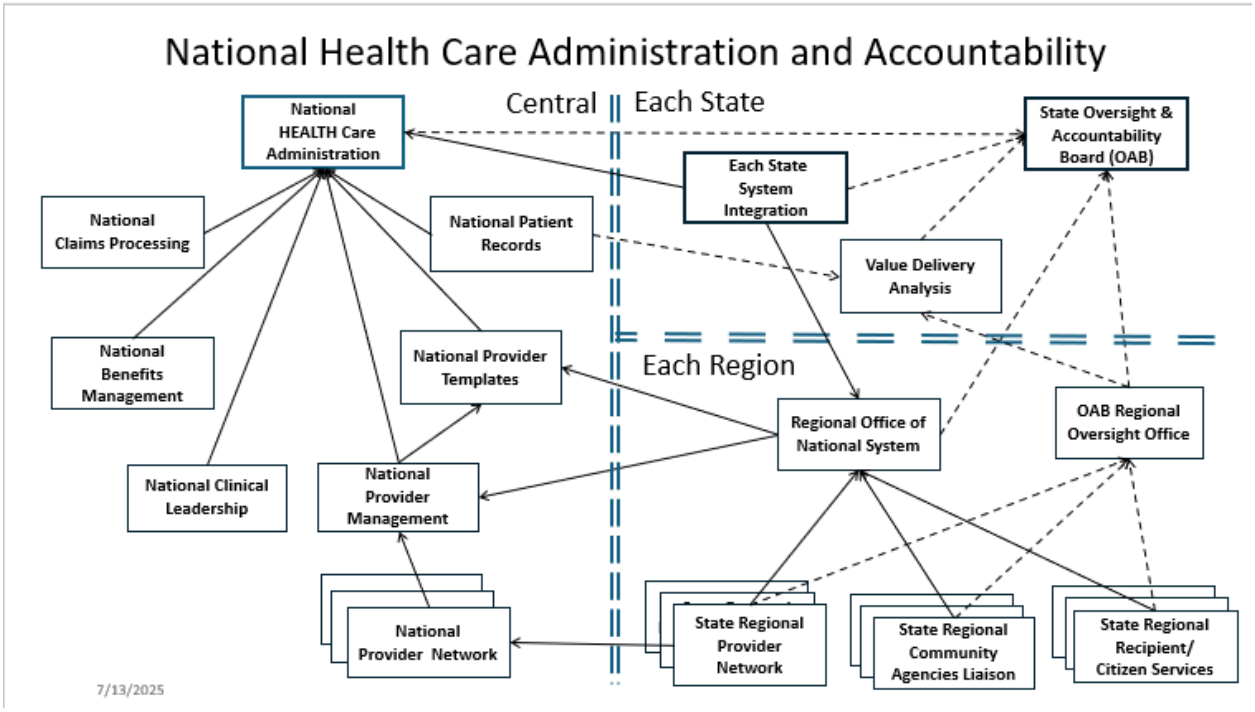
- Epidemic risk recognition, response and mitigation,
- Identification of long-term medication side effects and conflicts,
- Insights into the effectiveness of diagnoses and treatments
- Recognition of provider misconduct and fraud,
- Better awareness of health care capacity and readiness
- Transparency of health care, social, economic and quality of life consequences.
- Potential AI applications to discover correlations and exceptions

3 Part 3, Single Payer System Design Overview

This part describes the proposed single payer system, beginning with a list of strategic objectives, followed by a proposed organization structure and information systems to consolidate the existing, diverse, US healthcare system and improve the system equity, quality, accessibility, affordability, and accountability along with some potential advances.

3.1 Organization Structure Overview

This section provides an overview of the national single payer organization structure, depicted in the diagram, below. The diagram includes the national organization, linked to regional, state offices, the Oversight and Accountability organization in each state, with the Federal office that is the center of operations in each region. The organizations depicted in the diagram are each discussed in the following sub-sections.



Single Payer Organizational Structure Overview

This is a starting-point framework suggesting the general structure and functionality, where operational details will likely vary among the states and their regions.

What is important is that the interactions between these organizational units, as well as public or other outside user interfaces (e.g., portals) must be supported by standard information exchanges, protocols and user interfaces that are not violated by the internal processes and

capabilities of the more detailed operating units. In addition, each of these high-level units is responsible for master, business records that must have appropriate measures for security, privacy and access control that accommodates independent oversight.

The “Standards” are minimally standards set by the national health care system, but as a practical matter, they will have national, if not international, consequences. See reference 5.8.

3.1.1 Central Organizations

The following sections describe the elements of the above organization diagram.

3.1.1.1 National Health Care Administration

The National Administration box, at the top, will have overall administrative management of the national health care single payer system. It has primary Responsibility and Accountability for health care in all States and territories of the United State. There are five boxes below the Administration: National Claims Processing, National Patient Records, National Benefits Management, National Provider Templates, National Provider Network.

3.1.1.2 National Claims Processing

National Claims Processing is a department that accepts and validates provider claims and issues payments to health care providers across the nation. There will be some claims that depend on the circumstances of the patient and the provider as well as the specification of the benefit. Some may involve complex claims, involving multiple providers.

3.1.1.3 National Patient Records

Nation Patient records include the identity and relevant member information and attributes that may affect the fee paid for a benefit. The patient medical record is a history of medical conditions, test results, examinations, treatment plans and relevant events.

- Patient health records must be consolidated, including laboratory reports, so that multiple treating doctors are fully aware of the patient’s history and status for collaboration. Qualified Treating professionals must be able to access their patient’s records, nationwide. This requires support for all reporting providers with appropriate access authority. Patient records might be federated systems to avoid the need for all patient records to be managed in a single database for security and confidentiality assurance.
- Health records must be maintained for life. Certain aspects of health history, disabilities and vulnerabilities should be retained indefinitely for family histories.
- Much of this information will come from the care providers. Howerver, much also comes from labs, scans, therapy, or other work ordered by a doctor, but performed by an

independent provider and recorded on their independent patient records. Consequently, the independent patient records (outside labs, scans, etc., must be consolidated for inquiries about a patient so that they can find most, if not all of the patient's information in one place and correlated to support medical decisions, and the claims management process may inquire for relevant conditions and treatment to validate claims.

- It is proposed that the national patient records come from federated (integrated) sources, particularly while the system is being transformed so that multiple queries would bring records together from the many sources for the individual patient. However, this mode would consume considerable computing power for the final system, and the integration of the multiple systems would require continuing modifications as the potentially, thousands of source systems will continue to change. It is recommended that there be one source for all patients, but the master source might redirect queries to multiple segments of the master data that might be segmented by state, by patient birthday decades, or other ways to distribute the workload. Processing updates from thousands of independent and diverse sources of claims, is a challenge, it is also is a compatibility challenge. There must be a standard defined for the records delivered, but that standard may have different formats for differences in content from the particular source, in units of measure, or image format, as well as terminology, and may include textual descriptions of treatment plans, outcomes, etc. The stream of all such variations must be merged, chronologically, into a patient's consistent records.
- Records about the patient's identity and account should be in a separate file for security and privacy so that all of a patient's personal information cannot be found in one place. There may be authorized queries that extract certain patient records for epidemiological analysis, without patient identifying information. There may be queries to identify patient records for analyses of differences of outcomes, but expressed or complementary queries denied such that the analysts cannot derive unauthorized data about specific patients.

3.1.1.4 National Benefits Management

The national benefits system is the responsibility of a department, but it must be responsive to Congress and, more importantly, to the oversight and accountability agency in each state and the general public (see below).

It is expected that the current Medicare benefits package will be the starting point for the new system. However, there will be many changes to adapt to the objectives of the new system, to add benefits that are not relevant to the populations that are not currently included, particularly those who are not elderly or disabled. In addition, there will be different viewpoints

that must be supported, in providers, oversight and accountability, congress, advocacy groups, and more.

National Benefits Management is a department in the National Single Payer Administration. The department manages the national benefits package. Each benefit defines what is paid for, who can submit a claim for payment, what circumstances are required (recipient diagnosis or condition, etc. National benefits records define the billable benefits and the factors that might affect the validity of the claim or restrictions on costs that may apply to the particular treatment or medications to analyze outcomes for selected diagnoses.

The department must have teams for determining if a benefit is needed, the conditions for qualifying for payment, including diagnosis, possible reference to treatment plan, the amount of a claim that may be modified by an affordability determination, and possible limits on duration, number of sessions, frequency, etc. There may be restrictions that would raise concerns about potential fraud or overdose. Essentially the processing of a claim where there is potential to intervene because the health care system has much more information available to consider if the claim is legitimate, appropriate, if the provider is qualified, and if the benefit is necessarily in the recipient's best interest.

Then there is the question regarding the amount of the payment. The payment may depend on the specifics of the service and possible options, the qualifications/specialty of the provider, the circumstances of the delivery, possible recipient affordability conditions, possibly regulatory issues. There may be department specialists that contribute regarding various factors affecting the amount(s) of the claim. Reviewers of the final recommendation and approval. The amount of the claim may require several levels of review and approval inside and possibly outside the department of the system executives.

3.1.1.5 National Provider Contract Templates

A department will be responsible for the development and maintenance of provider contract templates. Each regional office in every state will apply the templates to the specification of provider contracts and add the results of contract negotiations that may be restricted by associated rules and contract format. Each template is specified for a type of provider related to required credentials and specialty and aspects of benefits they are allowed to bill. The purpose is to provide consistency of the required information and contract terms to achieve consistency and improve efficiency in creating, understanding, applying and enforcing the terms. There may be some aspects that are negotiated, and there may be some that are compositions of multiple templates for large, complex providers.

Provider templates are applied in the development provider contracts by the state, regional offices as they arrange contracts, and eventually update contracts with providers in each of their regions

3.1.1.6 National Clinical Leadership

This department is advisory to the system management and the work of developing and maintaining the benefits package, as well as providing leadership among the providers and the contract managers to pursue new practices and technologies to improve health care outcomes and promote quality of life. This may involve some efforts related to identifying and funding research opportunities, and proposal of clinical trials to explore innovative practices of new medications. This might include organizing conferences of professionals to exchange and report on potential advances and in practices or treatments.

3.1.1.7 National Provider Management

The National Provider Network group is responsible for review and oversight of the providers managed by the Regional Offices. This includes review of provider performance as well as the applications and maintenance of provider templates.

The national system is accountable to Congress, for funding and the objectives of the system, and to state legislators, the states and the general public for the objectives of the system and its impact on the country.

Unfortunately, Congress has no understanding of the shameful state of health care in the United States, and the current lack of accountability, except for cutting costs and the availability of quality care. However, see the state responsibility for accountability of the proposed, nation-wide system (see Secttin 3.1.2.1, below).

3.1.1.8 National Provider Network

This is a department in the National Health Care Administration. It is responsible for the creation and management of the national network of health care providers that can submit claims against the national benefits package. The operational oversight, contract negotiation and management of providers is delegated to the National, In-State, Regional offices. that are each responsible for the providers and health care recipients in their assigned region is a state.

3.1.2 Each State

3.1.2.1 State Oversight & Accountability Boards (OAB)

Oversight and Accountability is an independent organization in each state (or territory) of the United States, and it should be funded by the state/territory. It is responsible for oversight of the health care system and for holding the National Administration responsible for the proper

operation and improvements of the system. As a group the state OAB's have considerable power over the operation of the system because they effectively represent the interests of every citizen of every State.

State OABs should form an association of representatives to achieve consistency across OABs for common information systems, a common training/education program, possibly shared conferences for exchange of issues and practices, and discussion of actions to resolve health care systemic problems. They also might develop staffing guidelines considering variations in region sizes, populations, population density, climate, etc. This would provide a level of consistency and variances in funding of the OAB organizations in each state. An associated association might be formed for reviewing proposed changes to the national system, including information systems, the benefit package, etc. that would have common interests and sharing of expertise.

It is, effectively, an adversary consortium regarding corrective action with respect to the national systematic impact on the citizens of each associated state. It must be non-partisan and must not be subject to influence by national politics, nor health care providers except in the pursuit of solving problems. It should have personnel with medical and legal expertise in order to achieve objective recognition of problems, along with assessment of corrective action and potential, legal action for enforcement. It should be funded, at lease in part by both the state and the federal government, potentially the Federal portion should match the state allocation to ensure the Federal share might fall short due to a Federal, conflict of interest as the funder of the health care system.

In the diagram, the dashed lines indicate the oversight and accountability over the health care system.

3.1.2.2 Each State System Integration

This department is responsible to ensure that state and local agencies are appropriately integrated and coordinating with their Regional offices

. Each department or community agency in each region should support complementary efforts between each regional health care office and the other state organizations and local organizations such as criminal justice, welfare, housing, schools/children, and so on, to be a community resource.

3.1.2.3 Value Stream analysis (OAB)

Thid is the application of a computer-based tool to perform analyses of streams of billable treatments to realize an outcome, that may be for surgery, an office visit, a rehabilitation process, or a lengthy period of hospitalization. Analyses may be performed over records of

multiple patients that have received similar treatment plans to consider the effectiveness of the plans.

The tool uses a standard Value Delivery Modeling Language to generate models of the treatment plan(s) value streams. See Reference 5.8, VDML.

In preparation, the analyst identifies the values that are of interest at the selected outcome, generally when some series of treatments have been completed. The values are to be measured and compared to expected values determined by patients and/or the analyst, and the contribution of each billable action is measured and accumulated for each billable unit in each value stream, to produce a summary measurement for each value for the endpoint. Value types are recipient/family values of interest, time and cost measures, and some that may be of particular interest for a particular study. Different scenarios may be used represent variations in value measurements under different circumstances.

Value contributions of each step (benefit claim) are accumulated for a total result for each value of interest. This then provides different totals for the values produced for each step in the process of interest, for analysis of similarities and differences, and observations regarding ways the treatment plan(s) might have produced better results, and it may be applied for future patients. The value streams (treatment plans) may intentionally apply some variations in the steps to identify if some variations produce better results. The model represents each step as the “application of a capability” (i.e., benefit delivered) by the provider, who submitted the claim.

These analyses may be used for oversight, to measure performance, but more importantly, to identify potential improvement in procedures/treatment plans and outcomes as well as patient satisfaction.

This is enabled by the consolidated patient records, with robust and consistent detailed data.

3.1.3 Each region

3.1.3.1 OAB Regional Oversight Office

This branch activity of the OAB is likely located in the national system eachregional Branch office, the representative(s) will perform whatever studies/investigations are useful input to the state, OAB assessment of region and state performance, as well as concerns or complaints of recipients, families and interested community members.

Complaints will be recorded, investigated and reported to the region, the OAB, to the national administration, and summarized for Congress and state legislators, and for the general-public.

The OAB may take some action to demand or enforce corrective actions.

3.1.3.2 Regional Office of the National System

The regional office represents the health care system to the people, organizations, businesses, providers, related state and local, city, state government agencies and questions or concerns about the system, treatment concerns, how to get information, how to register a complaint, and more. The Regional Office is effectively the hub of the region. Most of the work of regional office is delegated to one of the three, specific, sub-departments, below.

- Regional Provider Network
- Recipient/Citizen Services
- State Regional Community Agencies Liaison

3.1.3.3 Regional Provider Network

The providers that are physically located in the region are members of the national network, but they are under contracts negotiated and managed by the regional office, based on the national contract templates. This also Includes addressing recipient/family complaints and community concerns regarding the provider's services. These providers can serve and bill for services it provides to any member from any other region, across the country.

Primary Doctor Role(s)

A recipient's primary doctor (a provider) is responsible for treatment planning and collaboration, placement with appropriate providers, review of patient records, and collaboration with other doctors, potentially a defined team. Collaboration is coordinated by the recipient's primary doctor assisted by a case manager, particularly if the recipient has complex conditions. The primary doctor will collaborate with relevant professionals in preparation of a treatment plan for approval by the recipient or a representative.

The primary doctor and case manager are preferably in the recipient's home region, but not necessarily, depending on circumstances.

3.1.3.4 Regional Community Agencies Liaison

This may be a team of people responsible for liaison with a number of different government or community agencies. Of particular interest may be education, justice, law enforcement, city leaders, welfare, family court, shelters and/or news media as well as concerned citizens. This may involve a team that investigates, develops a solution in collaboration with others, and proposes a solution for management consideration of investment in implementation. The region should have a web page to answer routine questions, refer a question to an answer, a person, or more general answers that should be available from the national system web site.

The regional office should get involved to resolve problems involving state offices and/or local agencies to collaborate on solutions.

3.1.3.5 State Regional Recipient/Citizen Services

This is where you go to get help or information. How to get signed up, how to find somebody, where to go to find out more, how to file a complaint, get information about services or a provider, or get more general information about the health care system. More detailed help may require assistance from one of the other two departments.

3.2 Major Information Systems

Following, are primary categories of information systems highlighted for the transformation:

3.2.1 Administrative systems

Administrative systems are fairly generic an can likely be adapted from the existing Medicare system

3.2.2 Benefit specifications

There should be many potential benefits systems that might be a basis for a new system. However, there will be new benefits and potentially more complex contexts/procedures/plans composed of multiple claims, and also new claims in long-term care, particularly mental health.

3.2.3 Claims management

Claims validation should have better patient information from multiple sources and patient history to identify mistaken or fraudulent claims (e.g., prescriptions from multiple doctors)

3.2.4 Patient health care records (milestones?)

There should be many existing systems that could be adapted as foundations. However, the new system should be more robust in including additional and more complex information regarding patient treatment, diagnoses, current condition, treatment plans and the patient's response to changes in treatment and circumstances, treatments and procedures to provide insights and potential comparison to responses by different patients and side effects. The system could be designed to trigger alerts regarding certain diagnostic criteria.

Patient profile records essentially identify each recipient and basic, non -confidential/private information such as address, email, maybe some other attributes and the restricted, confidential links to confidential information in other patient-related information including providers, treatment plans, etc.

Patient identification records should be stored, independent of other records to protect against identity theft and violation of privacy. These records will contain large aggregation of patient information and will be very attractive to potential intrusion to hundreds of millions of patient records. Potentially, patient identities should be encrypted so that intervention to one system does lead to access in all systems.

3.2.5 Provider contract management

This organization negotiates and oversees the provider contracts based on the national provider contract templates. They should be able to answer basic questions regarding the services offered by a provider and terms of their contracts. Provider records should include recipient access to provider qualifications and potentially some information regarding patient or family values delivered based on general, patient expectations and satisfactions. Patients/families should be able discus or submit complaints, and get formal responses.

3.2.6 Value delivery analysis system(s)

This includes new techniques for performance evaluation and treatment insights. Generic patient experiences/concerns should be identified for services delivered and assessed by individual patients and potentially families to determine what to measure and rate a value contribution from a patient perspective. These could be analyzed for provider performance but also for insights on recipient expectations, side effects and outcomes for different interventions. This information might also be beneficial for treatment planning and medical decisions.

3.2.7 Oversight and accountability

Oversight and accountability apply to evaluation by management and funding sources regarding their value delivered for their investment. However, this accountability is of most importance to the recipients and families that are affected (or not) by the care and treatment received (or not). This is directly tied to measures of value delivered, not only in terms of outcomes, but in terms of the time, cost and other contributions of each provider along the stream of actions performed by different provider along the way.

3.2.8 Customer and community services

There are a variety of actions by a regional office that go beyond specific patient benefits but to the broader community of persons who are in need, concerned citizens or agencies, regarding the quality of health risks and benefits.

In particular, current funding and insurance practices have essentially avoided recruiting or inviting potential recipients, because they will increase costs. The new system must encourage people to seek help, particularly those who don’t understand their need or risks, so they do not

become more ill or at greater risk, to themselves as well as others. This includes various forms of listening and reaching out, and improving awareness and access.

3.2.9 Epidemiological analysis

The national scope and detail of health care services and patient symptoms, diagnoses and outcomes will be a rich source of insights on trends, potential improvements, risks, and opportunities for intervention. This is subject to epidemiological priorities, security and costs.

4 Part 4, Single Payer System Transformation

Part 4 describes the transformation program for delivery of the national, single-payer health care system in two parts: (1) the development of a proposal to congress to approve the transformation program, and (2) an overview of the transformation program, in a series of phased development and deployments of the new system.

4.1 Program Proposal to Congress for Approval

This section addresses the development of a formal proposal for submission to congress to approve the proposed transformation program, involving multiple development projects, and deployment efforts, managed by the evolving leadership and staff of the growing federal organization.

4.1.1 Financial Projections

First, in this proposal, must be a projected budget for the transformation program, and a projected budget and financial implications of the new health care system. This analysis includes four segments:

1. The costs and staffing requirements for the development and delivery of this proposal to Congress,
2. The cost of transformation development and deployment, in each of multiple phases, including the expected cost of supporting, development-contractors and facilities needed for the transformation effort,
3. The emerging management and operating staff required for the Federal system, including regional offices, along with the proposed initial, evolving and on-going operating costs and staffing as each phase is deployed.
4. The on-going administrative costs and the cost of services delivered after completion of the completion of the transformation program.

This is essentially a budget projection for the transformation program. The projected funding must also propose funding sources to be established by congress, including federal taxes, premiums and deductibles paid by recipients to support affordable health care, the projected cost of benefit claims and subsidies following the deployment of each phase.

Here we will identify (1) funding sources, (2) savings that will affect the cost of the system, and (3) indirect costs, savings and benefits at various levels, that are anticipated consequences of the transformation and the impact of the new system, nationally (see Section 2.2, Broader, National Consequences). These have indirect, economic, social and health consequences.

4.1.1.1.1 Funding Sources

- Medicare Fund/payroll tax
- Medicaid federal share
- ACA federal share
- Federal savings from termination of insurance companies in management of health care
- Elimination of government employee health insurance premiums
- Consolidation to one contract for each provider
- Reduction in health care service claims from better Health care: early intervention, timely care, shorter less intense episodes, recovery
- Potential for better health care fraud detection
- Impoverished health care will have major impact on the potential recovery of persons formerly served by Medicaid
- Other savings will result from better outcomes that will be difficult to assess, objectively, because they are realized as shorter recoveries mitigated disabilities, and a better quality of life including possible gainful employment.
- Elimination of multiple levels of administration and contract management

4.1.1.1.2 Other FederL Savings or Revenue

- Income tax revenue from more productive, healthy lifestyles, revenue as a result of recoveries.
- Potential reduced federal funding of other Federal poverty-based programs due to reduction of People in poverty
- Reduction in seriously mentally ill in long-term care (currently life expectancy is 25 years younger than the general population).
- Reduced Federal prison populations.
- Current State share of Medicaid and ACA budgets for potential funding of related system operations within the state, such as the state Oversight and Accountability agency.
- Revenue from the deductibles on benefits that are assessed based on a graduated scale of recipient ability to pay, increasing a substantial percentage of the actual billable amount of the benefit. This technique is applied to some Medicare benefits.

4.1.1.1.3 State Benefits

- State oversight and accountability of Federal health care system
- School health care early interventions (particularly mental illness) resulting healthier young citizens
- Reduced school suicides, bullying, violence, drop-outs
- Reduction in claims processing and administration due to elimination of insurance company intermediaries.

- Potential elimination of Medicaid match-expense and any other health care expense. It would be reasonable for each state to redirect some of the savings to fund their oversight and accountable organization
- Elimination of employer health care funding for government employees.
- Elimination of government employee health insurance costs
- Reduction in criminal justice due to reduction in mental health crises, and domestic violence through better mental health interventions and treatment
- Reduced incarcerations, police interventions and court costs (primarily state and local savings)
- Elimination of Jail and prison, health care costs (only some states use Medicaid).
- Reduction in jail and prison costs due to reduction in mentally ill populations through early intervention, improved treatment and rehabilitation.
- An end to poverty-level, long-term care, and a 25-year lower life expectancy for persons who suffer from a serious mental illness.
- No more political battles regarding the state health care (Medicaid) budget

4.1.1.1.4 Benefits to citizens

- Dramatic improvement of health care for all, particularly, persons on Medicaid or otherwise impoverished, will result in a significant health improvement and quality of life. This will enable many families to find and sustain a way out of poverty and the opportunity for a better quality of life, and a more secure life-style.
- Crisis/emergency response teams can have immediate access to patient medical information and potential access to the patient's health care professionals or other emergency doctors who have access to the patients record, anywhere in the country..
- Elimination of Medicaid personal debt.
- Health care that is always there.
- Health care coverage premiums and deductibles adjusted to be affordable to recipients with limited economic means.
- Fewer persons in jails and prisons
- Reduced employee absences due to illness
- Reduction in welfare and social services costs by reduction in poverty

4.1.1.1.5 Benefits to Providers

- Reduced professional and direct care turnover
- Reduced clerical work load due to only one payer with on set of system interfaces and one provider set of contract terms

- Reduced clerical workload with consolidated patient records and one payer rather that multiple insurance companies with different cost-cutting schemes, and claim payment systems.
- Appropriate compensation for services delivered, and job satisfaction from providing good health care services.
- Compensation for professional collaboration and consultation.
- Reduced clerical workload with consolidated patient records and one payer rather than multiple insurance companies with different cost cutting schemes, and claim payment systems.
- Faster and easier for recipients and professionals to get relevant patient information from single point of access (time and completeness savings).
- Reduced search and analytical studies of patient records, for treatment and outcome trends and population diagnostic trends.
- Appropriate treatment and outcome for services delivered, and job satisfaction from providing good health care services.
- Compensation for professional collaboration and consultation.
-

4.1.1.1.6 General Indirect benefits to society

- No mor hospital, cost shifting to offset deficit from services delivered to people in poverty or covered by inadequate compensation by Medicare, Medicaid and the Affordable Care Act.
- Fewer people trapped in poverty by health care debt
- Fewer, if any health care bankruptcies
- An end to health care deductibles as financial barrier to recovery
- No health care economic risks due to a recession
- Identification of long-term medication side effects and conflicts,
- Efficient formation and effective management of clinical trials
- Improved epidemiological analysis
- Recognition and improved response to potential pandemics
- Reduction in shootings, domestic abuse and trauma through timely intervention in behavioral health disturbances

4.1.1.1.7 Indirect Costs

- Insurance company Employees loss of jobs. Potential assistance in development of employment opportunities, potentially in health care(?)
- Job losses of Health care personnel who do not meet certification requirements (Medicaid Providers).

- Job losses: State administration, Medicaid employees after Medicaid transformation.

4.1.1.1.8 Recipient/consumer benefits

- Cost of employer health insurance will become taxable employee income.
- Elimination of employee insurance fees, co-pays, deductibles, and premiums, as well as the risk of health care poverty and bankruptcies if recipient becomes unemployed or seriously ill.
- Common information systems at all levels. Reduced personnel training, system maintenance costs, less expensive, complicated and delayed system advance across multiple insurance companies
- Faster and easier for recipients and professionals to get relevant patient information using a single point of access (time savings).
- Remote monitoring and home support to allow people to live at home, independently or with less intensive support, plus more quality of life,
- Simplified and more effective benefit criteria, professional judgement, coordinated, collaborative care, and potentially better social and family relationships.
- Early health care intervention, less severity of illness, better outcomes, and better outcome measures.
- Analysis to improve treatment plan outcomes.

4.1.2 Program Structure

This very large undertaking is characterized as a "**program**." The program will be composed of many phases of completion, with **projects** involving changes to organizations, systems, facilities, and practices.

A primary driver of progress in this transformation is the deployment to segments of the intended population of persons to be recipients of health care services. These segments of the population are identified as those persons who are served by one or more selected health care, delivery system such as Medicare, Medicaid, the Affordable Care Act, or long-term care or non-governmental or specialized services. This involves different funding sources and variations in the benefits due to their financial status or type of disability or treatment requirements. This allows the transformation to be performed in smaller stages with similar requirements.

This has the benefit of delivering services to some populations with the greatest need and potential savings, without taking on all of the potential complexities at once. It should also achieve the greatest improvements in system equity, quality and savings early in the program, showing Improvements to the persons most in need.

The population served by Medicare will be the first deployment because Medicare has a fee-for-service foundation, and it provides an established benefit package that will require a good foundation for evolution of the final benefit package.

4.1.3 Program Branches

There are several branches of the program that will occur somewhat concurrently. They should all begin with staffing targeted at requirements to align with the first deployment. Some of the branches may have similar or related projects or sub-projects that may be bundled depending on the duration for alignment with the deployment target.

Each of these branches will have similar solutions in existing health care management systems, particularly for Medicare Fee-For-Service operations.

The focus for the proposal is to define costs and durations, potentially by deployment milestones in order to plan for costs, staffing, and program estimated completion schedule.

4.1.3.1 Deployments for Populations and Sub-populations

Populations of interest are people served by similar classes of health care service systems that tend to be aligned with funding sources. Within most deployments, there will be sub-stages by groups of states and potentially by regions within states. Medicare and Medicaid are primary targets because of the sizes of the populations and the need for substantial improvement, plus Medicare already has a Fee-For-Service model, and it is government funded. The deployment associated with each population segment is effectively the sequence of milestones where work on the other branches must converge to support the level of detail required for the deployment.

A suggested deployment sequence is discussed later. The sequence will also define stages for such factors as costs, durations/milestones, staffing, training, and more.

4.1.3.2 Transformation Organization Structure and Staffing

The basic organization design must be established early for the first deployment, but it will grow in size and detail with each deployment. Staffing requirements must address the changing requirements of people working on the transformation development, and the staffing of the growing, staff for the completed transformation.

4.1.3.3 Core Staffing Requirements

The effort to develop the program proposal will require a core leadership staff to develop the proposal, and who will define the essential requirement and lead design efforts and contractor projects to develop the proposal detail. This will be the core, permanent staff, while various contract developers may come and go as particular projects begin and end.

4.1.3.4 Development-contractor RFPs

RFPs must be created and issued to recruit contractors for the projects to deliver in the first deployment. Responses to the RFPs will be important for development of the financial plan. Some contractors may complete their objective by the first deployment, and others may continue to deliver incremental versions of their completed effort. Some of their employees may become employees of the permanent staff, as the system grows.

Their RFP responses are essential to further refinement of the transformation plan and the associated cost, time and staffing estimates, as the overall program progresses.

4.1.3.5 Facilities

Facilities, particularly office space, plus equipment, must be anticipated for the first deployment, along with organization and staffing, but the capacity required will grow and shift with each deployment. This will also be affected by the roll-out plan, the sequence of transformation in and across the states.

4.1.3.6 Information systems

Planning and design decisions for each information system should, in early stages, consider testing scenarios for single-system testing and, ultimately final-system testing scenarios and staffing for representative users, prior to each deployment.

At the same time, training materials should be developed, potentially video instructions to reach many potential users for independent learning, possibly complemented with Zoom sessions, questions and answers.

4.1.3.6.1 Existing Systems

Information systems, generally, align with the organizations that use them, but they must be integrated to support the flow of information, work and work products and data across the organizations and for updates to records as well as alerts to problems and changes.

Information systems work must be staffed to provide people to do the development work, and domain experts (health care, management, records, and workflow) that will be front-loaded but will evolve as the overall organization grows. Information systems and organizations also reflect the application of particular skills or capabilities of the people doing the work of the business and contributing value to the delivery of health care to recipients. These capabilities provide staffing requirements. Most of the systems will be similar to existing systems and must be adapted. Some may be vendor products, but they must comply with relevant standards and integration requirements. Some vendors should have useful experiences in health care systems.

4.1.3.6.2 User/web interfaces.

Human interfaces must reflect the context of the user and the various portals.

User interface design and implementation requires particular skills that address the contexts in which the users interact with the systems and how the interface reflects the system design and flow of work supported by the system. User interface people must be involved with domain experts as well as the system developers throughout the transformation. The user interface experts will also be required to support the training of system users during deployment.

4.1.3.6.3 Patient records

Patient records must reflect all potential content from the wide range of lab snd imaging reports to treatment plans. This includes the federation capability to bring all patient data from all sources into the standard, consolidated source of patient records. This also involves access and update security to enable the patient and authorized providers to obtain needed information from across the country, wherever the patient happens to be.

4.1.3.6.4 Benefit Package

The benefit package system may be very similar to existing systems except it must accommodate all of the diversity of benefit packages used by different benefit-payment organizations, specifically benefits of insurance companies serving different populations, in addition to patient record elements new to the national system. In particular, where capitated funding is used, there may not be specific, billable benefits and compensation for services but rather billing based on a functional group and the number of patients served during a time period. This may be typical of aggregate health care settings such as hospitals, but will still need cost per patient for the records.

The actual benefit specifications and the content and format of the records will require consideration of a variety of service qualifications, and features, as well as provider and patient qualifications.

The system must provide a variety of search, directory, and filter capabilities so that users can search for specific benefits or classes of benefits, providers and patients, along with context, billing factors, and so on. This will require considerable analysis by benefit experts.

The system should anticipate the future use of adaptive (case management) processes and AI analysis to support dynamic adaptations of the benefit details as a case evolves. See Reference 5.6, Value Stream Analyses, and see Section4.1.3.6.7, Administrative and Workflow Systems.

4.1.3.6.5 Value-Stream Analyses

A value stream, traces the sequence of delivery of services to a patient with the capture of values (including cost and time) at billable points (applications of provider capabilities) with

outcomes, such as the end of a treatment plan. Values of interest are based on both patient satisfaction as well as performance/outcome measures, from the perspective of an individual patient or primary, treating professional. The values of outcomes for the same or similar services to different patients can be evaluated for variations in diagnosis, treatment and outcomes, for consideration of outcome improvements or refused treatment plans, medications, therapy or other circumstances. Health care treatment does not simply follow the same sequence of actions, but it is typically an adaptive process, that may have general objectives, but the actions may change direction as the patient needs change or new conditions are identified. This is described as a "case management" adaptive process.

Claims as well as treatment plans will require more specification of patient context and treatment planning to support the treatment plan cost, duration, timetable and outcomes, as well as provider collaboration and treatment planning. AI may, eventually, be used to provide suggested decisions, or to gain insights on value stream differences and similarities related to outcomes.

Compensation for claims must be upgraded to meet new system objectives, data input requirements and claim-service provider qualifications. Patient records will be more robust and consolidated so that treatment teams, as well as ad hoc (e.g., consultations or emergency interventions) have the full picture of the patient, potentially from many sources.

Additional efforts will be required to validate the benefit specifications and to provide support for the continued training of the many operational personnel who will contribute to the records or manage the processing of claims and responses to claim exceptions.

4.1.3.6.6 Provider Template and Contract Specifications

There are many different services and requirements for expertise and for supporting systems for health care providers. However, the form and many of the terms of the contracts are similar, with variations of certain aspects. Contracts must be designed with similar structures and be consistent in the expression of the same or similar terms. There should be support for template design, and for the template application to support contract negotiations.

Effectively, contracts must cause providers to work in harmony with each other, the information systems and the patient health care as a whole. Like an orchestra, they bring different instruments, but they must play their parts in harmony of the same music.

The development of templates and contracts must begin early in the transformation, since a significant number of provider contracts will be required to support the particularly large number of providers that may be engaged by Medicare, and later added by Medicaid. It may be necessary to support provider transitions that occur during a deployment so that they might be allowed to submit claims to a previous benefit package/claims processing system, until they are

prepared to submit against the new benefit package (this is an open, design issue). Of course, the benefit specification and compensation may be significantly different.

4.1.3.6.7 Administrative and Work Flow Systems

Many of the administrative systems should be adapted from Medicare fee for service operations.

Many may need upgrades to reflect the future objectives (see Section 2.1)

Case Management Processes.

Case management systems manage adaptive, case management processes, that are modeled on computers. Case management provides a structure for adapting a process to an unpredictable process or a context where the circumstances are changing in real time. Patient conditions change during treatment, and new insights are realized so there may be an immediate need to consider a change. Administrators and providers should consider the value of adaptive processes.

The value stream (above) must follow the flow of the actual case of the individual patient, leading to outcomes, along the way and to any substantial shift in the patient's circumstances or diagnoses. Case management should also capture the reasons for decisions that may or may not change the expected flow of treatment and outcome. If a case management system is used to guide adaptive processes decisions, then the suggested alternative choices should also be captured for possible impact on outcomes. The decision alternatives are at the discretion of the treating professional, and they need not be formal alternatives anticipated or suggested by the automated, case management system.

A case may be a surgical procedure and recovery, a hospital stay and discharge, potentially with rehabilitation, and long-term care for a serious illness or disability.

4.1.3.6.8 System initializations

Every system may have initial data, historical data, and additions of new current data, to be ready for the next deployment. Some may be primarily a matter of converting the format for new files, but some will require new or modified data such as the Patient records, the benefits package and provider, contracts and templates adaptations.

In addition, for a less comprehensive, example, test files must be initialized for testing of individual systems during development, and more comprehensive system testing of system integration, and final testing prior to deployment. All without risking exposure of private data.

4.1.3.6.9 Pre-Deployment, System Integration and Final Acceptance Testing

Test cases/scenarios must address particular population segments where each branch of development has reached a completion that is adequate for the target population of the deployment.

Estimates of costs, staffing requirements and duration of efforts leading to each expected deployment are essential for the proposal and for subsequent planning during the transformation effort. Patient records and billings may be an important source for estimating, potential operating costs.

4.1.3.6.10 Deployment Roll-Out

A roll-out for one deployment will involve 50 states (plus territories?) and (maybe an average of 5 regions per state) maybe 250 regions(?). We should be able to do more than one region at a time, but each region could take a week (or more) to do training for the regional office and each of the divisions, plus each provider in the region. Note that each new provider will be operating under new' template-based contracts. Some support personnel will be required to be accessible on a continuing basis until the deployment is completed and potentially in the long term, growing as the deployed system expands.

The fist deployment will be the biggest since Medicare will likely engage a large percentage of all providers because most providers have some Medicare recipients. They should have internet access for web access to the systems they use, and should be able to participate in zoom "classroom" meetings. Possibly some could be recorded, You Tube videos, viewed at will with some social media questions and answers or chats.

Many providers will be pre-defined types of contract (claims against similar benefits) to provide more focused and complete negotiation and explanations.

It is important that the orientation and user training is not too far in advance of the actual operation of the system, so that the users put their knowledge to work before the training fades. It would be desirable that the systems could be operational for each user within a week or two of the training, or the hands-on videos for some of the topics might be available a bit earlier before the initial system operation for individual viewing. There will be a need to answer ad hoc questions after the system is operational. This might be done with a web site with questions classified and answers recorded so they can be looked up when the same questions are asked again by others.

Nevertheless, this is a major undertaking that must be well planned, with recorded material and schedules for expected user participation. Persons who participated as representative users during testing should be valuable instructors and ad hoc supporters.

4.1.4 Planning/Policy/Political Issues

These are issues that must be resolved, possibly in Phase 1 or well-before certain of the deployments.

- Medicare, Medicaid and the Affordable Care act have inconsistent financial requirements for getting health care coverage. This conflicts with health care equity and affordability, and would greatly increase the complexity of membership administration. There must be consistent criteria that apply to all citizens. Once enrolled, a person must not become disqualified, nor should benefits depend on being an adult or a spouse of someone who is employed. Premiums and copay adjustments for affordability are needed (section 2.1.4.1), but coverage must not be based on being a dependent of somebody who is employed, particularly if that employment determines premiums, deductibles and other costs that may contribute to economic burdens on a family as opposed to a person with an independent income.
- There must be a reasonable way to limit cost for some benefits or out-of-pocket-expense, or a Cumulative billable expense (without subsidy), or other criteria, Just a determination that somebody is poor (current Medicaid), but they must be poor enough. This is a critical issue for Phase 3.
  Risk might be a factor that might depend on the medical condition of the patient. Some less expensive alternative, with a less desirable procedure or prognosis might be alternative, but that may not be equitable or quality care.
- Medicare has an age requirement, and conditions based on prior contributions to the Medicare fund. Age should no longer be a qualification factor. However, age and employment are a factor in the early age for contribution to the Medicare payroll tax. Medicare and the Affordable Care Act, each have criteria for financial qualifications. Medicaid is the most restrictive, but directly conflicts with the reformed, unified system of care. This must be resolved, in a consistent way. ACA uses income level to limit subsidies which are conceptually consistent with the approach proposed in Section 2.1.4.1. However, this may overlap with Medicaid when a person loses their employment, but retains the ACA benefits for some time after. This must be resolved as clear transition to and from employment, without loss of coverage.
- Medicaid has created and sustained the lowest level of the caste system, and that must be eliminated. The distinction may be in criteria for acute care or long-term care as requiring residential care for treatment. These circumstances support more intensive and supportive care. This, then might be addressed by a more graduated scale of long-term/ aka, residential care with different levels of support and isolation. Other benefits could still be the same for other people, but those might include related/as needed

benefits such as transportation, housekeeping, meal delivery, or small group living with ambulatory assistance, or living with family with family benefit-compensation, etc.

- Compensation/premiums/costs based on recipient level of wealth (affordability)
- State participation in oversight funding
- Restrictions on services to non-citizens of various standings.
- Re-employment of persons who lose employment due to system transformation (qualifications, retraining, early retirement, and/or apprenticeships(?)
- Various, current awards/capitated rates for living expenses and other special circumstances.
- Long-term care without financial barriers and no claw-back of costs, regardless of disability
- Scheduling of employee compensation and associated benefit compensation upgrades in the context insurance company service shut downs, the progression of transformation phases and deployment, rollouts.
- Scheduling and coordination of deployments, for termination of insurance company policies and claims processing, upgrade of compensation amounts for appropriate, market values, scheduling of availability and access by user groups and recipients.
- Support for job-losses, new jobs for insurance company employees and under-qualified health care provider employees, particularly in Medicaid providers and long-term care.
- We need new policy, laws about when life is determined unsustainable, or not worth the distress of the person, and with the patient's understanding and sound mind of consent, or a competent legal representative.
- Need reviews from the state oversight and accountability consortium and a committee of independent, public advocates

4.2 Program Phases

This section describes the phases of the transformation program from the perspective the proposal development. The proposal must address the costs, durations, staffing, timetables and multiple projects of the transformation and the growth of the organization, facilities, and the permanent staff in the development of the proposal These estimates must be developed for the proposal, supported by input from contract provider, RFP responses.

This section begins with the formal launch of the transformation program supported by Congressional approval of the proposed program.

4.2.1 Phase 1, Program launch

This phase is preparation for the beginning of Phase 2, which will deliver the first deployment. Phase 2 will be the biggest and most challenging deployment of the transformation.

There are many actions to be taken for this first milestone:

Leadership

- Establishment of the core, leadership team of executive board and other leaders and experts needed to plan, review and advise the development of system designs, final negotiation of development contractor and provider contracts that start immediately, initial staffing for leaders of the subsequent phases to participate the plan refinements, acquiring of necessary domain experts for the next phase, acquiring of initial office facilities for Phase 2 and growth, and general orientation and team development.

Start of development work

- Development must start as soon as possible on each information system that is required to be integrated and deliver an implementation to support the deployment of Phase 2 of the program plan. Some branches may involve groups of smaller, related projects that have immediate operational demand, along with the experts that must participate in the early work of this phase, and, probably, subsequent phases. Much of this should be based on preliminary plans from the proposal development effort.

Preparation of Central and State Operations

- The first deployment and anticipated, subsequent phase deployment plans must be published in anticipation of deployments.
- Growimg staff size, organization structures, office and equipment facilities, and orientation, and initial training materials must be delivered, for all administration and operational sites, central and state locations must be established in advance of the scheduled roll-put.
- This includes all of the central administration and operating staff and facilities, the reginal offices and the Oversight and Accountability organizations in each state, and liaison with local and state government agencies, and affected provider organizations must be ready to go according to the roll-out schedule.
- This means facilities, staffing orientation and training materials, job assignments, organization structures and so on must be developed and distributed well in advance.
- This preparation work will be repeated, at a somewhat lower scope, at each phase-deployment.

Mitigation of job losses

- Programs for mitigation of job losses should be initiated as phases affect persons employed by insurance companies and current, less qualified service provider employees.

Anticipation of subsequent phases

- The following sections describe a list of subsequent Phases, based on the associated populations and the benefits, requirements and claims, to be managed, for the needs of the particular members of the population.
- The sequence of populations and thus the suggested sequence of these phases, is based on the severity of need as well as early cost savings and other benefits, but the program leadership may determine the need to adjust the sequence or bundle some of the populations to improve the schedule, realize some synergy or efficiency, or reduce the number of deployments, by bundling. Each of the phases describe factors that influence the sequence and considerations specific to that associated phase population.

4.2.2 Phase 2, Develop and Deploy Medicare, Fee-For-Service, Parts A, B, D and Supplemental (routine and acute care)

Intervention for children through school engagement, paid for and coordinated by the regional offices, might be included in this phase because of its urgent need, or it could be deferred to a later phase (Phase 3).

Notes on refinements to Phase 2:

- Medicare is based on contributions to the Medicare Payroll tax starting at an early age of employment, so that the fund builds up in anticipation of increased costs as each individual becomes older. This conflicts with health care equity. Children and un-employed spouses must be covered, but they may not contribute until later in life. In addition, Medicare will improve compensations after this phase, but Medicare does not include children and unemployed spouses (until Phase 5?), as does most employer-paid healthcare.
- Hospitals that accept Medicare or Medicaid must be included in this phase to eliminate cost shifting and eventually restore hospitals in rural or other low-income areas.
- Medicare already has a Fee-For-Service mode of operation.
- Medicare is effectively acute care, but some disabled persons may be receiving marginally long-term services that should be “blended” with long-term care that is currently dominated and under-funded by Medicaid.
- Medicare has an established benefits package for a large number of, citizens. Medicare has processed claims that are grossly under-compensated, and they have a significant economic and social consequences on the diminishing number of medical professionals and persons pursuing new careers.
- Hospitals (typically rural) serving a high number of patients on Medicare and Medicaid, are going out of business and other hospitals are cost-shifting to raise the cost of

services to everybody else. Will hospital cost-shifting continue after Phase 4 (end of Medicaid transformation?

- A large portion of this population will transition to long-term care, but Medicare only supports “acute care.” There must be an orderly transition between Medicare and Medicaid, including persons who enter long term care, but recover or can be served by less expensive, less isolating and better quality of life than the current model of “long-term care.” Need to determine when and how the levels of compensation will be upgraded at least by Phase 5.
- Medicare currently incorporates added premiums for Supplemental insurance that covers some benefits avoided by parts A and B. This means that some services are denied, and the quality, and equity are denied for people who do not pay for Supplemental services. Supplemental insurance must be merged into the Medicare deployment.
- Supplemental insurance was a Medicare afterthought that was exploited, to cut costs (politics) and create insurance company profits. This should be resolved by making the supplemental-coverage subject to the recipient’s wealth or income, similar to, the Affordable Care Act. This should also apply to co-pays, deductibles, and limits on coverage caps, to be consistent with equity, quality and affordability, core objectives. This would resolve this violation of the implicit promise of Medicare.
- How/when does coverage extend to children? Based on parent(s)? as dependents? Lineage (DNA)? When does each have a patient record, at birth?
- The new system must extend coverage to all ages.

4.2.3 Phase 3, Develop and Deploy Medicaid and the Affordable Care Act (routine and Acute Care)

Medicaid and ACA are intended to address different groups of persons in need of health care services, particularly different financial circumstances, but the methods are difficult to reconcile in the transformation to a single payer system. There will be no intervening insurance company, there are currently many people who have similar economic challenges, but who should not be confused about their affordability to meet their need for services without adding to their frustrations or financial distress.

4.2.3.1 Policy issues

Program Recipient Qualifications.

Medicaid and ACA have different requirements for qualifaction for services, that may be addressed as qualifications for subsidies. There must be clear mechanisms/processes for transition between these qualifications (or consistent qualification for both) at deployment.

However, the criteria must be requirements regarding employment that are iconsistent with affordability.

Implementation of Subsidies.

ACA implements a benefit by communicating to the recipient's insurance company that a specific subsidy adjustment is paid against a pending charge before it is delivered to the recipient. That is okay, but, first, there will be no insurance company, and second, the current system aggregates the subsidies applied, and awards a tax credit for the cost of the subsidy—essentially a payment by reduction in the recipients tax return amount, *assuming* that the recipient will receive and tax return fee that will be reduced by the subsidies paid. That is not acceptable. They must keep the subsidy, because they deserve it, and it is not a debt. Don't play games with the tax return to take steal it back by reducing the return credit.

In addition, subsidies have a broader role when considered in the affordability of the consolidated system and the national citizenry, that may evolve and the circumstances of individual recipients evolve over a lifetime.

4.2.3.2 Medicaid

- This phase expands the Medicare population to include spouses and dependent children, so coverage is birth-to-death. This might have been resolved in a preceding phase as the expansion of Medicare age requirements. It must eliminate the financial boundaries for Medicaid, and it replaces them with affordability measures (see Section 2.4.1.4).
- This phase involves differences between states regarding qualifications for some benefits that are not always available and the economic requirements to qualify for services.
- These should all be resolved based on the objectives in Section 2,1 and, in particular Section 2.1.4.1. (subsidies). For all recipients including this deployment, apply Section 2.4.1.4 d for a consistent application of subsidies for accountability.
- The single payer transition must achieve the same, fundamental objectives without confusion or disruption in the delivery of services as people lose or gain employment or have a need for services that is confronted with confusion about what they must pay in the transition from transitioning from Medicaid or leaving poverty.
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4.2.3.3 ACA

Subsidies must still apply, but must be applied directly by the claim payment process. There is no need to claw it back in any way. Furthermore, the Medicaid financial rules about qualification for care, income and asset restrictions, and employment must disappear.

Essentially the ACA model using subsidies determines the qualifications based on the income-based subsidies. People are not required to remain in poverty.

- The Affordable Care Act overlaps with Medicare (routine and acute care), but generally serves a population of low-income people, primarily with capitated (rationed) funding, some of which is effectively converted to fee-for-services by contracts to, for profit, “insurance” companies. Not all states have adopted the Affordable Care Act, but the new system should address the same population, nationally, including people employed but with low income.
- The new system will not include a Medicaid match nor the same financial constraints on access to health care. The effect of the objectives (Section 2.1) will effectively expand the ACA provisions to consume Medicaid with same benefits as Medicare but with affordability subsidies based on income level (see Section 2.1.4.1).
- There is supplemental funding of grants or special programs, that is not part of the general Medicaid funding and are probably not equitably applied. These may be dropped, and incorporated as additional benefits, or left as independent government programs.
- There no longer, traditional capitated budgets. There may be some capitation-like expenditures where a group of people act as a team to serve a group of patient such as on a hospital ward.
- For mental health and disabilities, the care models tend to be forms of long-term care, including contracts with private hospitals and state hospitals for severe cases.
- However, hospitalization in general, hospitals should be within acute care which should include persons who are admitted for acute care, regardless, of Long-term status (equivalent to CMH admission.) There may be a distinction for persons committed to hospital services by court order due to security requirements, but not services provided.
- Medicaid long-term care must be blended with Medicare/Medicaid acute care so that appropriate services are provided in similar and/or different approaches depending on the patient disabilities and the specific care requirements. Much “health care” is delivered as institutional, residential care in various forms including group homes, and nursing homes, but many people could have more personal settings for assistance such as forms of family support with some family assistance and financial assistance.
- Medicare. Directly or indirectly, funds special grants or services that are rationed to selected recipients. These must be available to everyone qualified for the benefit, if they are essential to health care.

- Some of these grants not be necessary for health care or accommodation if they are appropriately funded under alternative funding sources, but they should be moved to other, state or Federal programs, and may be funded from the state funds Limited to recipient, special circumstances might be restricted based on criteria similar to the application of subsidies (see Section 2.1.4.1)
- The system will no longer support a health care caste system.
- The system will no longe create barriers to marriage and family life except as required by medical care.

4.2.4 Phase 4, Develop and Deploy Medicaid Long-term Care

- This applies to Medicaid for behavioral health and other disabilities, as well as services to the elderly, predominantly in nursing homes. These populations are the most likely to be served by different funding systems in different states. Mental health services are most likely to include people who may be in Medicare and/or routine or acute care and move to/from routine or acute car and long-term care. This may include specialized hospital benefits for persons suffering from a mental illness. This phase eliminates insurance companies in long-term care that may otherwise provide health care coverage to persons covered by both Medicare and Medicaid, which should ultimately be consolidated to the single payer system, benefit package. States currently differ.
- Long-term care covers persons who are elderly, seriously mentally ill, or seriously disabled, but the health care benefits and the care facilities are determined by their health care, safety requirements, required skills and practices of health care personnel and potentially consideration of social compatibility.
- Incarcerated persons may be included at the discretion of the state or Federal administration. But the cost, the continuity of care and benefit of therapy should improve behavioral problems and reduce recidivism, and potentially reduced incarcerated populations
- Jails should be included in the state regions in which they are located, but the inmates should be allowed to be cared for in whatever region they are in as if they were traveling in the region of the jail, thus maintaining continuity of care , potentially by virtual through collaboration of their primary provider and consulting team members. Ome Jails are already covered (in some states)
- Prisons and state hospitals are more appropriate as long-term care, and may have inmates from across the state, or across the nation. They may become “residents” of the state region in which the prison or hospital is located.

Who Qualifies

- Who qualifies for long term care in the new system without Medicaid restrictions and no restrictions under the state match? Again, this is determined by subsidies for affordability issue (Section 2.4.1.4). The practice of denying Medicaid because you are not sick enough, or because you difficult to treat, must stop. State hospitals should be restored as the appropriate facilities for long-term care persons who require restricted treatment facilities due to their threating behavior.

Better Living

- typical model for elderly is a nursing home. Not everybody needs it, or necessarily wants, a nursing home. The new benefits package must support alternative living conditions, are better for the person and reduce costs. They should, if possible, sustain social relationships and hopefully family relationships. Families should be enabled to include elderly member(s), in the family home as an alternative that does not impose a burden, financially or personal time or assistance except as by choice. Bedridden care might be considered for palliative or hospice care. Funding of part-time staff should be considered.
- Belonging in the family and other social relationships is very important to the elderly person's quality of life and sense of purpose, as well as mental health.
- Long-term care also applies to persons with severe physical or mental disabilities and mental illness. These may involve residential care or with family, or in a specialized residential facility. Residential facilities must include quality of life aspects of belonging, levels of Maslow's needs for personal satisfaction, and physical activity and social activities. At the same time, there must be consideration of health improvement, not just custodial care, waiting for death.
- This is true for persons with severe disabilities or a serious mental illness, both of which should include therapy of different forms. The current mental health system(s) focus on acute care and long-term care, are treated as maintained to achieve passive stability with little hope for improvement the rest of their lives. Their lives should include continued innovation, therapy and hope for a better life if not recovery. It can happen.

Coordinated Care

- Long-term care must be coordinated with the acute care to provide an orderly transition of people in treatment as their condition changes and they go into long-term care, or they return to routine or acute care.

Qualified Personnel

- Long-term care under Medicaid, tends to employ less qualified personnel, particularly for those suffering from a mental illness. This will be a factor in transforming these

services to the quality , equity and accessibility objectives of the new health care system.

- Long-term care should also be fee-for-service for accountability, proper funding and accurate patient records.
- This Phase deploys to patients in Medicaid Long-term care, however, not everybody in long-term care is on Medicaid. It must include other forms or funding for long-term care (i.e.., private pay). In many cases, people receive private, long-term care, based on an initial investment, and will switch to Medicaid when the investment expires, and the provider will then accept Medicaid. That should no longer be a necessary option, unless the patient desires more attractive or accommodating options.

4.2.5 Phase 5, Deployment to Recipients of Employer-Paid Coverage and Others

This phase brings the single payer system to a population that includes children and families, explicitly. After this deployment, the system may be opened to persons independently served by insurance companies, or who have no health care insurance. This may occur by individual decisions to replace the insurance-based coverage or otherwise, to join the single payer system services.

- Services to schools should be extended by regional offices providing for assistance to teachers for intervention with children and their families for students with evidence of problems in school.
- Intervention and potential enrollment in services must be established before this phase is deployed, so that everybody gets the same benefits.
- The employer cost of employer-paid, employee insurance becomes an employee raise when the employees no longer need that benefit. At the same time, the employer saves the cost of the insurance and the associated administration costs.

This phase may lead to the phase-out most health care insurance companies.

Plan B Ends

Consequences of Phase 5 Completion

- Children ,and families of employer-paid, populations
- Children in schools?

Ready for self enrollment of other persons other health care services

- Plan B is completed at the end of Phase 5.
- All the populations in Medicare, Medicaid, Affordable Care act, including Medicaid long term care, will have new contracts with the national provider network (the providers

- engaged through Phase 5).and submit claims to the new claim processing system against the enhanced Benefits Package.
- All beneficiaries of the new system will have the benefit of most of the Objectives of Part 2.
- On-going support, maintenance and assistance of deployed systems and service continue.
- This may be a decision point for continued deployment of Plan A phases and deployments.
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4.2.6 Phase 6, Provide populations in non-Govermental health care services, specialized clinics, persons-in-poverty, homeless, living with friends or families,…

- Admit them for health care when they show up or apply. No free ER cost shifting, hospitala must enroll the patient to submit claims. Regional office should provide assistance.

4.2.7 Phase 7, Develop and Deploy for Jails, Detention facilities, Prisons and Government Hospitals (State or Federal) and Clinics

- All of these become providers engaged by the particular residential treatment detentions, and prisons may be very similar to normal health care except for the setting.
- Potentially an inmate could have his/her visit the jail/prison for an appointment, assuming they are located near-by. However, that may not be acceptable to the physician. Better case would be that professionals in the vicinity would agree to make visits to serve a number of patients, potentially the same patients, as appropriate and bill for the additional time and effort. If there is a need for a specialist/ this might be a consultation with the primary (visiting doctor) or a visit similar to the other visiting doctor. However, at some time there will be needs for other services, blood draw,, x-ray, MRI, surgery, etc. Most of these may require a visit to a hospital or clinic, requiring special arrangements and approvals, if there are not portable or on-site facilities (potentially in large prisons(?). Thes might be similar to Medicaid long-term care, but with additional concerns level of medical care vs security care, and work-place conditions/security.
- Therapy is also very important for inmates, particularly those who might be more amenable as preparation for parole. Some might be group and some individual, but

most inmates will have some need for therapy. This may be more dependent on potential professionals nearby, willing to serve.

- These should all be included as providers in the state and region in which they are located. That will keep jail inmates close to home, assuming they are in the same county. The remote citizens may become associated with providers near the facility.
- Treatment of incarcerated patients should have benefits with enhanced compensation for the more challenging circumstances or patient behavior.
- Some persons who suffer from a mental illness may be quite functional in the community but cause disruptions that put them in Jail. With proper treatment and screening, these could be closer to a reasonable level of recovery, and potentially a reduction in jail population (cost savings).

4.2.8 Phase 8, Develop and Deploy for Citizens, visiting out of the country

- These people are presumably receiving health care in another country. The question is how can they pay for the services. Potentially they pay in person and bring back a bunch of bills. That might be addressed by a regional administrator to use a "special" process to translate the bills into benefit claims to an intermediary, or the patient for payment of each benefit. This is a matter of defining the process for translating and entering the bills to produce a compensation payment for the recipient. Not much involvement of the regular payment system or provider network.
- Consequently, there is a need to define the (alternative?) processes for consistent services to be available in each region where potential tourists live.
- This service might be incorporated in an earlier phase since it does not seem to require a formal deployment like other phases.

4.2.9 Phase 9, Develop and Deploy for non-citizens, legally in the country

This is likely to have political issues. Technically the issue is how do these people qualify for service, do they have a subset of available benefits, how are they identified and will they need special providers or assistance for communication or transformation.

This, as above, does not appear to require a special deployment, except there may be a need for coordination of recipients and providers to establish special accommodations and authorized providers.

Note that a primary concern is that there be large numbers of temporary workers or tourists in (or coming into the country who may need treatment in an epidemic and could be at risk of contamination of others.

5 Thought Leaders (References)

The following references to expand on certain enhancements to the operation, culture and treatment planning and benefits of the future, US Health Care System.

5.1 Healing: Our Path from Mental Illness to Mental Health,

by Thomas Insel, M.D., former Director of the National Institutes of Mental Health, Dr. Insel discusses his experience at NIMH, thinking he would find the medical cure to mantal illness, and realizing that the greatest need is to provide therapy, potentially complemented with medications, to heal the brain and effectively re-program the brain to restore healthy thinking. He is an active advocate for a new approach to cures.

5.2 Belonging: The Science of Creating Connection and Bridging Divides,

by Geoffrey L. Cohen, professor of psychology and James G. March Professor of Organizational Studies in Education and Business at Stanford University. It is about the importance of being interacting about things that are bigger than yourself (oversimplified) for people in mental health care and nursing homes, this is a major failure in having a meaningful life, but it also applies to everyone.

5.3 Maslow's Hierarchy of Needs, multiple sources, Google, Amazon.

Discussions of the hierarchy describe how satisfaction of the needs at multiple levels is important to leading to a more satisfactory life. Important for consideration of the importance of multiple aspects of a good life for people in poor physical or mental health.

5.4 There is Nothing for you Here: Finding Opportunity in the 21st Century,

by Fiona Hill, tells her personal story and reflects on the repeating, abandonment of large populations impoverished in countries that experience economic crises, redirect the economy due to new or abandoned industries and technologies such as out-sourcing manufacturing, decline in coal mining, and the shift from fossil fuels to renewable sources of electric power. We periodically create new towns in poverty.

5.5 Building the Agile Enterprise, with Capabilities, Collaborations and Values,

by Fred A. Cummins, retired Hewlett Packard Fellow and co-chair of the Omg Business Modeling and Integration Task Force, and advocate for health care reform. This book provides some insight on Value Delivery Modeling and Case Management, modeling of adaptive business processes.

5.6 I Am Not Sick; I Don't Need Help,

by Xavier Amador, PhD, past professor at Columbia University and New Your University. Dr, Amador is known for his book, that provides insights on how to communicate effectively with people who suffer from a mental illness, with anosognosia (without appropriate awareness and insight into their illness and reality).

5.7 The Crisis of Our Middle-Class Constitution,

by Ganesh Sitaraman, Alfred a. Knopf, New York, 2017. This is a history of the rise and fall of democracies, starting with the ancient Greek and focusing on the development of the US constitution and it's challenges to sustain democracy over the years. This history supports the need for a strong middle class that will not be overcome by the wealthy or elite, particularly thorough power to dominate the government. If you cannot find time to read it from the beginning, start at Chapter 2, page 59, that starts the focus on the American revolution and the formation of the Constitution. The framers knew the risks.

5.8 Object Management Group (OMG),

1) The OMG is an international information systems standards organization. Their main focus is on integration, interoperability of systems and modeling systems to model, modeling systems. The OMG, Health Care Domain Task Force has developed a variety of standards for the health-care industry, in cooperation with HL7, a major health care industry group. They have developed a number of standards over the years. Recently, they have been working on a BPM+ integration of process modeling for health care. OMG works on system modeling, interoperability and integration standards as a primary objective.

   A task force, Business Modeling and Integration, is responsible for several modeling standards of interest:

   - Business Process Modeling and Notation (BPMN)
   - Case Management Model and Notation (CMMN)
   - Value Delivery Modeling Language (VDML)

5.9 Coming Up Short: A Memoir of My America,

by Robert B. Reich, former Secretary of the Department of Labor under President Clinton, involvement in government and politics, in many ways for many years, with many leaders, an advocate for democracy and Professor of Public Policy at University of California, Berkeley.

5.10 When the People Speak: Deliberative Democracy and Public Consultation,

James Fishkin, Professor of Political Science and Director of the Deliberative Democracy Lab at Stanford University, California. Professor Fishkin has done extensive deliberative sessions, around the world organizing deliberative sessions with groups of people with diverse views on a political topic, and they reach consensus solutions. These have demonstrated how people can reach agreements on controversial topics through listening to each other, face-to-face, in a relatively short period of time. A conceptual model for politicians, and political problem solving.