Proposal for An Accountable Health Care System

Toward a More Perfect Union

Sunday, December 21, 2025, Draft

by Fred Cummins (fred.a.cummins@gmail.com)

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 the economic, social and quality of life issues. This ia an important step toward restoring the “middle class,” and providing health care that restores our ideals as the world’s beacon of democracy. Thus the sub-title.

There are two plans proposed in this document: Plan A and Plan B.

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 of this document, and principles of our democracy.

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, as a 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.

It does not achieve the economies or scale and the unification of the entire system, and it does not eliminate the waste, profit-taking, conflicts of interest and accountability failures of the remaining, un-transformed system. Consequently, Plan A must be complete with full benefits and savings, even if the end of Plan B is just a check point.

The difference between Plan A, and Plan B, is specified in Part 4, as a completion of the transformation through Phase 5 the limitation of the transformation phases presented in Part 4. Plan B stops after deployment of Phase 5, deployment of Medicaid Long-Term Care, that includes mental health. That includes Phase 3, Medicare expansion to eliminate the Medicare, lower age limit and to include the coverage for spouses and dependent children, starting with employer-paid insurance coverage, along with intervention for children in public schools.

The consequences of the expansion and certification of health care personnel, and the assistance to displaced personnel to provide opportunities for new employment will continue, along with expansion in various classes of health care personnel, particularly psychotherapy professionals, will take more time due to establish appropriate education for this significant expansion for mental health development and recovery for a wide range of unmet need.

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 nor the millions of people that want something more, mostly the most disadvantaged populations, particularly those who have not been part of the “middle class,” and those who have fallen out of the middle class due to circumstances beyond their control. In the meantime, more people are dropping out of the middle class. The system continues to deteriorate. Medicare is now a big part of the problem and Medicaid is an even bigger, growing problem. Medicaid is estimated to cover 88 million people in 2025.

This proposal specifies a new future for national health care. It is a dramatic change because there is no quick fix. Simple fixes fail to appreciate and fix the real problems, and failure to meet the needs, they just continues to make it worse. Initiation of education, staffing and benefits for psychotherapy is a major advance, extending beyond the phased deployments.

The Congressional Budget Office (CBO) has conducted a number of studies, over the years regarding single payer systems. The development of this document, used the May, 2019, report as a reference to consider it’s “Key Design features,” based on six countries” (Australia, Canada, Denmark, England, Sweden and Taiwan) along with “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

Table of Contents

Proposal for An Accountable Health Care System

Toward a More Perfect Union

Fred A. Cummins (fred.a.cummins@gmail.com)

1 Part 1, Why 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.

1.2 What is a single payer system?

A single payer health care system conceptually, is a government organization that manages the funding and payments for health care services for a whole country (or province, e.g., Canada). 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 systems, for example Canada has a different single-payer system in each province.

A new, national system is proposed here, that supports an integrated, full range of health care services, from birth to death, based on a single package of benefits and associated compensation rates. For the most part, the providers are independent companies, from a doctor's office, or technical medical service, to a large hospital or a government service, like the Veterans Health Administration. 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.

This single-payer proposal relies on a fee-for-service payment approach for accountability to ensure that the cost is billed based on delivery of the benefit received by the specific patient. There are many organizations and many levels of delegation, without accountability.

The patient record is updated with the benefit, the provider, the compensation amount, along with related information, such the diagnosis, the outcome and related notes. The payment for medications and some services may vary somewhat in specificity, but the result is a

compensation payment is made to a provider for delivery of a specific benefit of a specific patient, including pharmacies (i.e., Medicare Part D) that submit claims for payment to a provider for a service, including medications or other supplies. The current system disregards accountability for delivery of intended patient value.

There is a single, patient records system, and one national, registered provider system, so authorized providers can access their patient records from anywhere in the country, and the patients can obtain services anywhere in the nation, with selected providers and potentially providers can collaborate regarding a particular patient and view the shared record of the patient records. Much more will be developed in the objectives defined in Part 2 of this document.

This proposal has the following parts

1) Why a Single payer system
2) The future of US Health Care
3) Single Payer System Design Overview
4) A System Transformation Program Plan

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. 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 payers and thousands of health care providers with different groups of payers, subscribers as well as state laws and regulations. The information systems are fragmented and incompatible, and the benefit packages may be similar but are different. The compensation of providers for service delivery and other expenses vary widely, and many costs are out of reach for most low income or poor recipients. 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 quality of services, starting with those, at the bottom, 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." In this poverty population are 42 million people in the United States who rely on food assistance programs for their daily meals. This poverty should not exist in this country. There are an estimated 88 milion people on Medicaid in 2025.

Below is an example list of categories of people in this CASTE system, from the most wealthy to the most disadvantaged.

- 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
- Incarcerated People in Jails and Prisons
- Elderly Poor People
- Seriously Disabled, Low-Income people
- Moderately Mentally Ill People living with Families
- Families in poverty, without health care insurance
- 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.

Except for the first bullet (the wealthy), the next 5 bullets, ending before People on Medicaid, effectively represent the current "middle class." Members of the middle class are expected to be the voters who represent the super-majority of the nation's eligible votes, whose "one person one vote," is expected to overwhelm the undue influence and bias of the wealthy and powerful voters. Obviously, those 5 bullets list do not represent that expected "middle class."

- Some of the 42 million people on food assistance and the 88 million on Medicaid are not all of the poor people of the United States who are in the bottom level of the caste system. They are victims of a mentality that, if you can't afford to eat, then you only deserve charity, funding for survival needs, not equity, including health care.
- People at the bottom are suffering from poverty and homelessness, along with inadequate or no health care and mental illness.
- People who are employed may have Affordable Care Act insurance (Obama care) where payments are still made by insurance companies, and the recipients have terrible deductibles that can put them in poverty or, if they can't pay, they lose their insurance.
- 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) in an ACO (Affordable Care Organization) that is paid a bonus by Medicare for cutting 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 low-income people
- who 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** they may be at risk of health care bankruptcy.
- Seriously mentally ill people have a life expectancy 25 years younger than the general population (primarily due to poor health care). "Life is hell, and then you die."
- Medicaid 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. Furthermore, 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, physician appointments, etc.). This is exacerbated by politicians that insist that people on Medicaid get and report sufficient time on jobs, likely jobs that they can't keep or achieve a living wage.

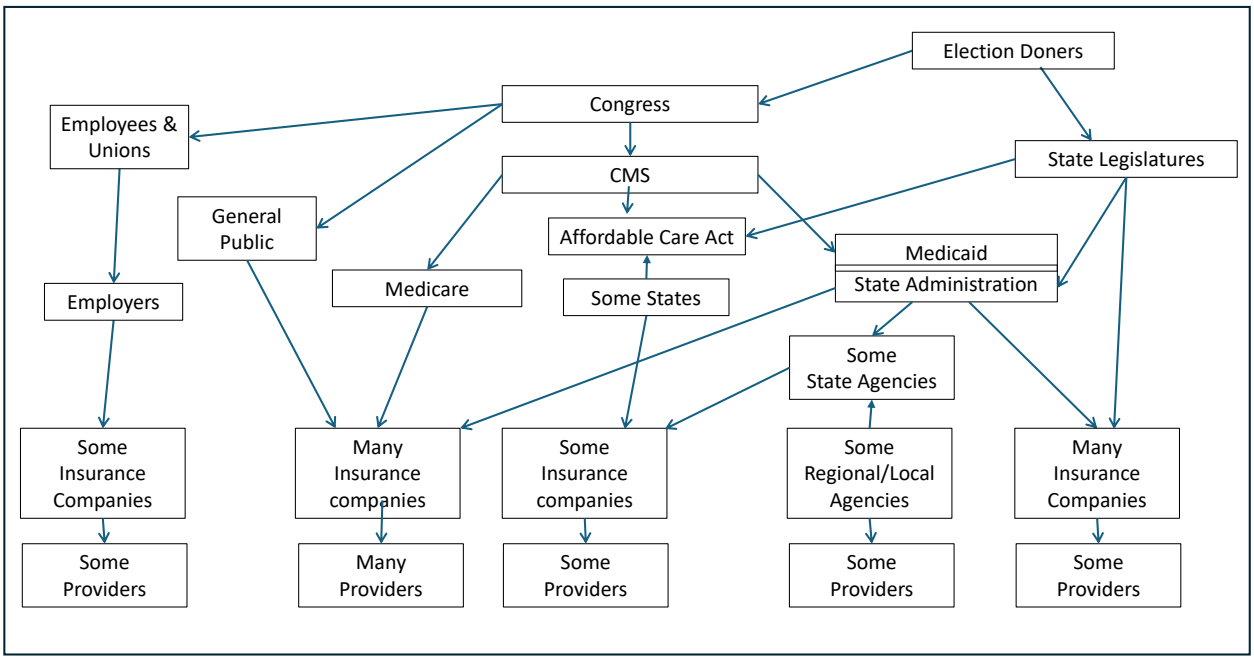
Together, this is a large population of people without much respect for our system of government, elections and capitalism. See references in Section 5

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 actually is (or is not) accomplished in the delivery of good health care services to everybody. No national assessment of provider performance, NOR accountability for value delivery.

The Un-Accountable Health Care Hierarchy



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, unless it becomes a national debt, tax increase issue. 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 bankrupt by health care bills. Many are victims of economic

turmoil: disappearing industries, corporate takeovers of bankruptcies, 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, unaffordable and unavailable to millions of people. State-regulated Insurance companies are typically payers to their own networks of providers, who will also be providers for other insurance companies as well. These insurance companies all have benefit packages that they regulate to ensure profit-making.

State agencies may pay provider compensation, but they are funded by Medicaid, capitated "rationing" budgets, and have no real accountability because they are not funded to provide adequate and appropriate services.

Many providers are also compensated, directly or indirectly, by Medicare or Medicaid, yet they are paid by insurance companies who are only accountable to state regulators and their boards of directors, for making a profit.

Congress, CMS, Medicare, the Affordable Care Act and Medicaid have budgets regarding what they spend, but they are not accountable for actual delivery of specific services, and potentially the outcomes. 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. That can happen, with the state-level Oversight and Accountability (O&A) agency(s) required by this proposed single payer system (See Section 2.2.6 and 2.2.5.2, Private Funding).

1.3.2.3.1 Insurance Companies Avoid System Accountability, and Much More

Insurance companies dominate the current system. They are integral to health care in the general public marketplace. 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, priority over quality care.

- Insurance companies create a barrier to accountability, disconnecting the levels of funding heath care from accountability for the services actually delivered (or not) to the people in need of services. This in reinforced by capitated (rationed) funding).

- Note the Un-Accountability Hierarchy in Section 1.3.2, Cost Sharing in Section 1.3.2.3.2, below. and capitated funding used at many levels in the un-accountable, CMS funding streams.
- Insurance company provider networks have influence over treatment choices to save money. Choice of provider is limited by a penalty for using an “out-of-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 there 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 actually deliver no health care, and they abandon people when care is needed the most (see Section 1.3.2.3.2 Cost sharing, and Section 2.1.4.2, Subsidies Are Essential)
- They are barriers to accountability, that foster poor care, cutting benefit compensation, 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 (causing fewer health service claims for patients, inmates and inmates and fewer unmet needs of homeless people.
- Psychotherapy is a new expense requiring more professionals, more benefits, more money, but better health, and potentially much less poverty.
- 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, that is 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

A 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 payment of 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 oversight process 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 at all levels as a practice and as a failure of accountability. It is endorsed by CS.

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 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 provider or the funding manager, or others up the management, (accountability) chain. Patients generally accept delays/denials of insurance companies as being the last word, because appeals depend on the budget manager accepting some responsibility.

1.3.2.3.4 Limited choice of provider

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

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, then 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 many people, most in need, 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 costs. Generally, Each insurance company has a 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, resulting in increased clerical cost.

1.3.2.4.2 Union Employees with Company Paid Group Policies

A union may participate in the insurance-company negotiations. Union members are just happy that their employers are paying the bill, even though, they may be getting bargain-rate coverage, with excessive "Cost Sharing" (ransom) 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 if they can't pay.

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 which will be exploited by insurance companies where employees don't necessarily understand the immediate/potential risks to them and their families covered in the benefit specifications.

1.3.2.4.4 Government Employees with Group Insurance

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 omission, reduction or denials of some coverage to meet the budget, where recipients have difficulty recognizing the difference.

1.3.2.5 Health care providers

State regulation of providers includes licensed professionals, 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, with 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 contracts with potential variations in terms for each).

Providers are essentially controlled by the funding of benefits by insurance companies, unless they are operating as an independent provider with direct employment by the recipient or a benefactor.

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 payer 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 approval 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, and their average cost of services, 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 considered in budget decisions, and the records are scattered all over, at least, all providers and insurance companies. However, the Medicare costs per patient are certainly captured and might be a consideration if the costs were a summary of the costs to individual recipients, and better yet if the cost of benefits needed, and delivered with outcomes, were reported. Such details are not currently available, but they are scattered over numerous insurance company and provider records.

1.3.2.7 CMS (Centers for Medicare and Medicaid Services).

CMS is managed by an administrator who reports to the US Secretary of Health and Human Services.

- CMS and Congress are responsible for the national health care caste system: a shameful, failed system
- Growth in poverty is the primary driver of the bloated costs of Medicare and Medicaid and the decline of the US middle class
- Failure to address poverty and mental illness that are large, expensive populations, should be addressed by a demand for a national focus on recovery from both mental illness and poverty.
- There is a need for mental health focus on children regarding early signs of mental distress or illness and the incidence of bullying, suicide and mass shootings by current or prior students. The education system requires increased attention to the development of young minds and mature, healthy adults. This is a health care issue.
- Absence of traceability and accountability is responsible for out-of-control budgets. Fee-for-service billing is a fundamental enabler of accountability.
- Capitated budgets are fragmented throughout the CMS systems resulting in inadequate funding, poor care, inadequate compensation for mental health personnel and a total failure of accountability from top to bottom.
- There is no interest in delivery of the proper value of health care benefits with timely, adequate and appropriate services.
- Insurance companies are a major contributor to the high cost of health care, lack of accountability and conflicts of interest. They are contributing to a national decline in the quality of health care and increases in long-term care and premature deaths.
- CMS fails to even think about the basic objectives defined in Part 2 of this proposal to properly serve the interests of the people.

- No progress in recovery of individuals from poverty and mental illness. These populations are a major responsibility, and a major impact on national and state budgets. These populations suffer from unacceptably poor quality of life, and they both require psychotherapy for recovery, and none is provided.
- Failure of mental health for children, failure to develop brain for preparation for adulthood and realization of the American dream (not greed, wealth and power vs democracy).
- Hospitals in low-income and rural areas are going out of business because they can't afford to pay Medicaid and Medicare compensation and give free care to people in poverty. Professionals are staying away from these areas because then compensation is too low.
- Successful hospitals are being consolidated into large corporations for profit. Many of their communities built these hospitals as non-profits and their focus is now on national corporation profits.
- The national health care information systems are fragmented and inconsistent, resulting in increased administrative costs and no national health care database for monitoring fraud and improper practices, denials of care, and outcomes, as well as epidemiological analyses for early recognition of epidemics and other health trends.
- Degradation of the capabilities and contributions of health care professionals and minimum-wage direct care workers through inadequate compensation and budgets that restrict the quality and availability of services. CMS encourages insurance companies and providers to cut the cost of services to save money and ensure profits. The health care workforce is declining in quality and numbers.
- There are millions of people without health care insurance who are at risk of serious illness and poverty if they are not already in poverty.
- States have a conflict od interest in accepting Medicaid funding because, if they do not fund the Medicaid match, they will lose Medicaid funding for everyone served by Medicaid in their state.

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. The budgets are cost controls, not planning estimates.

CMS takes no responsibility for the equity, quality, affordability, and accessibility of the benefits delivered to the people served. Medicare does respond to present service complaints, but Medicaid delegates that responsibility to insurance companies or state agency budget-control managers/payers.

1.3.2.7.1 National Health Management Problems

The following are health care delivery issues that are the responsibility of CMS and Congress.

1.3.2.7.1.1 No Budget traceability to service delivery

The Medicare budget is national. The rest, Medicaid and ACA budgets, are essentially rationed to states, and then, by each state, the state budgets are rationed again, through subsequent delegations until it reaches a 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 for specific patients, by various interests, the least of which represent the actual needs of the persons to be served. The primary concerns, are cost control and profits, not satisfaction of needed value to the patients.

1.3.2.7.1.2 Intervention Avoided

Many persons in need of services are avoided 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 psychotherapy to resolve mental disturbances and misunderstandings. Incarceration provides an opportunity for intervention, as well as temporary hospitalization that does not "qualify" for Medicaid when discharged." There are many who need services but there is no outreach to engage them.

Capitated budget managers don't care, because they already have too many patients. Intervention would mean working to get more patients, and they would break the budget.

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 plans and priorities.

1.3.2.7.1.4 No Psychotherapy

Particularly in long-term care, the transition to long-term care is a major life event. You leave your family and friends behind, you leave your way of life behind, and you need psychotherapy to cope. If you suffer from a mental illness, you already need psychotherapy, but the need is more intense if you are hoping to return to a more normal life, with many new challenges due to limits of recovery. There should be a focus is on need for adapting the mind from physical or mental trauma or other neurological disturbances then to find a new purpose to pursue.

In any case we must recognize that Maxwell's needs hierarchy still applies, although the solutions 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 psychotherapy to address Maxwell's level 3 needs. People have meaning in their lives from the environment in which they live, the activities, and relationships with shared interests and purpose relationships, and who you are. Patients lose much of this when they go into long-term care, and patients are 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 require 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, physician visits 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.

1.3.2.7.2 Fundamental Systemic Problems

1.3.2.7.2.1 CMS Does Not Care about Accountability.

Apparently, Congress does not want to hear about it either.

- 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 people 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 find better-paying regions.
- Larger hospitals in more affluent areas are doing fine, but they are now shifting the losses from the 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 people delivering health care services.
- Need appropriate compensation for expertise and commitment
- Downgrading of professional certifications and roles to cut costs
- Need leadership to strengthen objectives and accountability.
- Need leadership to optimize outcomes.
- 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 (no accountability to face reality).
- 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.
- With no accountability, the whole hierarchy, politically, rationalizes that care is poor because the federal budgets are all we can afford. (of course, we still pay the insurance

companies their cost for cutting costs, business operations and their profits). Insurance companies are the primary barrier to accountability. That is the way those who should be accountable like it (including CMS and the insurance companies). Without accountability, the system will remain broken, and it may get worse.

1.3.2.8 Medicare

Medicare was originally created to serve retired people. The funding is primarily a payroll tax on all taxpaying employees 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 achieve a greater aggregation as each contributor gets older, and have anticipated, increases in health care costs. Beneficiaries are not eligible until a retirement age, but some disabled recipients become qualified earlier which increase claims but reduce the fund growth.

Medicare has been expanded to cover a younger age, and Medicare coverage has also been opened up for people with severe and persistent disabilities, depending on age of onset and other factors.

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 CMS and the insurance companies.

Medicare delegates all benefit payment management to insurance companies for fee-for-service payments based on the insurance company benefits package, but, apparently, Medicare takes no advantage of these records to face the reality of where the money is actually delivering services, or not.

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 insurance policy. Then Medicare Part D (medications) is also separate, and Advantage plans 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 ACO groups of specialties for economies of scale. However, the

real incentive is that Medicare will award bonuses to the ACO, and implicitly the members, for cutting costs, effectively raising savings while cutting quality.

This is not just an incentive for individual doctors, but it creates a community of doctors with a shared financial conflict of 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 an illegal conflict of interest.

1.3.2.9 *Medicaid Budget*

1.3.2.9.1 State Allocation and State Match.

Medicaid allocates the national Medicaid budget (including ACA if adopted by the state) to each state, based on ”need,” and the state funding match. The state internal budget is another level of capitation (rationing) to the state’s different programs, such as elderly, developmentally disabled, seriously mentally ill, persons in poverty, as defined and organized by the state legislature and the state government administration. From this point forward, each state is different, but, of course, with 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 the general Medicaidbudget (another capitation.

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 should be prohibited. For example, denial of a surgery benefit because “the condition is not bad enough yet,” could be regulated as an intentional risk that the patient will suffer a more serious onset, maybe a risk of death (death costs nothing).

Nevertheless, legislators do have significant control over the Affordable Care Act and Medicaid which are both funded by the state Medicaid budget. The state legislate does not control the Medicaid budget, so they are “not responsible.” 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 reducing 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, then the potential return is reduced or eliminated and some or all of the subsidy is reduced or eliminated. Section 2.1.4.2, Subsidies are Essential.

Note that the ACA subsidies do not meet the objective of "equity" in Part 2. There are too many factors involved in determining the amount of the subsidy depending on the policy category and further adjustments involve additional or or reduced costs to the recipient (see Section 2.2.4.2.3).

1.3.2.11.1 Cost Sharing

The major ACA cost control "Cost Sharing" See Section 2.2.4.2.3). When the recipient's total out-of- pocket cost reaches a certain threshold, that invokes a super-cost, deductible (ransom), that must be paid in order to continue further coverage. (see Section 1.3.2.4.1). That saves money for the insurance company, but it severely cuts health care for recipients that need it most, and they can't pay the penalty they lose their coverage. If the penalty is paid, the benefit claims are zero until the end of the policy year, then 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

Medicaid other than the Affordable Care Act allocation, 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.

To qualify for Medicaid, 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 recipients responsible for the cost of their services, but since the budget is rationed, their cost may just be their share of a program pot regardless whether their care actually cost mor or less. The insurance company may actually use a benefit package for payment for services, but the payment authorizations are managed to comply with the budget, including profits. (no Medicare accountability). Neverthe less, the patient owes their rationed share of the budget, so that is what they pay back if they ever get out of poverty or die (not in all states, but acceptable to CMS).

Clearly, Medicaid is not accountable, nor is any organization down the Medicaid funding chain. Accountability would expose all levels to shame, at the risk that Congress would find another quick fix to obscure the problem. See the Objectives of Section 2.2.

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

1.3.2.12.2 Medicaid Systemic 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. States accept that the budget is all they can get, and they appear to be correct, but the manage to pay the budget match (Ransome?) to get what they can.

1.3.2.12.3 The Medicaid Debt Trap

Medicaid (in many states) captures the costs of care for each recipient, and it aggregates a 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 nothing 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.
- Whie a recipient accumulates a debt for bad services, their family, or other benefactor is not allowed to better care, because that would be "income" that would violate their Medicaid income restriction and they may lose their enrollment, and their health care coverage, which of course they depend upon.
- A Medicaid debt is ultimately due on death of the recipient, 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 sale of the house or death of the spouse, and there is likely nothing left for the rest of the family who may have suffered debts 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 get 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 (sometimes amended), annual (capitated) 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 the state administration viewpoint, 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)

Medicaid also pays for special programs through waivers for specialized services. These come out of the budget, but the accountability for recipients is determined by the state Medicaid administration.

1.3.2.12.5 Medicaid State Agencies

Each state determines how to manage its 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 engages insurance companies or directly with providers of various services. Regardless, they end up with more capitated budgets 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

If they have Medicare, and they qualify for Medicaid based on their income and assets and they he have a qualifying need, they can join Medicaid, without losing their Medicare. Essentially, they have health care coverage for part of Their “benefits” from each, presumably with Medicare primary. The difference is that Medicare has poor benefit compensations, but better benefits, but they likely drop out if you get Medicaid long-term care.” But it is possible to get assistance from both Medicare and Medicaid together, but they both will both take their share of the costs back if there is a relevant lawsuit award for the cost of your medical injury.

This program will be replaced with coverage that is unified, affordable and equitable.

Dual eligible coverage will be replaced by better and less complicated form in the new, national system.

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. This program will be replaced by better, unified coverage of the new, national system

1.3.2.12.8 Quality of Care

Medicaid recipients are, for the most part, members of the lowest levels of the health care caste system and with the lowest level of health care coverage. The new system will not be a caste system. Currently, 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 may 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 to be income, and the recipient could be disqualified for continued Medicaid services. In addition, many doctors are warned not to accept Medicaid patients privately. Essentially recipients are stuck with underpaid doctors associated with Medicaid insurance companies.

Medicaid health care will be replaced by a affordable, equitable health care coverage from the new, national system.

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/continuity with community providers from before and after incarceration. Other states may just interrupt the Medicaid coverage during incarceration, and that may result in unnecessary gaps and 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.

Under the new, national system, inmates should receive unified health care coverage before, during and after incarceration. This will save states and counties a lot of money. This should include psychotherapy to help them return to their community with a better outlook and quality of life with needed Benefits

Many inmates are excluded from Medicaid coverage while they are incarcerated while incarcerated, depending on the state. Their health care is provided by the jail or prison. Their care should be overseen by their stat's O&A agency.

Frequently, a person's condition is not severe enough to merit care, particularly a person with mental illness that is not a danger to self or others. 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 course this would likely increase the state, Medicaid funding match.

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 may 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 of 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 people 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 Guardianship

Many people, in long-term care, do not have the mental ability to represent themselves for legal, financial 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.

If you anticipate that you may need a guardian to make your decisions in the future, there is an alternative, while you are still competent to make legal decisions. That alternative is a "power of attorney" document. The document assigns decision making authority to somebody you trust. The authorization may be for one or more types of decision. There could be multiple documents

to assign different decisions to different people. Of course, you must establish that you are still competent to make the decision to sign the document.

1.3.2.13.2 Public guardians

A public guardian is typically a lawyer (selected from an authorized pool) to make decisions, such as medical decisions for the ward, that a health care professional is not allowed to make. This applies to many people in long-term care, particularly elderly and mentally ill patients. The status, role and compensation of a public guardian depend upon the state and the presiding judge. 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 and periodic, financial review by the court. A guardian makes decisions, and may take some legal actions, and will charge the ward's assets, unless the ward has no assets, then the services are essentially charity, and the guardian will create a debt account to aggregate fees for the guardian's services. If the ward gets money, then the guardian will pay the ward's debt. The guardian is effectively in charge of the ward's assets) any debt account is charged 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 the result of an auto accident that caused debilitating injuries and gets lawsuit-award for damages. Of course, Medicare and/or Medicaid will collect the medical bill award first.

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. 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, a nursing home budget is capitated, so there is no tracking of individual diagnoses, delivery of services and outcomes. Medicaid will use the capitation, average cost to compute the patient's lifetime debt. See Section 2.2.3.10.2 for future guardianship, oversight and accountability.

1.3.2.14 Psychotherapy for a Better Future

Psychotherapy 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. In the future, psychotherapy must be recognized as a legitimate health care treatment for various forms of mental disability, trauma or stress, particularly if a recipient does not understand their need for treatment.

Psychotherapy is a new perspective on mental health care., (See Reference 5.1), and Section 2.2.7 for Mental Health Strategic Objectives).

2 Part 2, The Future of US Health Care

This Part is focused on the requirements for a reformed health care system. The requirements cannot be met as incremental improvements, because the core structure of the system is flawed and unaccountable.

First, we consider Maslow's needs hierarchy as a model framework of individual needs to realize levels of quality of life, that may be enhanced by their receipt of appropriate health care.

2.1 Maslow's Needs Hierarchy

Maslow's needs hierarchy, depicted in the diagram, below, represents the needs of individuals to achieve levels of satisfaction of a quality life. The satisfaction of these needs depends upon the individual and their personal challenges, interactions, and interests within the context in which the individual lives.

There are many factors, but here we are focused on health care as an important factor in that environment, particularly the delivery of health care in the United States including mental health. The delivery of health care depends, indirectly, on many other factors in the environment, including the economic issues, health care technology, environmental conditions and events that affect health care needs, the health care technology, the health care work force, the network of health care providers, the suppliers of equipment and medical supplies and facilities, such as hospitals.

The environment also includes many other government services, national and local, that affect the individual quality of life, and are linked to the health care system, because they are involved in various ways with individuals who may need health care or who need for health care related to these government services, such as criminal justice, regulators, social services, social security, and more. The health care system must collaborate with these other services to provide appropriate integration for the individual and the community.

2.1.1 This is a Personal fulfillment Hierarchy

Maslow's hierarchy is not a wealth-hierarchy, although poverty is associated with level 1, and the potential to achieve the higher levels. However, you do not need wealth to achieve the other levels, just ambition for personal fulfillment. That fulfillment need not have a national or global effect, but rather an inspirational level of accomplishment to the individual.

In colonial America, you could be a small, independent farmer and achieve level 5 among your family and community, and that is still possible for many ambitions. You could be a struggling artist, a journalist, a priest, a volunteer, and achieve higher-level needs. You could be a political

prisoner or a refugee, but you could still satisfy needs at higher levels. At the same time, you could be a billionaire, and fail to get to level 3.

Maslow's Needs Hierarchy

Maslow's needs hierarchy depicts the priority of needs starting at the bottom and rising in levels of personal fulfillment. People at the bottom the health care cast system are at Level 1 of the hierarchy.

However, level 1 does align with bankruptcy, poverty, and homelessness. Health care is some of those physiological needs, including mental health, and it also aligns with other needs near the bottom of the health care hierarchy, discussed later.

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

Health care is a fundamental factor in the satisfaction of the needs of Maslow's hierarchy, Consequently, Maslow's hierarchy provides a context for the delivery of health care to mitigate the impact of poor health and the delivery of health care to enable individual opportunity to satisfy Maslow needs. Of course, there are other critical needs that must be addressed for people to escape from poverty and return to a satisfactory life after rehabilitation from a serious mental illness. The cost to address these additional needs should be substantially offset by the savings in health care costs for these disadvantaged people.

In the Unted States, everyone should be able to achieve Maslow's level 3. That is effectively the bottom of the "middle class," and the "American dream." Wealth is desirable, but it does not, necessarily, get you to satisfaction of level 3, or higher-level needs.

2.1.2 More about Maslow's needs hierarchy

The following hierarchy outline suggests how the delivery of health care, particularly in long-term or care as well as mental health, is important for individual, successful satisfaction of Maslow's needs hierarchy.

- (1) Physiological Needs
    - This begins with nurture of a child.
    - These needs must be addressed, but they are much more than health care needs. They are essential to good health, but not sufficient.
    - These needs depend on sustained health, that means individual responsibility for personal risks and behavior, but also responsibility for health care for mitigation of health risks and exceptional health care needs (illness, injury, trauma, etc.). This requires a basic level of satisfaction for survival to enable progress toward the other levels.
    - Level 1 is the essential foundation of the needs hierarchy. It is survival with social assistance for people who are in poverty or suffering from serious disabilities, including aging and other mental disorders.
- (2) Safety Needs
    - These needs are more related to the environment, and thus they are primarily government and community responsibilities except as safety depends on individual behavior, risk, and relationships. Safety may also be at risk if the household suffers from domestic violence.
    - If a patient requires "custodial care" when in the hospital, in rehab, or in long term care, these needs must be addressed as a component of health care that exceeds the normal needs of independent living.
    - Satisfaction is important to achieve level 3.
- (3) Love and Belonging
    - Belonging expands to serving and building broader relationships and appreciation of individual contributions, collaboration and leadership. This requires contributions to interpersonal and community relationships, that may involve talent, skill, empathy, friendship, and charity.
    - These require health care that responds to mental health needs, in order to develop and sustain human relationships and collaboration, interacting with others, and coping with conflict.

    - It would seem reasonable that the United States “middle class,” representing a large majority of voters, would be within level 3 and above: economically stable, employed, socially active, adult population. The middle class may extend to the top of Maxwell’s hierarchy, the “American Dream,” but, in general, the middle class (intentionally defined by the country founders), does not include the wealthy or powerful voters who are biased by their wealth and/or power, or their aspirations. (See Reference 5.7, regarding the middle class).
- (4) Esteem
    - A need to have a personal purpose
    - This requires self-respect, pride in skills, knowledge and accomplishments, and it calls for interpersonal respect.
    - Health care providers must respect the recovery need of individual purpose to inspire recovery.
- *(5) Self Actualization*
    - This requires the opportunity and passion to aspire to achievements that are, or will be, within the individual’s mental and physical capability, are based on a passion to address their sphere of needs and to enhance the lives of others.

2.1.3 Psychotherapy and Maslow’s Hierarchy

Maslow’s hierarchy includes aframework of needs for Belonging and Finding personal purpose/aspiration, and passion, to contribute to improved lives, that is bigger than self (e.g., contribute to a better world)

Wealth is not the goal, per se, but is a resource for altruism (Bill and Melinda Gates foundation, Warren Buffet), Managing inspired employees, research for understanding/improving a challenge, true government leadership, non-profit endeavors, public service, volunteerism.

This proposal leverages this Maslow’s Needs perspective to focus on how health care, and particularly psychotherapy, will support the improvement of individual lives and the lives of others around them.

Section 2.2.7 will further explore Psychotherapy strategic issues.

2.2 Health Care Reform Objectives

The essential role of health care delivery is reflected in the following strategic objectives of a reformed health care system discussed in the following sub-sections.

- Health care as a human right

- Health care equity
- Health care quality
- Health care affordability
- Health care accessibility
- Health care accountability
- Health Care Efficiency Management
- Strategic Health Care Priorities

2.2.1 Healthcare As a Human Right

There is a human right that may not be explicit in the Constitution, but it is no less than the right to national defense, and rights to police and fire protection, without charge as well as a right to clean air and water. There is clearly a right to protection from infections and pandemics in our globally integrated world of commerce and tourism.

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.

We expect everybody to have police and fire protection without deductibles. We have roads and bridges that givesus 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, national defense, and they seldom suffer from lack of health care, personal bankruptcies, and poverty from lost jobs.

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

2.2.2 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, wealth or other suspect categories as well as 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 **choices.** 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 and potentially enabled for belonging, purpose and passion (Maslow levels).

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 their respect for the needs of the persons they serve, as well as the desolate circumstances under which they are required to deliver care and achieve their personal fulfillment. This is a provider leadership, responsibility and must be reflected in the provider obligations and recipient services.

The current system ignores equity. Equity is impossible when the system is dominated by insurance company cost controls, capitated budgets and profits, that are determined by politicians and bureaucrats who have no awareness nor 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 health care reform objectives: equity, quality, affordability, accountability, accessibility, and advances in psychotherapy.

2.2.2.1 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, decrease the cost or deny coverage, in order to cut costs, and ensure profits, including "Cost Sharing." There must be one national benefits package, and no cost sharing (see Section 1.3.2.4.1), Cost sharing is a violation of equity. It clearly discriminates against economically disadvantaged recipients by defining a cost threshold where they must pay a large deductible or lose their benefits. The national benefits package is the foundation of health care equity. See Section 2.2.4.2 regarding affordability as an aspect of equity).

2.2.3 Health Care Quality

There are many factors to be addressed for health care quality, discussed in the following sub-sections.

- Federal leadership and accountability
- Psychotherapy for Mental Health
- Quality of life
- Treatment based on professional judgment
- Professional collaboration
- Early Intervention
- Health care Culture that cares
- Quality improvement oversight
- Direct care certification and compensation
- Restoration of professional qualifications
- Long-term care model

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”).

2.2.3.1 Federal leadership and accountability

Quality requires top-level leadership. This means leadership gives high attention to the advances in health care technology, practices and pharmaceuticals, and is accountable for the appropriate delivery of health care services that properly deliver current and advanced health care capabilities with accountability.

Consequently, top management must be advised by experts in health care practices, technology and pharmaceuticals. Then appropriate changes must be made to the benefits package, affected providers must be represented in the development of guidance in the consistent changes to practices, and the state Oversight and Accountability agencies must be informed regarding appropriate issues in the appropriate delivery of affected benefits.

National medical leadership is needed to evaluate and gain insights to maintain and disseminate new technology and practices, and to assess outcomes to discover and evaluate current, innovative and clinical trial practices for improvement. Using analytical computer tools to exploit the depth and breadth of the national patient records database (with secure, and restricted pivacy/confidentiality and authorization controls).

2.2.3.2 Quality of Life

Health care must serve the whole person from a health perspective. This must also be considered in the context of Maslow's needs hierarchy, discussed in Section 2.1.

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. Thus, health care is critical to achievement and sustainment of higher-level needs.

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 5.3), and "Belonging," (Reference 5.2) 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 Section 2.2.7, Mental Health Strategic objectives.

2.2.3.3 Treatment based on professional judgement

The current system constrains doctors in many ways. They are underpaid, by restrictive benefit specifications, payment practices and under-funded compensation, and by Medicare, and by Medicaid by 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 should 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.*

2.2.3.3.1 Potential Limits on discretion

There should be some limits on discretion, particularly high risk or high cost. Some constraints should at least raise 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 the most effective due to their side effects, their personal DNA, or other conditions or circumstances. Physician discretion is essential for quality health care.

Consider the following options for doctors and possible variations for other professionals:

- Give the doctor an expected, typical compensation, but then allow the doctor to adjust that to reflect the increased cost of treatment and/or support required.
- The doctor must record the reason for adjustment and the expected outcome in the patient's record. For significant alternatives the doctor would be advised to (1) consult another doctor, preferably a specialist, for consensus also recorded. This could be a phone call. All of the patient's records are immediately accessible in the national system. Maybe the doctor 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) maybe a (referral?). In any case the specialist gets compensation for his time and expertise. The health care issue is quickly addressed, without unnecessary delays, and, possibly, a good outcome.
- Alternatively, the doctor knows a quick and inexpensive fix, but this patient is not typical, and s/he is aware of an alternative procedure that might have a significantly better outcome, with faster recovery. In all cases, the proposed discretionary treatment should be reviewed, along with benefits and risks for the patient's approval.
- In the patient's record, the doctor reports the proposed/selected alternative plans, their reasoning, and the expected beneficial outcome to the patient. The doctor includes the additional compensation, if any, and that of the specialist and the expected outcome. After the outcome is clear, the doctor again reports the actual procedure and the outcome, along with the consulting specialist. If 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 doctor or other 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 consulting with specialists, as well as treatment planning and collaboration with treatment teams (see Section 2.2.3.4). This should be an explicit, billable benefit, or incorporated in a more complex benefit. It should be noted in the patient's record and entered in the doctor/provider performance record.

2.2.3.3.2 Current Denials of 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 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 regardless of health care needs or medical consideration. Generally, these are budget/compensation decisions (not professional).

2.2.3.3.3 Treatment options

A benefit package should identify treatment options for a recipient decision or doctor's discretion. These might provide differences including the diagnosis, type of procedure, the risks, the possible outcomes and rehabilitation duration. These might be options on one benefit or alternative, linked to alternative benefits. The patient must be informed of the alternative(s) and give informed consent if there are concerns.

The doctor must document his/her recommendation and the recipient's choice in the patient's record, followed by a report of the outcome.

2.2.3.3.4 Primary Care

Primary care is a practice for a primary care provider/professional/physician (PCP) to coordinate the care of a patient to address the needs of the whole person. This may involve a patient with only one doctor with a role to monitor the patient's condition, monitor and treat recognized, various minor infections or injuries, the annual health exam, and possibly provide specialized care for one condition such as a pediatrician, cardiologist, internist, or other specialty. In any event, the PCP is responsible for engagement and coordination when there is one or more other specialist(a) to ensure that the specialist(s) treatments are compatible and potential interactions are recognized and considered by collaboration. The PCP need not be a specialist, but as a doctor, s/he must be knowledgeable as a doctor to have the expertise to address minor infections/injuries, and to understand when a condition calls for the expertise of a specialist.

Unfortunately, the role of primary "provider" (PCP) has included certified nurse practitioner or physician assistant, who is authorized to write scripts and provide PCP care for multiple patients. This is particularly attractive for long-term care where an actual doctor may be occasionally present for face-to-face contact with the patients or grand rounds, or on call if there is something the acting PCP realizes s/he cannot handle. This arrangement is obviously a cost-saving technique, where patients and families are likely unaware of the lesser level of competence.

The role of PCP should require that the PCP is a medical doctor who actually supervises the "assistants" and actually sees the patients, (more than an annual health check) to properly recognize when the primary care requires a doctor, or participation of a specialist. Apparently, there are also PCPs who are "doctors" who are graduates from abbreviated medical curricula, presumably so that their education is cheaper and they get paid less.

If a patient has multiple conditions, involving multiple specialists, the potential complexity of the case increases. If the complexity increases or involves more specialists, the PCP should develop a treatment plan, in collaboration with the specialists, which may include levels of need

for interventions beyond monitoring by the PCP, along with expected outcomes if there are treatment changes for one or more condition(s) being addressed.

This is all good. The PCP might be the PCP for multiple patients, particularly patients served in the same long-term care facility, who may involve nurses or other professionals in the monitoring of patients and their routine needs under the care of the long-term care doctor. The doctor is still in charge of the treatment decisions and coordination of treatment plans that may include other specialists, therapists, or other professionals. There could be multiple doctors with the same specialty for different patients with the same PCP. This is (sometimes?) the real world in private practice.

If nothing else, there must be formal restrictions on the roles and authority of a non-physician PCP and required review of their treatment decisions and scrips written, along with the formal oversight responsibility of the "real PCP" physician.

Collaboration is a key aspect of the primary physician role, discussed below. The primary physician should collaborate with specialists treating a patient, or a specialist consulted as an expert regarding a patient's diagnosis, treatment, or participating in the development of a treatment plan for a patient with complex needs.

2.2.3.4 Professional Collaboration

Professional Collaboration is particularly important in complex or evolving cases

Collaborations should als0 be routine if a treatment plan is not necessary, and the treatments of the associated specialist(s) are relatively stable. Collaboration should happen with appropriate specialists when there is a significant change in the care or treatment of the patient, particularly when the PCP is not specialized in the condition under consideration, or the treatment is a matter of discretion or other exception, and a specialist should concur with the treatment decision and the expected outcome.

All collaborations must be documented in the patient's record, including notes from the collaboration and the outcome expectations, and actual outcome(s) when the procedure/treatment is completed. The "real PCP" may delegate responsibility for coordinating consultations and drafting meeting notes and treatment plans, along with day-to-day oversight and interaction with patient and treatment of minor conditions.

Consulting doctors must each be compensated for their time and expertise. 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 be billable. A primary doctor is

ultimately responsible for treatment decisions except as a particular treatment or procedure was recommended by a specialist who has responsibility for recording collaborations and consensus in the patient's record.

The collaborators will depend on the situation and judgement by the primary physician, with patient, informed consent.

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

Remote monitoring can provide continuous monitoring of a patient, living at home and living with family or support staff. Monitoring services that actively track a remote 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 by somebody on the scene with a brief synopsis of a problem about somebody in distress who the operator knows nothing about, nor what the caller may observe. First responders only learn more about the patient's medical conditions when they arrive at the scene. Active, remote monitoring may be a significant alternative to 911 for residential, nursing home care or for patients who have remote monitoring at home or on their person.

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, most of these patients are currently served by Medicaid, and such attention is not likely to happen. Too often, they only receive attention for one of their conditions. They don't have specialists because that is too expensive and inconvenient. Typically, they don't receive 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. The new system will not be burdened with both Medicare and Medicaid inadequate funding, and the Oversight and Accountability (O& A) agency will be watching for unresponsive services and may require monitoring devices or staff arrival to identify inappropriate delays.

An equitable health care system will identify a primary care physician, who, as needed, will 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 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.

2.2.3.5 Early Intervention Is Good Health Care

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

2.2.3.5.1 Physical Health Early Intervention

Examinations for early intervention are generally accepted in physical health care. However, this may not be adequate in long-term care since Medicaid is a common funding source, and routine diagnostic procedures are avoided as extra costs, particularly in care for serious mental illness and incarcerations.

Early intervention currently is a problem among low-income and impoverished people, who are less-likely to seek medical care due to cost, inadequate care due to Medicaid capitated funding (care rationing) or they may fail to follow up on medical diagnoses due to personal budget challenges. This is a similar problem for people in Medicaid, long-term care.

2.2.3.5.2 Children

Early intervention is also a significant problem for children who suffer from mental disorders. Mental illness in children was long ignored, because it was viewed as a behavior problem to be addressed or caused by parents. Pediatricians, and psychiatrists may caution against labeling children as mentally ill. Many children suffer through childhood without mental health intervention. Some mature with severe, untreated mental illness as adults, and some perform acts of violence or suicide. There must be intervention in schools, but currently, educators have no necessary skills. (see Reference 5.22, Triger Points).

Early intervention for children must be addressed by the capability and obligation of teachers and administrators to identify children with potential need for help and engage a mental health care professional with support from mental health care services if needed. See more in Section 2.2.7, Mental Health Strategic Perspectives.

2.2.3.5.3 Mental Health Early Intervention

Early intervention is a particular concern for people suffering from a mental illness, because of lack of awareness, stigma, denial, lack of insight (anosognosia), cost saving by the insurance company or low provider compensation under Medicaid. Today, the public mental health system does not recognize the need for care until a mentally disturbed person is, legally, a **danger** to themselves or others. Many families suffer severe distress, attempting to cope with psychotic behaviors. The result is often incarceration for criminal behavior or suicide. Such denials would violate the objectives of the reformed system.

Long-term care is a particular problem, because care is focused on symptom management, typically under Medicaid, because there is minimal contact with any physical, health care doctor.

2.2.3.5.4 Neural or Genetic Disorders Early Intervention

Such disorders may dismissed as simply disabilities, but they may still be able to have a more satisfactory if they have therapy to adapt, that may be characterized as education, physical therapy or Psychotherapy. Early intervention is particularly important if there is early brain development or rehabilitation involved so the patient does not become committed to their disability. This may require long-term care.

2.2.3.5.1 Intervention for Elderly in Long-term are

Long-term care requires attention to intervention, because care tends to focus on the primary affliction or ***just age***, and care by specialists requires extra effort to identify a need and engage the appropriate specialist, who either requires arrangements for transportation from the residential to the specialist's office, or a specialist's visit to the residential facility, potentially, multiple times—not today.

There might be an arrangement to identify patients might need a specialist, and a day could be scheduled when a specialist visits those with a potential need with access to their current medica records. For those patients with a diagnoses or risks, the specialist might then consult with the patient's Primary physician regarding potential follow-up.

2.2.3.6 Health Care Culture that Cares

Professionals are frustrated. Particularly when they are only paid for a specific service, they don't have time to fight battles they can't win, or complaints are not taken seriously. They can't take it anymore, and they quit. One more member, gone from the workforce. Providers and the system must respect professionals for the expertise that they bring, and for listening to, and personally caring about the patient as a person.

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 should be "agents" (with clear obligations and job protection) for reporting to the O&A organizations to hold the system and the contractor-providers accountable.

The states will not continue to accept inadequate and inappropriate care, because the states will no longer be complicit in the inadequate services and underfunding, 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, and who to call. 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 capitatrd 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.

2.2.3.7 Workforce Changes

2.2.3.7.1.1 Direct Care Certification and compensation

In long-term care, particularly in mental health care, direct care workers, 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 care) 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.

2.2.3.7.1.2 Restore Professional Qualifications

Legislators must not listen to insurance company cost saving schemes that give profits and budget cuts priority over quality health care and the proper qualifications of health care professionals. 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.

2.2.3.7.2 New Long-Term Care Skills and Expertise

Many people of the current workforce do not meet requirements for the new, certified workforce. These requirements will be a challenge for health care reform to fulfill the objectives of section 2.1. This shortage must be met by upgrading the knowledge, skills culture and certification of the existing workforce and resulting in new and properly certified employees. Part of this will be programs to provide rapid paths for current employees to improve their qualifications and practices, potentially some form of apprenticeships, while communicating to potential, future employees regarding the improved employment opportunities to develop the next generation work force.

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.

In some health care services, 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.

Provider accounting and time reporting may be a challenge, depending upon how work is assigned and scheduled.

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 delivered by a properly qualified provider in accurate records of the services performed and who was properly paid. The problem will be to get all the people actually doing the work to properly make the claims and update the patient records needed, to get paid, and be accountable.

2.2.3.7.3 Fee-For Service practices

Long-term care tends to be effectively capitated care. Staffing is based on the number of patients and the severity of their disabilities, but 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.

The current health care system suffers from a declining workforce due to poor compensation, demanding work, frustration with service constraints and lack of job satisfaction. Otherwise, dedicated employees are unable to fulfill their expectations as a health care provider.

2.2.3.7.4 Jobs changed

In addition, health care reform will disrupt many health care employee-jobs with changes in responsibility, requirements for job qualifications and certifications, and loss of jobs of some who do not meet requirements, and Jobs eliminated

2.2.3.7.5 Jobs Eliminated

Jobs of insurance company employees will disappear. Most will not find similar jobs unless in other insurance company roles, e.g., other insurance policy claims processing.

New communities of poverty may be created due to this health care transformation (as well as other economic disruptions) and they will need mental-health-recovery help. (See Reference 5.4).

2.2.3.7.1 Recovery from Job Loss

There will be jobs lost as a result of the single payer health care reform. Job loss usually has a significant economic impact on the family that results in some level of stress or trauma or depression. It must be understood, in the context of Maslow's needs hierarchy, that there may be many needs to address beyond getting another job, for a satisfactory recovery. Just telling people on Medicaid that they must get a job may just increase the trauma and despair for the whole family. Psychotherapy may be an essential treatment for recovery.

2.2.3.7.2 Absence of Psychotherapy Professionals and Benefits

People, not only those with a mental illness, need psychotherapy 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. Psychotherapy is seldom even considered in today's health care. There must become an expanded, national market for professionals with psychotherapy skills and knowledge. See the strategic future of health care in Section 2.2.7. Shortage of qualified care givers.

2.2.3.7.3 Development of the Psychotherapy Workforce

The introduction of widespread demand for psychotherapy services will create a great demand for people who are educated in new psychotherapy disciplines. (see Reference 5.1 and accompanying video). There will be a significate requirement for patients in long-term care, including in incarceration, who need early intervention or crisis care for people in long-term care, incarcerated, and persons who are unable to escape poverty.

The psychotherapy workforce must include a range of depth and specialization. There is a need for some direct care workers to have some basic skills and empathy for dealing with those people who may have behavioral symptoms that make them difficult to work with and uncooperative, but cooperation will not be improved by confrontation. Some professionals, such as case managers and nurses may need training is some forms of diagnosis and therapy and also some awareness of symptoms that call from some medication to manage impulses, depression, and delusions. Getting the right balance between medication and psychotherapy requires a medical doctor with some training in psychotherapy from a diagnostic perspective, others who specialize in psychotherapy will be needed to bring a deep understanding of the needs for medication and/or psychotherapy. A major part of the psychotherapy workload will

require a high level of interpersonal skills, but balanced with the medical expertise of a physician with both psychiatry and psychotherapy knowledge and diagnostic skill, particularly at early stages of diagnosis, but continuing as the patient recovery may reveal changing treatment in both medications and psychotherapy techniques.

In addition, there must be psychotherapists and psychiatrists focused on childhood brain development to grow a next generation of well-adjusted adults, to grow families out of poverty and antisocial behavior, while treating other childhood disturbances that interfere with successful maturity.

We still don't know the causes of various forms of mental disturbances, particularly the interplay of "nature vs nurture." Particularly in early childhood, brain development may be influenced both by genetics and by physical illness, and by experiences and environment such as stress or violence and interpersonal relationships.

2.2.3.8 New Long-Term Care Model

Long-term care refers to care provided in a facility where the recipient lives for a significant period of time receiving care from a staff associated with the residential facility. Consequently, the staff and the facility may be managed ty the same provider. Generally, the staff consists of personnel needed to serve patients with similar, primary heath afflictions, so the facility achieves economies of scale of staff members in particular knowledge, skills, experience and job responsibilities.

A the same time, the facility will be operating in the context of the new, national single payer health care system, as a health care provider, that is compensated for its services based on the national system benefits package, and supported by the national patient records system, and in compliance with a provider contract based on a national provider, contract template. The compensation is based on fee-for-service.

Today, long-term-care services are effectively capitated budgets as opposed to compensation based on actual services delivered to specific patients. This is a significant change in accounting practices and worker accountability, Job satisfaction, scheduling and workload.

Of course, providers of this type need predictable budgets for their staffing, facilities, and other expenses that will vary as patients come and go. Their contract must provide for an expected of number of patients and their needs for an annual budget, possibly with monthly adjustments for actual services delivered and other cost variances. The national health care system will be required to forecast and manage their budgets in a similar manner, but the budget is not capitated to control expenditures. This is the real world when you are accountable for what you actually do or don't deliver. The provider must expect that there will be periodic adjustments in the budget to reflect the services actually delivered in the period with appropriate workloads.

The providers, the national organization, and congress will need to learn that the people who need and receive services cannot be penalized when the providers, and all the other budgets, up the organization hierarchy are no longer in control of the budget limit, per se, but are in control of the forecasts that will be adjusted after reality happens. After all, that's one reason why the US government, periodically, must adjust the national debt limit.

This also applies to hospitals. Note that when you don't spend what you forecast, you don't get to take the rest as profits, if nothing else, the excess is rolled into the next year's budget (forecast).

Essentially, long-term care facilities are similar in the basic format of care delivery—residential care for a significant length of time. However, there are basic differences in the needs of the different patients and thus different contract categories based on their class of patient health needs.

This then includes

- Hospitals
- Nursing homes or other facilities for the elderly, patients, physically or mentally disabled patients, distinguished by the types of disabilities and needs that they suffer.
- Mental illness providers of group homes or independent patient residential supports, and club houses for social and work, structured activities.
- Residential physical rehabilitation services
- Other, recovery for hospital, step-down care.
- Health care in jails and prisons.
- Health care in veteran hospitals.

The fee-for-service billing and budget management may result in better clarity of the services that must be available and delivered to patients in each particular facility. That, in turn, may result in more specialized skills, more refined benefit specifications, and more appropriate compensation for the services delivered.

This will also clarify the qualifications of staff members required and available to deliver the benefits for which they are compensated (accountability). This is particularly important where Medicaid has resulted in services that are so lacking in quality that patients are effectively warehoused, rather than having reasonable support and recovery services for quality of life within their capabilities.

This is a major challenge for the development of the benefits packages that replace the unaccountable, capitated budgets of many of these providers. It will also be a challenge in the specification of contracts template and the negotiation of provider contracts and budgets. The

budgets must not become essentially capitated budgets. The state, O&A agencies must ensure that the patients are receiving appropriate services and quality of care.

When patients get the services and quality they need, more patients will improve or recover, and costs will go down. That is the type of outcome that should be encouraged with incentives, and professional recognition.

Generally, 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 "resident medical expert" for all the afflictions of potentially hundreds of residents.

The proposed, single payer system will result in consistent health care without variations introduced by different funding sources, benefit packages and cost-cutting incentives, so health care should be more consistent and accountable, although related living conditions and quality of life issues will still need attention.

See Section 772 for strategic changes driven by advances in psychotherapy affecting widespread improvements addressing Maslow's needs and health care.

The care objectives must be the same (equitable, quality, affordable, accountable, accessible) and with optimal mental health) for everybody, all levels of normal or long-term care. We might define specific specializations of health care, including long-term care, based on stages of life, suggested, below:

The lifetime stages for the health care system might be characterized as

1) childhood, where we develop physically, mentally and socially,

(2) adulthood, where we develop and a full life with purpose,

(3) retirement, where we slow down life to a reduced pace and intensity of activity, with more pleasurable, potentially more altruistic purpose,

(4) decline, where we anticipate a reduction in physical, social and/or mental capabilities, while sustaining purpose and belonging, with assistance as needed, to have a satisfactory quality of life given our biological limitations. Specializations might accommodate individual challenges for normal functioning (incapacitated), activities of daily living, , ambulatory, assistance, staffing (level and skills?), mental competence, disoriented, (24-hout treatment plan required?), facility economy of scale, satisfaction of needs and adaptability.

2.2.3.8.1 Coordination of Acute Care and Long-Term Care

People 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). Essentially, they must be consistently placed in an appropriate facility to receive acute or long-term care. This appears to be neglected in the long-term population, particularly under Medicaid, because Medicaid is not funded to accept them from acute care. The transition 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.

The long-term care provider may fail to properly intervene when there is a need for acute care for timely transfer of the patient, back to acute care but maybe not the same, previous acute care. Patients often arrive at a new facility without patient records, and, particularly a list of medications.

2.2.3.8.2 Major Long-Term Care Populations

First, we consider several important categories discussed in the sub-sections that follow.

These all have, in common, the requirement for patients to continue to receive health care that is equitable, quality available, affordable and accountable (discussed in Part 2 of this document).

There will be a need for some forms of accommodation of the facilities, and treatment specializations (e.g., staffing). Nevertheless, these are all facilities that must address levels 1 and 2 of Maslow's needs hierarchy (See Section 2.1).

In general, the patients will also need primary care with treatment planning, coordination and objectives that address their particular health care challenges, with a focus on assessment of progress toward long term outcome.

2.2.3.8.2.1 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 the 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.”

2.2.3.8.2.2 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 Psychotherapy to “rehabilitate” the brain. In the meantime, there are at least hundreds of thousands of people 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), they 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 independent 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. They tend to disrespect persons suffering from a serious mental illness, as lazy, who don’t deserve living more comfortably, although more isolated, than their staff.

Their lives care is custodial. No Psychotherapy, 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 serious, reorientation of treatment as a combination of psychotherapy balanced with medications to control a biological disturbance (see Reference 5.1, along with5.2).

2.2.3.8.2.3 Care for the people with severe, long-term disabilities

Medicaid beneficiaries are poor people, with limited incomes, and limited assets, who require substantial assistance for daily living. Although it is funded by Congress like charity, it must be equitable with appropriate quality, but assistance and health care are restricted by budget limits that ensure that it is not even good charity. Some states even consider it a loan that should be paid back. Care is often more caring and supportive, probably because many families continue to be fairly involved in their lives.

2.2.3.8.2.4 Care for people who suffer from addiction disorders.

Treatment for addiction disorders may be shorter in duration, but they require residential care for withdrawal and recovery. They require a distinct form of health care, integrated with conventional heath care for other conditions. They will require a distinct form of psychotherapy, focused on the risk of relapse, followed by coordinated treatment after discharge for continuing support and potential relapse.

2.2.3.8.2.5 Care for people who require confinement

This applies to such facilities as state psychiatric hospitals, jails and prisons, and youth detention facilities. These are quite different in terms of accommodation and security requirements, but the people in these facilities should, nevertheless, receive health care that meets the objectives of the new, national system (Part 2, of this document), particularly equity, quality and accountability. They will also have quite different psychotherapy needs.

2.2.3.8.3 Public Guardians

Public guardians play a major role in the care of patients in long-term care who are unable to make personal decisions regarding their finances, health care or their living circumstances. See Section 1.3.2.13.2, 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 patient's record, identifying a person representing the patient in health care decisions. The health care professional, who is 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.

Effectively, guardians, particularly public guardians, have significant conflicts of interest and no effective accountability. Effectively, a guardian has unilateral control over the ward's life, such as the following subjects:

- Legal decisions
- Financial management
- Residence and transportation options
- Medical treatment decisions
- Activities of daily living

These decision-making powers should not all be vested in the same person, particularly legal and financial decisions, since these are decisions that may create major conflicts of interest. If nothing else, a family member or friend, with no conflict of interest, should co-sign these decisions.

The state O&A agency should have an identified person to review the guardian's decisions and possibly have approval authority in certain categories of guardian decisions.

Currently there is no accountability for guardians except for the court assignment, and that is not recognized as a benefit nor recorded regarding compensation. The guardian, potentially a family member) has a conflict of interest regarding compensation (or patient assets), and there is no review of medical or compensation decisions, except by the court without any health care system oversight. This calls for Federal legislation regarding guardianship. This is a similar issue for family members as guardians, where the presumption that other family members are performing oversight, but that is informal. (see Section 2.2.7.4, regarding future guardian accountability)

2.2.3.8.4 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).

In addition, all direct care personnel should have some basic understanding of patient psychotherapy needs, if only an adaption to a restrictive, isolating treatment environment.

Hospitals, nursing homes, small direct worker companies, independent professionals or groups, are all providers that may fall short as qualified workers. However, in the future, the available workforce 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 the needed skills, and to 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 benefit: those who are delivered by certified personnel and those that are delivered by a person who is not yet certified, but who is engaged in a strict improvement program to qualify for certification in a specific period of time. This practice should require some assessment of each, uncertified 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 well as the currently expanding need for climate change industries. (see Section 2.1.8).

2.2.4 Affordability

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 until adulthood.

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

2.2.4.1 Health Care Affordability for Life

Primary goals of this proposal are 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. The need for health care does not stop when a person is above the Maxwell's, level 1, Physiological needs, nor when they have serious, safety needs, and their health care coverage should never disappear.

Hospitals should not be responsible for the cost of care for anyone that is received in an emergency without health care coverage. The hospital should take care to identify the person, or their citizen status. The hospital must treat them, but the hospital must get them registered in the national system so the hospital can submit claims for the services delivered.

See "Subsidies Are Essential," (Section 2.2.4.2), 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. Many of those benefits are out of reach of poor and low-income people who are just trying to survive. The American dream is out of reach for them until they are at least at Maslow's level 3, and have the ability and opportunity to aspire for a better future. This will require more help than good health.

This objective, to make health care affordable to all, is to reduce much of this inequity, and give at least equitable health care to many people suffering economically and are at risk of greater losses. Health care should also address the trauma and despair of those in poverty, to give them the mental strength, hope and purpose to build a future. They need hope of realizing a piece of the American Dream. This requires assistance beyond health care, to get out of poverty.

Realization of equitable, quality, affordable, accessible, accountable health care should be a responsibility of our government, to be supported by those who can afford it.

Affordability is a systemic problem throughout the US health care system, but the greatest impact is on those who are most disadvantaged.

2.2.4.2 Subsidies Are Essential

We must have the same benefits package for everyone for equity and quality. However, not everyone can afford all the services that they or their families need. That affects more than poor and low-income families, because some benefits and the costs of some illnesses may also be devastating to most middle-income families. We should not be driving families into bankruptcy

or poverty. Health care must be available to all without the sacrifice of Maslow's (1) Physiological or (2) Safety needs or (3) Love and Belonging needs, in other words, a reasonable quality of life.

2.2.4.2.1 General, Benefit-Cost Adjustment Considerations

Here we consider general factors for consideration.

2.2.4.2.1.1 Other Costs of Living

- Unfortunately, dependence on level 1 assistance does not stop if the patient is no longer in poverty, but the patient has some increase in income, and s/he may still be unable to meet the same needs, afford increased health care costs, and avoid risks of descent back into level one. Consequently, the adjustment should reduce the cost to reflect the increased financial means, but not hinder further recovery, nor cause a risk of return to poverty. For example, the recipient may be able to afford housing, or more inhabitable housing with a raise, but not if the subsidy is dropped. At the same time, a subsidy should not help a recipient create more debt that increases their risk of returning to poverty. Generally, we buy insurance so that unforeseen misfortune protects us from loss of our standard of living, not to "win the lottery."

Income/assets/wealth

- Income, alone is not a good measure of financial need. Some billionaires may report very low levels of income. There could be some enhanced measure of wealth, such as consideration of assets, unrealized income, and stock options, in order to assess the personal budget impact of health care costs. It would be desirable to determine some alternative level of burden or urgency or stress to be addressed by subsidies, since the burden of a benefit cost is closer to the size of subsidy that is needed. The point at which the subsidy shifts to a surcharge should be where the recipient experiences no serious burden from the surcharge.

Family size and dependents

- Generally, family size is a factor in low-income health care cost impact. Family size may include ages of dependents (potentially dependents under age 26 to accommodate education, employment, and a sustainable career)

Tolerable level of Individual health care costs

- This is a more political measure of a tolerable level. How much will people of various levels of wealth, tolerate enhanced coverage premiums or benefit surcharges for the

purpose of shifting costs to those who have an obligation to support the cost of the universal health care system.

Very-high-cost benefits

- When do we say that is just too much for the system to bear? Or do we just define these as a class of "enhanced benefits," and make them available to persons willing to pay a premium in excess of the high cost (without driving them out of the system) so we can adjust the high cost, so that it is more affordable to low-income people, even thou they have a comfortable income.
- A long-term treatment plan could represent a commitment to a treatment protocol over years. That should be segmented to be more tolerable, such as monthly segments, or more specific elements in the context of the treatment plan, thus more affordable segments with subsidy.

Enhanced benefits

- Cost adjustments should not only reduce costs of benefits to poor and low-income people, but they should increase benefit costs as effectively a service charge for more wealthy recipients to cover some of the cost of the system, including the cost of "subsidies."
- Possibly a turning-point in the subsidies where it turns into a co-pay, maybe roughly in the middle of the "middle-class" income.

Cost Adjustment Formula

- Create a cost adjustment formula that applies both to subsidies but to surcharges for high income recipients to contribute more to the operation of the system overhead and offset some of the cost of subsidies. The objective is to balance health care cost to be affordable to everyone, but at a balanced level of burden. This means considering adjustments to smooth economic shifts, consider, for example, family, with children, trying to build a career. Consider a lifetime expectancy and treatment risk regarding authorization of an expensive treatment and potential alternative treatments.
- Medicare recipients will receive coverage that is extended for long-term care, so they still have a benefit for their lifelong contribution to the Medicare fund. Long-term care should be a higher cost benefit for the wealthy as an elevated co-pay, or, if they want a more luxurious long-term care facility, that might be a private-pay option, that would avoid the co-pay, but should have a national system service fee, maybe equivalent to a co-pay.

Private pay option

- Should we incorporate private pay for selected or custom benefits not available from the national system (including very high cost, high risk, or leading-edge technology with limited availability. So we don't deny the benefit to wealthy people who can afford to get it with benefits delivered directly or indirectly plus cost adjustment(s) to cover costs of integrated system support plus mark-up for contribution to national system revenue. (See Section 2.2.5.2.)

2.2.4.2.2 Possibilities for subsidy specifications:

- Define a maximum subsidy per year for a zero billable amount, focused on Maxwell's levels 1 and 2 which may depend on each state's level of assistance for non-health-care level 1 and 2 needs (may depend on state and local circumstances).
- Based on income, gradually decrease the subsidy, but allow for some increase in income and spendable fraction of income. Allow for some increase in spendable income as incentive to grow.
- When increasing income reaches a middle-class ("standard of living"} threshold, that is a subsidy limit for routine or moderate benefits. There might be higher, specific benefit limits based on the severity of the disability, national frequency of concurrency, risks and life expectancy.
- Potentially a national fund benefit subsidy to cover a certain illness/affliction due to epidemic, new treatment or inoculation with significant, national impact exceptional health care illness cost?
- Premium that starts at middle class cost income level and ramps up to Billionaire level to cover some portion of (normal?) health care system costs?
- "Income" should include annual income, more than income-tax reported, income, such as stock options market value and appreciation, owned, stock-market investment growth, private business ownership value assessment and profits, and so on.
- Premiums are adjusted based on incomes, corresponding to benefit subsidies.
- What about cost of level 1 and 2?
- Define strategy objectives: middle class standard, wealthy burden, income/wealth-gap by corporation/employer.
- Consider impact of reduced population in poverty, and criminal justice costs over time.
- Adjust the "middle class." Age, geography, family size/dependents subsidy amount for middle-income and below?
- Keep "tax/premium, mark-up charge" associated with national health care, decline of cost?
- Essential Health Benefits are defined for the Affordable Care Act to identify 10 categories of essential health care for exceptional coverage (See Section 2.2.4.2.3, below). Presumably these identify high-cost categories that can be evaluated for risk

based on actual occurrence data to put a price on a fund that would level the cost for everybody, then determine how that cost should be covered by subsidy or surcharge depending on income/wealth status(?)

- This analysis might be approached as the potential cost of an insurance policy to pay for these high-cos health care occurrences, and use that figure to determine how much individual subsidies/surcharges should this "insurance premium" be offset by individual subsidy/surcharge based on income or other measure. That determination might also be based on other risk considerations for the individual/family.

2.2.4.2.3 Affordable Care Act Essential Health Benefits (ESB)

The ACA defines a set of 10 Essential Health Benefits, listed below:

- Ambulatory patient services
- Emergency services ›
- Hospitalization
- Mental health and substance use disorders/behavioral health treatment
- Maternity and newborn care
- Prescription drugs
- Rehabilitative and habilitative services/devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including oral and vision care

It seems that these categories of benefits are suggested as requiring special attention, perhaps to ensure that they are not avoided due to cost considerations, and they could have long-range consequences if they are ignored.

It is good to consider these exceptional categories for some special priority and/or subsidy consideration. However, in the ACA, these are treated differently among the four treatment plan tiers: Bronze, Silver, Goldd and Platinum. Furthermore, there are special "cost sharing" considerations to be considered among the tiers. This is obviously and attempt to manage exceptional costs, but, unfortunately, it has violated the proposed "Equity" objective of this national system proposal. These Essential Health Benefits should be considered for exception to the cost leveling of the subsidies/Surcharges.

The ACA has defined some cost sharing mechanisms for controlling high cost of services. See Section 1.3.2.3.2, Cost Sharing). These EHB categories should be refined by different levels of subsidy/surcharge or discount to equalize the burden of having a national health care system for all. So the ESB categories might define a different adjustment to these benefits to the

subsidy/surcharge to ensure that they are not avoided due to a casual “not important enough now” attitude because it requires some sacrifice of other needs that are more important to financially stressed recipients, that might be due to other current circumstances.

ESBs are also implemented differently is some states. That would not be allowed in the national system as a source of unnecessary confusion and additional work. Such variations must be resolved in the transformation proposal development, Part 4.

2.2.4.2.4 Treatment Planning

A high-cost illnesses or multiple afflictions should have a treatment plan. There may be expected change over the course of an illness, and there may be medications or other episodic treatment for each illness/affliction as recurring expenses. The treatment plan should track outcomes for the concurrent bundles of billable benefits. This requires a Primary Care Physician for coordination and incidental changes. This scheduling and bundling of benefits may have billing-implications. The treatment plan should consider various contingencies and diversions.

The high cost should be considered by providers, the potential benefit claims, and the risks of alternative sub-plans and outcomes.

Private pay may be an option where exceptional treatment is not covered, and the other sources may be available options depending on the patient and family resources. Should there be other factors for alternative benefits, and payment adjustments, such as consideration of risks of procedure failure, the patient’s life expectancy, the existence of young dependents, possible lower cost alternatives with greater risk, or the social/political status of the patient and/or family??, This may, ultimately, be a question for Congress, because they will be accountable for the answer.

The plan should have peer review of patient profile and health circumstances, options, risks, outcomes, beneficial expectation for the patient, and expected treatment and recovery costs and duration. The review process and documentation will be documented and validated against standard thresholds, for final approval.

2.2.4.2.5 No Poverty Trap

There must be no health care (e.g., Medicaid) poverty trap. Currently Medicaid drops if a recipient exceeds the income limit. Medicaid collects the lifetime Medicaid debt, when the recipient loses Medicaid coverage. The result is that Medicaid not only stops needed health care, but it asses a debt, likely to push the recipient back into poverty and deny health care resulting in may risk to the patient’s relapse or survival.

Subsidies could be a trap if they drop too fast when the recipient starts to get their life together. Bills don’t disappear. A new job is a challenge, and may need time for pay to be adequate

We need to help people get out of poverty, help them raise and retain an income, to aspire to a better way of living, giving them psychotherapy, opportunities, collaboration and other assistance to help them achieve growth toward a better life—to join the "middle class."

2.2.4.2.6 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 people not qualified for subsidies.

The single-payer system will make these decisions much more objective, because the cost/risk and efficacy of a medication will be more visible in reports of patient outcomes, and the pharmaceutical companies should have records regarding their investment in research and reasonable expectation of return on investment, including market potential.

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 and intermediary broker profits.

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, while 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.

2.2.5 Accessibility

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

Relevant factors:

- Intervention in immediate needs for health care of an individual
- Prohibitive distance to reach sources of health care services
- Lack of transportation for recipients to reach their needed health care services
- A lack of adequate Professionals and specialties to meet the need, particularly in low-income areas.
- A lack of awareness and interventions to obtain needed services, due to cost avoidance, particularly in mental health care, where millions of mentally ill persons receive no services, in part, because families and others do not know where to go for help.

- Need for more Intervention to address needs that are avoided due to awareness of medical conditions, cost of care, denial of need, failure to address mental disturbances that interfere with individual performance in education, employment and family harmony.
- Risks of harm to self or others, that is an inappropriate threshold for access to mental health services.
- Inappropriate delays or denials by insurance companies and other funders (i.e., CMS, Medicaid, Medicare) may result in no benefit.
- Long-term care that provides inadequate care, and neglects needs for a reasonable quality of life, particularly for people, who might be above Maslow's level 1 needs, in terms of their level of satisfaction.

2.2.5.1 Health Care Service Capacity and Geography

There is a lack of adequate capacity of health care services, particularly in low income and rural areas, and psychiatric, long-term hospitals.

2.2.5.1.1 Health Care Deserts

Health care professionals are not attracted to low income and rural areas due to compensation and poor job satisfaction. The new system needs improvements in the available workforce and growth of new workforce categories. Timely corrective training and hiring should be an oversight issue and an aspect of system transformation.

2.2.5.1.1.1 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.

2.2.5.1.1.2 Health Care Professionals Missing

- 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.

2.2.5.1.2 State Behavioral-Health Hospitals

State, long-term care hospitals currently serve persons with serious mental illness or disabilities. Many of these were phased out years ago to shift funding to local services covered by Medicaid. There is a widespread inadequacy of behavioral health hospitals results in patients discharged from acute care, but not recovered for community-based care.

The reduction of state hospitals also resulted in few such hospitals located in rural areas and thus significant travel times for visiting families or friends, with loss of contact with the home community (Belonging, reference 5.2).

- There is still a need for isolation of some persons that represent a risk of criminal behavior or danger to self or others, but those should be treated as extended acute care or long-term care with confinement for public safety, but psychotherapy should continue, under acute care, to establish the long-term need or an appropriate, less intensive/isolating care-placement.
- The need for psychotherapy dramatically changes the nature of the long-term care needed in existing state hospitals, including the administration and recording of fee-for-service billing.
- State hospitals or other, long-term facilities must serve the substantial number of patients with dangerous behaviors, so they can transition to a focus on recovery to return to community support, and to progress with further recovery, toward improved quality of life and progression in Maxwell's levels of need.
- State hospitals are addressed in Phase 4.

2.2.5.1.3 Shortage of Qualified, Transformed System Employees

Many existing health care employees do not qualify for similar positions in the new health care system. There will be a major shortage of qualified employees with appropriate levels of skills and knowledge in psychotherapy as an expanded mode of behavioral health care. (See Section2.2.3.4).

2.2.6 Accountability

Accountability is a major issue in the US health care "System" not only for the cost, but for the actual delivery of adequate and appropriate services. This section first addresses the need for independent oversight and accountability enforcement. Subsequent sections address more specific aspects to the unaccountability of the current system explored in Part 1of this

document. (See the Un- Accountability Hierarchy diagram, in Section 1.3.2, and the new system organizational structure in Sections in Part 3)

2.2.6.1 State Oversight and Accountability agencies (O&A)

The major contribution of this proposal to accountability, is formation of the state Oversight and Accountability agencies O&A that are independent organizations, one established in each state, and systematically integrated with the national health care system, and state government services to hold the system and related government agencies accountable for the quality of health care services in their state. That is, accountability to the people.

These organizations have administrative and legal authority to investigate, report on complaints and systemic problems to Congress, state legislators, state administrators and to the public, to recommend corrective actions, to bring legal actions if necessary to ensure realization of the strategic objectives (Part 2) of this proposed health care system. These efforts may extend to consideration of the actions of the related state agencies that are responsible for regulation of health care providers, as well as operational interaction of other state agencies, such as welfare, criminal justice, housing, transportation, and so on, and operational interaction with the national health care system, particularly the state offices.

Major changes are

- These organizations represent the interests of the people of the state and are independent of partisan politics, and other financial interests, and conflicts of interest.
- The state will no longer have a conflict of interest in the funding of health care services in the state, no Medicaid match.
- These state O&A organizations can collaborate on the resolution of national concerns and advocate for change.
- Thes organizations should be funded as a mandatory item in the national health care budget, as a fixed percentage of the costs of health care benefits delivered in each state.
- Thes organizations will expose conflicts of interest, at all levels, that interfere with outreach and delivery of needed services with proper standards of care and dedicated performance of delivery. They will then take legal action, if necessary, to resolve the conflict of interest or any other failure to meet the objectives described in Part 2 of this document.

2.2.6.2 Government funding

The current, federally funded services are the most seriously under-funded, and they serve the largest populations, where the majority of the people 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, particularly for Medicaid. There is no consideration of the needs nor satisfaction of needs of millions of real people. Medicaid serves an estimated 88 million people. There is no information regarding the actual services needed, but not provided, for the individuals who are, or should be, in the populations seved.

There should be no more capitated funding, but services that are numerous, brief assistance that would cost more to record than to perform should bundled for benefit compensation. There will be capitated budgeting for financial planning, but with periodic adjustment to the budget to reconcile with reality. In addition, there will be claims for services that require investments for facilities and technologies that must be based on the expected usage and lifetime or the expected obsolescence of the technology, along with the expected capacity and frequency of patient benefit claims. This is a sort of capitated funding that is reconciled by fee-for-service billing. The claim is negotiated based on expected claims revenue and risk of obsolescence and other funding sources such as donations.

At the state level, there is currently another level of capitation (rationing) where funds are typically allocated to populations with specific categories of services, and to geographical areas of the state. But that is budgeting, the delivery of care must be accountable at the real patient level.

Conventional capitated funding will not be applied by the state, but it will shift to specific, practice component costs closer to be incorporated in fee-for-service services with patient records of services delivered by staff actions taken and services delivered, to the extent practical. There is likely some experience hospitals and insurance companies) with efforts to approximate patient-level fee-for-service/time reporting or formulas and patient records for claims made with reasonable approximation of patient fee-for-service claims.

Improvements in the tracking of specific benefits and staff tracking may yield improved service delivery (such as workloads, scheduling and employee recognition). Methods may be developed for efficient future activity tracking technology.

There may still be a level of capitation by teams, such as ward staffing levels that require worker scheduling and payment for being present. That will require attention to efficiency and individual performance, that may be addressed as acceptable overhead. Treatment schedules, with level of capitation for provider compensation or for private payers. Providers may receive capitated funding for the residents of residential facilities because they need to have budgets

for planning, and the number of residents will vary. Capitated budgeting is needed for financial planning, but with annual adjustments based on actual patients served, which should be reported as fee for services, to track by service delivery by patient. The budget can be based on staffing levels, patient conditions and workload, without specific value delivered to each patient based on actual needs of the population be served. These levels each create limits on accountability for the allocation of funds and the quality and accessibility of care.

Accountability is required 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 individual patients. Compensation will require allocation of overhead for fixed and administrative/management costs, but overhead should not be a fixed cost for everybody, but managers must be accountable for the performance of their employees, and the quality of care delivered to individuals.

2.2.6.3 Private Funding

A Private payer will be allowed by contract with the national system to provide specific custom benefit(s) to a recipient under the private-payers contract to use the private payer's private benefit service. The recipient must also be registered in the national system (with a patient record), and the Patient must have a contract to receive the private payer's service. The private Payer is not allowed to offer benefits that would duplicate benefits already in the National system benefits package, however the private benefit service may incorporate (engage) other services for the identified patient, at the standard compensation rate.

2.2.6.3.1 Private Payer and Payee Contracts

The private payer contract must specify the unique benefit, with a unique name to be used under the private payer contract with the particular recipient. The associated provider, who will deliver the private service, is a registered provider in the national system, and may deliver services for other benefits for the same or other recipients/patients. The private payer service must be incorporated into the national system so that the recipient is covered for the private service and any services it may incorporate. All compensation claims will be through the National payment system, posted to the special service recipient, and forwarded to the private payer with an added service charge.

This facility will enable private-pay services, using the national health care system infrastructure including the state Oversight and Accountability agencies, that also support state regulators. Private payers will be required to use this facility and the associated infrastructure, and pay fees for the private pay contract, and integration of the private payer operation and access to authorized portals, along with the private payer service charges.

Availability of this private payer service will discourage the rise of any insurance companies, competing with the national system. All national system records will be consistent with the use of the private benefit service by the designated private benefit recipient along with any other benefits the private benefit service may incorporate, directly or indirectly. All such services will be compensated through claims submitted to the national payment system, as services delivered to the designated private service recipient.

2.2.6.3.2 Summary of Requirements:

- The private payer operations must be integrated to operate in the context of the national system as a supplemental payer for delivery of a unique benefit. The private payer benefit will be engaged by the private payer request for the benefit in regard to the private pay patient.
- The private payer will agree to a contract with the national system, to request the private benefit on behalf of the private payer benefit, who must be a registered patient/recipient of the national system.
- The unique benefit(s) will be delivered by a specific provider, who is a member of the national system provider network, under a national system provider contract, amendment for the unique, private payer benefit.
- Access authorizations, through national system portals, will be authorized based on the patient profile and the private benefit specifications.
- Providers, accessed by the private payer, benefit service have their norma access authority, based on the private service patient profile.
- The private payer, benefit will be authorized for specific patient(s) registered with the national system with associated fees, paid by the private payer and specified in the private payer contract.
- The private payer contract with the national system will specify the unique benefit, the provider for that benefit, a specification of unique benefit offered by the private payer and approval of the provider contract specification of the service to be delivered.
- A private payer contract template will specify the interfaces and protocols for integration, as well as the fees to be negotiated including the implementation fee and cancellation termination conditions and procedure.
- If the private payer is a business, offering a private payer service, it must be regulated by its residence state regarding its marketing and service offerings as a health care insurance company would be regulated. This does not apply to an individual benefactor.
- The private payer will be subject to oversight and accountability O&A agencies.
- State Oversight and Accountability will operate the same for privately paid services as for other providers and national agencies and state operations.

- The patient's records will be updated as they would be for any service delivered or associated provider report where compensation is due.

The private integration requirements and contract templates should be established early in the system-transformation program to accommodate possible exceptions sto ervices offered to the general public.

2.2.6.4 Guardianship Accountability

See Section 2.2.3.10.2 regarding current guardianship problems. Effectively, guardians, particularly public guardians, have significant conflicts of interest and no effective accountability. Effectively, a guardian has unilateral control over the ward's life, such as the following subjects:

- Legal decisions
- Financial management
- Residence and transportation options
- Medical treatment decisions
- Activities of daily living

These decision-making powers should not all be vested in the same person, particularly legal and financial decisions, since these are decisions that may create major conflicts of interest. If nothing else, a family member or friends with no conflict of interest, should co-sign these decisions.

The state O&A agencies should have an identified person who will review a guardian's decision, with approval authority over certain decision categories.

In all cases, the decision of the potential ward's competence should be independently determined. AI-based evaluation (See Section 2.2.8.3.2) may be an important contribution to competence determination.

The separation of subject matter categories (above) and competence may depend on the above subject matter category. A ward may be competent to have a valid opinion that should control, choices should at least be considered, if the subject is considered relevant by the independent approver(s) of decisions with a psychotherapist's advice regarding the ward's mental state.

2.2.6.5 Guardians as providers

Guardians are appointed as a result of a person's incompetence disability. As such they should be viewed as a health care provider, and be reimbursed as a provider, based on the services they provide, and with oversight by the state, O&A agency on Legal, financial, residential placement, relocation, quality of life, ward level of competence, and reporting to the presiding court.

2.2.6.6 Traceability

Accountability requires traceability. The funding must be traceability to the product (health care services delivered) that must be known. Currently, we may know how much money is spent (budgets) by a guardian, but we don't know how the money relates to specific services delivered to individual patients and we don't know if the services resulted in appropriate outcomes. There are several failures of traceability. This requires specification of benefits to be delivered by a guardian, for submission of claims.

2.2.6.6.1 Capitated budgets

A capitated budget is an estimate of the number of people who will receive services and the average cost per person of the services expected to be delivered. After-the-fact, we may know who delivered, how many patients were actually served, and who provided those services to each patient. The compensation must include the overhead of the immediate provider and the master contract (umbrella) provider, not profit, and not "charity" services provided at no cost.

Obviously "overhead" is a big problem. It is not just a big estimate, but it must be accountable, also. Some elements may be estimated costs or pending invoices, but they must be reconciled, with the reported overhead, after the fact, periodically. That should be good accounting, subject to review/oversight.

Budgets are for planning for costs, and budgets are always wrong because unexpected things happen, budgets must be adjusted for those things that happen.

Budgets are not criteria for actions. Proper actions must be performed because they are right, not denied or modified to meet the budget. Budgets are potential conflicts of interest for decisions on the delivery of health care services.

Fee-for-service is a defense against budget control. The budget can be based on historical costs, corrected for new and anticipated requirements. The compensation and performance required for delivery of the benefit do not depend on the budget.

We know that the budget will be wrong, and when it is affected because we know when reality defines the actual costs. The budget must be amended periodically, to be aligned with reality and to make adjustment to financial plans.

Adjustments ultimately affect all the summary budgets, up the hierarchy. If a budget is exceeded, then there must be contingencies for covering the shortfall so that the budget does not take control of the delivery of needed services.

Accountability requires that the budget does not take control, or the contingency is inadequate, and the manager must be held accountable for the failure to achieve proper performance, to meet the obligations, to deliver the proper services, to have proper funding for contingencies.

2.2.6.7 Conflict of Interest

Conflict of interest is a systemic failure of the current health care system. While this failure is focused on Federal funding, its effects propagate through the entire system, like a pandemic.

- **Insurance companies** have the primary conflict of interest that has had a direct impact on the cost of health care and the decline in the quality of health care.
- **Congress** also has major conflicts of interest, since they are supposed to represent the interests of their constituents (their voters). Unfortunately, due to the funding of election campaigns, and **lobbyists**, the congressional member election funding is in conflict with their loyalty to their constituents' interests.
- **CMS** has a conflict of interest as a result of the constant demands from **Congress**, and advocacies for tax cuts for reductions in Medicare, Medicaid and related budgets. In addition, CMS, through Medicare has fostered the formation of professional, **Accountable Care Organizations** (ACO) with bonus awards for measurable reductions in cost of health through reductions in the cost of benefits they deliver. These provide leverage for conflicts of interest among their members.
- **States** currently have a conflict of interest, because they are given inadequate funding for Medicaid and they must match this funding with state revenue. Consequently, they become complicit in cutting costs and the delivery of inadequate and inappropriate care for people already in poverty and with low incomes. Many states pass this responsibility to **insurance companies** to avoid accountability.
- **Medicare and Medicaid** health care providers become complicit because they experience cost cutting in both Medicare and Medicaid provider compensations, and in cost shifting of hospitals, that they are required to provide, at no cost, for health care to emergency-room patients who do not have health care insurance. This has caused health care deserts in low income and, particularly, rural areas where hospitals and other providers are losing money because there are too many patients on many Medicaid and Medicare bargain rates, along with no-charge patients without insurance.
- **Guardians.** Guardians should be engaged as health care providers. See section 2.2.6.4.

2.2.6.7.1 The Remedy for Conflicts of Interest

The remedy is to bring the power back to the people. The state-level O&A agencies are responsible for ensuring that the Federal funding results in the delivery of adequate and appropriate services to all, and for brining any failures to the attention of their state legislatures (who are responsible for the regulation of providers and health care professionals), and to their

members of Congress , along with national coalitions of those independent O&A agencies and their citizens, and the general public.

2.2.6.8 Accountability Tools

The national Patient Records system is a critical component of accountability tools. A Value Delivery system will support a range of analyses of value delivery from the flow of benefits and outcomes of individual recipients, comparisons to similar circumstances for evaluation of variations in outcomes. Other tools will provide identification of fraud and improper treatment practices among providers, and potential provider shopping by recipients to get redundant prescriptions. Review of benefit claims will also expose trends in overuse or unnecessary use of expensive treatment practices

AI should be considered to analyze patient records and value delivery for identification of potential concerns.

2.2.7 Health Care Efficiency Management

A fundamental, management and oversight objective must be efficiency of the operation of the national system, including the state Oversight and Accountability agencies and the provider administrative overhead.

There are many efficiencies built into this proposal, and as the system continues to evolve, these efficiencies must be sustained, and new opportunities for efficiency must be recognized and addressed. Below are fundamental principles for achieving efficiency. These are not explicit in the proposal, but they may all be applicable in the details in the development and delivery of the transformation.

The same Value Delivery Modeling Language that is suggested for analysis of service delivery accountability, can be used to develop the design of the single payer business to incorporate these principles discussed below.

Many opportunities to improve efficiency should be identified and exploited in the development of the reformed health care system, and other opportunities should be identified and exploited as the system grows and evolves in terms of populations, health care technology, practices, workforce development, and providers.

2.2.7.1 Accountability

Accountability is a major driver of efficiency, if the accountability is properly focused. The core-accountability of the new system, is to the public, and particularly those who are underserved. The system is managed with a conflicts of interest, from Congress on down. Consequently, the Oversight and Accountability agencies in each state must bear the burden.

2.2.7.2 Economies of Scale

“Economy of Scale,” typically means that where there are separate organizations doing essentially the same work, you may have an opportunity to do the work in one organization where you cand potentially specialize the work of some people to do their tasks more quickly, and with less distraction, or just improve utilization of fixed cost elements. In the proposal, the consolidated patient records system creates a consolidated service without consolidating the current providers, but rather “federating” the services to report the updates to the single records management system. The system will be viewed by users as consolidated, but the source organizations need not change. (they may stop providing a general inquiry service).

In the proposal, economy of scale is achieved for providers by reducing the number of different insurance company benefit packages a provider must work with to make claims.

2.2.7.3 Consolidation

Consolidation typically involves merging multiple organizations that are doing the same or similar work to leverage special skills, balance workloads, and cover absences and terminations. In the proposal, the elimination of insurance companies is a consolidation of provider contracting, patient records and benefit payments. That is a major source of savings in administrative as well as payer management personnel, in addition to elimination of the non-beneficial cost-cutting and denial/delay of service authorizations.

2.2.7.4 Consistency

Consistency primarily applies to consistency of the tasks performed by people, more than employees, particularly in the proposed system. It includes provider personnels, patients, and Oversight and Accountability agency personnel In addition, much of the tasks of how the work is being done is driven by information systems, particularly the user interfaces. This also yields savings in the development maintenance and adaptation of the systems to business changes.

The development of shared provider systems for claims submission and patient record updates, and the development of shared design of portals means that everybody who interacts with the national system, including its providers, will be comfortable with the same terminology, configuration and commands to the extent they apply to all of the portals. Again, this will also save time and money for ongoing maintenance and adaptation of systems.

Consistency is also critical to agility. If the business changes the adaptation involves fewer and simpler changes in personnel tasks and information systems.

2.2.7.5 Simplification/abstraction

Simplification or simplification applies to how people do their work and how well they understand the meaning, impact and responsibility of their work. It means their work is supported by a viewpoint that is less complex that the details of how a system, or business operation, actually works (an abstraction), and the viewpoint reflects how they think about the impact of their role on the larger system.

The tasks of individuals may be simplified regarding the various decisions they must make and the viewpoint of an affected system that expresses the related aspects of the system. The viewpoint must avoid unnecessary detail, or easy access to details that are sometimes needed.

This applies to the design of tasks as well as the design of user interfaces/portals. It reflects an understanding of how the user thinks about and needs to know about their participation in the greater system. That is also important to their appreciation of why they are doing the work, their responsibility.

2.2.7.6 Delegation

Delegation means passing work or responsibility for a complex task to another group or another algorithm of a computer system. This is particularly beneficial when the work requires special skills or knowledge and the same work can be delegated by multiple operations that share that same work, but don't need to share the knowledge, methods, resources, or skills required.

This is applied in the new health care system in the development of provider contracts. A national team is responsible for the design of contract templates to support the consistent format, organization, terminology and obligations of providers so the many contracts are easier to understand, and will be interpreted consistently although the actual contracts may have very different details regarding the delivery of different services and the context in which they are performed. The details are left to the regional office contract managers for the specific providers who will use the templates, and may refer to the template designers if they need some clarification, modification, or new development of a template.

2.2.7.7 Capacity Management

Capacity relates to the resources, machines, facilities, personnel, inventories, and more that are required to fulfill the delivery of a quantity of services of a particular administrative activity or management of central business operations, or operations of a particular provider or a Overview and Accountability agency.

This requires a knowledge of the volume of activity normally encountered, in the variance in that volume, and the delay that may be experienced, and/or the source(s) of additional resources that could be engaged when the volume increases. The critical issue is the severity of

variances that require on-site resources, on-call resources, response delays and back-up resources, and the costs, and duration of such reserve resources. This is typically a question of personnel, but it may also be a matter of fixed resources such as building space/rooms, imaging equipment, surgery facilities, and so on, depending on the provider.

These issues should be addressed based on national standards and the knowledge and expertise of a leadership team to ensure that the national system is ensuring the ability to respond appropriately to unforeseen circumstances without a massive reserve of personnel and other resources.

This issue is not addressed in the proposal, but is an issue for careful consideration in each up-coming deployment of a transformation phase.

2.2.8 Health Care Strategic Priorities

This objective is to focus attention on the future, both for immediate concerns and for continued improvement of the health care system based on an overview of the operational system and the experiences and health challenges of the people that are or should be receiving services and those who need refinements in how the their needs are addressed.

The national system, together with the state Overview and Accountability agencies (O&A), will have a broad perspective on the current operation, but the patient histories and outcomes will provide insights into potential improvements, and the patient records should also provide a basis for clinical studies and trials.

The strategic perspective should provide a basis for national investment in continued improvement in the following domains of expertise:

- **Research** on new core technologies, including basic understanding of the current and future medical knowledge, medications, cures, therapies, and the human body system.
- **Development** of the application of insights and technologies based on research.
- **Education** of health care knowledge for research, development, practices and delivery, including the general public and political leaders.
- **Practices** of health care providers,
- **New benefits,** funding of the actual delivery of better health care and quality of life to the people of the nation.

Some particular strategic concerns are described, below as issues to be addressed as the system transformation is under way.

2.2.8.1 New Forums for Collaboration and Leadership

Leaders from the national system of health care delivery, from the state Oversight and Accountability agencies and leaders of providers should participate in professional associations to address the strategic priorities and potential advances in their domains of expertise.

This requires an administrative activity and an overhead fund for participation of internal leaders and leaders identified from providers and O&A agencies.

Informal leaders should bring their initiatives to the attention of their state Overview and Accountability agencies for assessment of impact and approach to delivery of new benefits and proposals for funding of research, development and advocacy to the general public and political leaders.

These efforts muar change the priority on advances from increasing profits and cutting costs to improving effectivity and advancing methods and technology to improve the delivery of better health care, and delivery of new solutions to improve lives, as well efficiency is a beneficial objective.

2.2.8.2 A Current, Strategic Priority: Psychotherapy

Current mental health care is primarily focused on people who suffer from behavioral symptoms that interfere with orderly-thinking , impulse-control, or perception of reality in the form of depression, delusions or hallucinations. Some of these may be a consequence of childhood brain development or adult trauma, but all of them can have better outcomes with psychotherapy that help to achieve better outcomes to adapt their brains to cope more effectively with their disturbed or disordered thinking and realize more desirable accomplishments.

Unfortunately, these symptoms of mental disturbances tend to first be blamed on bad parenting, maybe bad inheritance, then just bad behavior, as they get older or more disruptive. We have focused on medications as the primary solution to control the bad behavior. Recently, Doctor Thomas Insel has brought psychotherapy aro the forefront as an essential component for treatment and recovery from of the wide range of mental disturbances from anxiety and suicide to mania, hallucinations and violence. (See Reference 5.1 and the associated video).

Unfortunately, the current health care system, and particularly public mental health, is focused on medication as the primary, health care treatment. That may be appropriate for care of acute disruptive behavior, but the public mental health system systematically excludes people who only need acute care when they exhibit behavior that makes them a present risk of “danger to themselves of others” (i.e., “severe mental illness”). Those accepted are most often “warehoused” with symptoms controlled with medications, and no psychotherapy to recovery

or adapt their disordered thinking. That must be transformed, at least to recognize that recovery is essential, and psychotherapy is an important treatment option.

This proposed health care system transformation cannot immediately solve this problem, nor address the actual scope of the need. See Section 2.2.6.1, Current Mental Health Intervention).

Reference 5.11, “Healing,” reports on progress to bring real recovery to people suffering from mental disturbances, through psychotherapy. See also the associated video with Dr. Insel, presenting recent advances in psychotherapy.

Psychotherapy is based on brain elasticity that enables individuals to adapt, based on experiences, to cope with changes, trauma and stress as well as learning. People with serious mental illness have difficulty with perception of reality of various forms, causing them to develop responses to their perceptions that may result in paranoia, unrealistic emotions, hallucinations, imaginary voices in their heads, and violence. Medications can help control this disordered thinking, but it does not help them adapt their brain to properly perceive and react to the real world. Psychotherapy can help the brain to adapt. This recovery/habilitation for healthy minds has broad implications.

2.2.8.3 Emerging Psychotherapy Technology

See Reference 5.1 that describes the revolutionary work of Thomas Insel, M.D., to redirect the focus of mental illness research to psychotherapy, complemented by psychiatric medications as needed, to enable persons suffering from serious mental illness, as well as lesser mental disturbances to the individual to learn, adapt and recover through psychotherapy. See also, the associated video of a more recent meeting with Dr. Insel.

2.2.8.3.1 Psychotherapy, Health Care for the Mind

This proposal introduces psychotherapy as a fundamental form of health care that is essential to widespread quality of life. This is discussed at length in Section 2.2.8, Health Care Strategic Priorities. The extensive use of psychotherapy is a strategic objective, because it is emerging as a major advancement in mental health, along with diagnostic technology.

Psychotherapy is a part of health care for the whole person. It is particularly needed as a result of a traumatic experience or other mental disturbances. There are many circumstances where psychotherapy can be essential, and it may be life-saving.

Sometimes, the difficulty may be resolved by family or friends. But physicians and others must be sensitive to circumstances that suggest a mental disturbance may be a physical, medical problem, a perception problem, a perceived disability, or a lifetime risk.

2.2.8.3.1.1 Psychotherapy Today

- Psychotherapy is very limited in general health care, and it is very underutilized. Serious mental illness is treated for acute care for a limited duration in hospital care.
- Serious mental illness is almost exclusively treated in Medicaid in various forms of long-term care, but it is generally denied unless there is as a present danger of, injury to self or others, including suicide.
- Use of any psychotherapy is very limited for less serious mental disturbances under Medicaid. The rate of suicide has been increasing in teenage children, but there is seldom intervention before suicide is attempted.
- Psychotherapy is recently applied for PTSD in Veterans Health care.

The future of psychotherapy will have a major impact on society, beyond current health care. See section 2.2.8.4 for Psychotherapy Major Opportunities.

2.2.8.3.2 Advances in Psychotherapy

Reference 5.1 includes a link to a YouTube video of Dr. Insel discussing his more recent work at a conference. He includes work to explore the potential impact of psychotherapy on a variety of groups with different thinking disorders to significantly adapt their minds to an improved outlook on their lives. This is not just persons with serious mental illness, but also persons with less severe disorders that interfere with their emotional, social and learning experiences. This is a foundation for major advances in health care and rehabilitation of millions of people who suffer from disabling mental disturbances to be addressed by psychotherapy.

2.2.8.3.3 AI Mental State Diagnostics

Dr. Insel also discussed work on computer applications (AI?) to interpret a person's visual expressions and conversation to essentially evaluate the nature and severity of their thought disorders, potentially an analog to laboratory work that measures diagnostic symptoms and medical conditions. This is a major advance for mental health diagnosis and treatment and evaluation of outcomes. Objective assessment of needs, along with objective assessment of meaningful outcomes are essential for accountability of psychotherapy benefits in a future health care system.

2.2.8.3.4 Psychotherapy *Clinical Research and Trials*

Dr. Insel has conducted various clinical studies in the potential outcomes of psychotherapy in selected domains of people who are affected by mental disturbances The expansion of research in clinical trials is of particular importance in the domains discussed, below. These domains also reveal the need to address aspects of level 1 of Maslow's needs hierarchy and to address complementary needs that are associated with these major, national disturbances.

Clinical trials may be a good application of private funding, from a separate budget but with use of the national system resources for formation of studies and trials and capture of patient outcomes.

2.2.8.4 Psychotherapy Major Opportunities

There are millions of people who are desperately in need of psychotherapy help. Recovery of a small percentage of these populations could have a major impact on improved quality of life and billions of savings in Federal funding, both for health care costs, and the cost of assistance for persons who are functioning at level one of Maslow's needs hierarchy.

2.2.8.4.1 Poverty Mental Health Psychotherapy is Critical

Systemic poverty is so serious, and growing, that recovery measures cannot be delayed. Our national economic-system, systematically creates new members of people, particularly families in poverty because of economic crises, changes in employment markets, changes in technology, failures or cut-backs of corporations and governments, as well as individual economic crises due to costs of severe illness or injury.

This is the front line for introduction of psychotherapy. A plan must be developed for emerging practices in early phases of the transformation to start growing a workforce with training and recruiting to serve some people who will benefit, possibly from short-term interventions as the work force grows in size and levels of skill.

2.2.8.4.1 Recovery from Despair of Poverty and Other Thought Disorders

Many people may be lost from despair resulting from various forms of loss or trauma, and they may just drop out or pursue a destructive purpose, without raising attention or concern by others around them who don't know how to help. They need psychotherapy

- Recovery from economic crisis (parents and children are different)
- Childhood recovery from childhood trauma or mental illness
- Adults with serious mental illness who don't know they are ill {anosognosia}
- Recovery from death of a loved one
- Street gang member recovery of purpose
- Inmates, recovery from criminal conviction?
- Recovery from loss of belonging in aging, dementia
- Recovery from serious mental illness despair in failure of recovery
- Recovery from trauma or abuse
- Recovery from loss of purpose

- Recovery from disparagement or degradation

The following are large populations that are suffering for need of psychotherapy, but they may also need help address other needs in Maslow's needs hierarchy, that may not be addressed by good health care.

2.2.8.4.2 Children in school with thought disorders

Children, with developing minds that suffer mental disturbances that may be caused by biological brain disorders, trauma, other handicaps, resulting in domestic violence, abuse, criminal behavior or participation in criminal enterprises. Many children need help in their current mental state and in the development of their minds to become well-adjusted adults, prepared to join the "middle class," who can cope with the complexities, challenges, disappointments and trauma of a complex world.

This raises a desperate need to expand the scope of our education system, to educate children about the United States system of government and political, social, financial, economic, health and lifetime issues that they experience through public media and their family circumstances and behavior, before the graduate from high school without the knowledge and skills to become members of the real world of adults, and the educated voters expected by the country's founders. Studies of history are important, but don't address understanding of today's world. Contemplation of graduation and the actual experience may be cause of serious needs for psychotherapy. This is also a period when many young people experience an onset of serious mental illness.

2.2.8.4.3 Persons with a serious mental illness

Hundreds of thousands of persons suffering from a serious mental illness have misperceptions of reality that result in bizarre behavior and further impairment of logical and socially accepted behavior. Many end up spending the rest of their lives in isolation, supervised or assisted care, with no future. Psychotherapy may achieve recovery for many of these millions of lost souls.

Mental health psychotherapy is a missing component for recovery, from serious mental illness as well as lesser disturbances that burden otherwise productive lives and quality of life. We have begun to recognize psychotherapy is an essential component of recovery, Reference 1, "Healing, Our Path from Mental Illness to Mental Health," Doctor Thomas Ingel, M.D., former Director of the National Institutes of Mental Health, asserts that psychotherapy should be a primary treatment for many cases of mental illness, that may or may not require complementary medical treatment.

Reference 5.1 and the accompanying video presentation, describes the value of psychotherapy as essential to all mental disturbances, potentially alone, or as a complement to medical treatment that heals the brain to enable acceptance of psychotherapy.

Reference 5.2 describes the importance of “belonging,” joining with others in shared interests that are bigger than yourself, an aspect of Maslow’s, levcel-3 needs.

2.2.8.4.4 Persons trapped in poverty

Millions of persons in who are in poverty, live in despair, with no hope for a better future, only threats to their survival and safety (Maslow’s bottom, two levels). Theu need to find hope and purpose, along with assistance in the realization of opportunities to rise above poverty for a better life. Currently 42 million Americans rely on Federal food assistance, and their basic survival needs are at risk. This is a growing population as more people are driven into poverty by circumstances beyond their control, such economic crises, natural disasters, job losses by changing markets or corporate failures, and mental illnesses.

2.2.8.4.5 Criminal Justice for Mentally Disturbed People

Hundreds of thousands of persons are in jails or prisons because their symptoms of mental illness caused them to exhibit criminal behavior. Many of these actually have capabilities obscured by their mental disturbances, and they may return to productive lives with psychotherapy and possibly some medication to control symptoms. There could be recovery for many of these people before they are arrested, or when they are incarcerated or after release. This could dramatically reduce bloated jail and prison populations, in addition to reducing the criminal behavior that gets them arrested and convicted.

2.2.8.4.6 Elderly Psychotherapy

Elder patients potentially who are suffering from life-threating illness, may have particular needs for psychotherapy. These issues may not be fully resolved by psychotherapy, but the therapist can help clarify needs and challenges and assist in finding help and identifying new personal purpose. The following issues for psychotherapy may be more common with elders.

- Mental state assessment regarding, e.g., anxiety, depression, complaints, aspirations
- Competency assessment for consideration of guardianship
- Distress resolution regarding personal concerns
- End-of-life anxiety
- Death with Dignity
- Preparations for Death
- Putting life in order, e.g., finances, relationships, assets, beneficiaries.
- Power of attorney for delegation of decision-making authority
- Consideration of palliative and/or hospice care

See Section 2.2.5.3 regarding guardianship accountability.

2.2.8.5 Alternatives to Long Term Care

In addition to recovery, psychotherapy may reduce the need for long-term care through changes in health care funding and new programs to support independent and family living with disabilities. Long-term care is often a choice as a result of a lack of support services and burdens on the family care-givers. Families may also find other alternatives when poverty is no longer a requirement affordable health care.

Many persons living in long-term care may be able to live independently or with family at lower cost and better quality of life, without undue burden on the family or risk of being alone in an emergency.

Some potential health care benefits that might be funded with proper consideration of circumstances:

- Physical handicap Assistance
- Daily living assistance
- Medication management
- Remote medical status monitoring
- Remote psychotherapy
- Transportation (visiting doctor or nurse)
- Financial management assistance

2.2.8.5.1 Long-Term Care Providers

Employees with limited interpersonal skills now care for people who are in long-term care.

Patients may be at Maslow's level 1, physiological needs because they are not treated as real people that need help. They do not have their normal homes and relationships for extended periods of time and may have continuing family financial challenges. In addition, they continue to have higher-level needs that they may have lost by being isolated from their normal living environments.

Workers involved may be a relatively stable workforce, but they should be appropriately educated and certified in their caring roles, with proper compensation and staffing levels, but also empathy for patient difficulties and losses from their former lives.

Patients have lost their normal opportunity to satisfy higher levels of Maslow's needs hierarchy, and they may have lost some levels of need-satisfaction that they had achieved. The long-term care environment becomes their whole life for satisfaction of the higher-level needs. Psychotherapy can help them adapt or overcome these disappointments, and find a new, less ambitious purpose, potentially related to other patients.

Patients will need programs to fulfill some higher-level needs, particularly engaging with other patients or staff in interesting activities, possibly related in some way to do volunteer or

collaboration work or social activities, even if only through social media or on-line meetings or group discussions. There can be more inexpensive approaches, but it requires staff time to plan and organize such activities, with attention to the physical and mental limitations of individual patients.

Reference 5.4 describes the pandemic effects of economic crises causation of poverty in the United Kingdom, Russia and in the United states, and the desolation of impoverished families.

2.2.8.6 Mental Health Interventions

Mental health is an important, misunderstood, component of general health that is essential to quality of life, no less than fire protection, criminal justice, natural disaster response, national defense and management of international pandemics.

It is an aspect of economic crises that, like biologic epidemics, drives segments of the population into personal economic crises, and often poverty, untreated health conditions, and homelessness. These “epidemics” often “infect” the future generations.

There may be a need to address a critical event, or a transition(s) with continued psychotherapy.

Intervention in mental disturbances, is particularly important, if a potential recipient does not understand their need.

2.2.8.6.1 School Child Interventions

The education system is not only important for development of basic skills, but the environment in which the brains of children are developed as members of society and personal relationships, as well as formation of interests and aspirations are important, and formative. These aspects of education are ignored, instead, the focus is on competition and winning, rather than collaboration and teamwork.

There is a need for the health care system to be connected to the education system to provide professional intervention when individual children exhibit mental disturbances and challenges that can be improved with psychotherapy or other treatment to address less apparent disturbances or disabilities. This can improve their whole future. In education needs to include development of adult minds, capable of coping with a complex world, and understanding why we have a Constitution.

2.2.8.6.1.1 Family Interventions

Families have problems with domestic conflicts and mental disturbances of their members, particularly their children, that they don’t understand, and they don’t know where to turn. Today a seriously mentally ill family member may be causing serious problems for the family or community problems, and the public mental health system ignores these problems

unles12/21/2025s there is evidence of potential harm by the person to themselves or others. These concerns should be addressed as quickly as a common injury or fever.

2.2.8.6.2 Homeless Intervention

There are many people who are homeless with health care needs, some without the mental opportunity, initiative, competence or awareness of their needs. They must be contacted in the shelters, on the streets or identified by people who have contact in places where they may congregate (police, libraries, soup kitchens, churches,,…). Currently, public mental health services funded by Medicaid may avoid intervention unless they are seriously mentally ill and at risk of injuring themselves or others.

2.2.8.6.3 Long-Term Care Intervention

Persons in long-term care may need intervention to deal with the life change entry into long-term chare: isolation from friends, family social relationships, general contact with the outside world. Particularly in care for the elderly, their mental state may change, they may be suffering from changes in an illness, or pain, they may have lost a loved one and have been separated, they maybe contemplating their end of life. Their staff may or may not recognize their need for help coping with such events. These may have long-time effects on their quality of life that can be improved with even brief psychotherapy.

2.2.8.6.4 Workplace Interventions

Employees often evidence mental disturbances or irrational behavior that is a concern, but may result in discharge rather than help, because there is no way to call for objective, outside assistance. Sometimes these situations can turn into violence, and there should be ways to engage professional intervention, before there are serious consequences.

2.2.8.6.5 Crisis Intervention

Public health services must respond to mental illnesses crises with corrective intervention rather than dismissing the problem unless there is clear evidence of potential harm to self or others. A crisis is clear evidence of a serious mental health problem that must be addressed.

2.2.8.6.6 Criminal Justice Interventions

Police and other criminal justice agencies will become aware that their intervention is needed to ensure that a problem is properly, professionally addressed, even though the complaint may be minor, but is evidence of a mental disturbance. Professional mental health assistance should be engaged, possibly just providing referral for families or other associates. Many criminal behaviors of persons suffering from a mental illness may be prevented before the behavior becomes a criminal justice problem. There are multiple points for potential intervention as a person goes through the criminal justice system:

- Arrest
- Pending trial,
- Incarceration
- pending discharge
- Discharge

These are events where the person will experience significant stress and difficulty adapting to the circumstances, the change, and freedom restrictions. Inmates may each have different challenges that require psychotherapy to adapt and potentially find new purpose. Successful psychotherapy might result in discharge to a new life purpose and recovery from the circumstances of the criminal conviction, potentially including management of a mental illness, (but not likely in the current national systems).

Early intervention and appropriate psychotherapy at any stage could result in major savings in the cost of the criminal justice system, and particularly the bloated populations of jails and prisons.

2.2.8.7 Psychotherapy National Benefit/Savings

- Children (Successful, educated citizens, increased middle class (versus drop-outs, antisocial behavior, bullies, suicides, mass shootings, protests, and financial assistance)
- Poverty (meeting Maslow level 1 to 3 needs, reduced costs of assistance, reduced unemployment, increased tax revenue)
- Serious mental illness recovery (health care costs, lost productivity and increased tax revenue), plus major improvement of their lives and their families
- Long-term care (distressed, mentally challenged, poor quality of life improved for remaining years of life)
- Hospitals (cost of uninsured (eliminate charity health care costs and cost-shifting)
- Incarceration (Rehabilitation, reduced jail and prison costs, potential reduction in crimes and criminal justice costs and injuries)
- Street gangs (reduced violence and other crimes)
- Reduced unemployment, entitlements, subsidies)

2.2.9 Information System Objectives

2.2.9.1 Enhanced, Core, Health Care Information Systems

Many of these systems manage information of interest or provided by different groups of users. Each of them must have portals designed for the interests and ease of access by their different interest groups with associated privacy and threat controls.

Some of the systems described below provide fundamental facilities today, but they must be significantly enhanced as part of a national system. Others are providing new capabilities or economies of scale not achieved before. Economies of scale bring reduction in the cost of better sources and insights from the shared information

2.2.9.1.1 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, including records as multiple doctor's offices. 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 that 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.

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

2.2.9.1.2 National, Equitable 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.

Other changes must be reviewed by representatives of the O&A agency of the reco[oemt's state. Changes to the system design should be reviewed by O&A and other advocates in advance.

2.2.9.1.3 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.

2.2.9.1.4 Value Delivery Analysis and Accountability

VDML (Value Delivery Modeling Language) is an industry standard modeling language based on the analysis of the sequence of value added to a flow of work (or funding) to deliver an end product.

Essentially, patient records will be a detailed, patient history of the delivery of health care services and outcomes, as 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 that 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 of doctors, or patients with certain diagnoses, and so on. This provides a number of options for analysis for a variety of reasons, including statistical analysis for accountability and delivery of values.

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

In particular, analyses of diagnoses, diagnostic and therapeutic techniques, and outcomes could be valuable for advances in application of AI for psychotherapy diagnoses, practices and outcomes for advances in this expanding field.

The patient records must be defined to identify and capture the measures of the value types of interest, and other treatment information when they submit the claim. The service providers (or the recipient) must record the recipient's value satisfaction level. 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 reported for the patient record, already. The extra value reporting/analysis would be done by computer based on the analyst's query (with strict controls of the scope and depth as well as access authorization to ensure privacy and confidentiality).

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

2.2.9.1.5 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, 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 change, the system changes must be effective to each of the providers affected.

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

2.2.9.1.6 Oversight and Accountability Systems

Systems for resolution of complaints and violations will need attention, but these agencies will need analytical tools for review of patient records a provider's performance, along with access to oversight portals on provider systems to consider qualifications, employee assignments/scheduling and outcomes.

2.2.9.2 Information Systems Technical Requirements

Technical aspects of information systems, discussed, below, are critical to the health care system: Reliability, Privacy, Standards, efficiency models and perspectives. These must be considered in the context of the size of the national system, the critical dependencies on continuous operation of the system, particularly emergency response to patient records b key providers, as well as privacy and confidentiality.

2.2.9.2.1 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

2.2.9.2.2 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 some 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 query must be kept to ensure accountability for potentially, 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

2.2.9.2.3 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.

2.2.9.2.4 Operating Efficiency

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

2.2.9.2.5 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

2.2.9.2.6 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)

2.3 Major 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.

2.3.1 Improved Individual health care

- Better outcomes through prevention, early intervention, appropriate care and rehabilitation
- No more rationed health care (capitated budget controls)
- Loss of health care coverage is no longer a risk of change in employment
- Affordable health care
- Psychotherapy for a health mind
- Potential recovery from poverty or mental illness
- 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

2.3.2 Improved Economic Welfare

- Uninterrupted health care coverage.
- Fewer people trapped in poverty by economic Despair
- Fewer, if any, health care bankruptcy
- Fewer families forced into poverty to gain access to health care
- Employees with employer health care will see their benefit converted to income
- Employers paying for employee health care will no longer have that big cost.
- 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

2.3.3 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

2.3.4 Enhanced Epidemiological Analyses

Depersonalized access to national health records for various forms of 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

2.3.5 Accountability in health care management

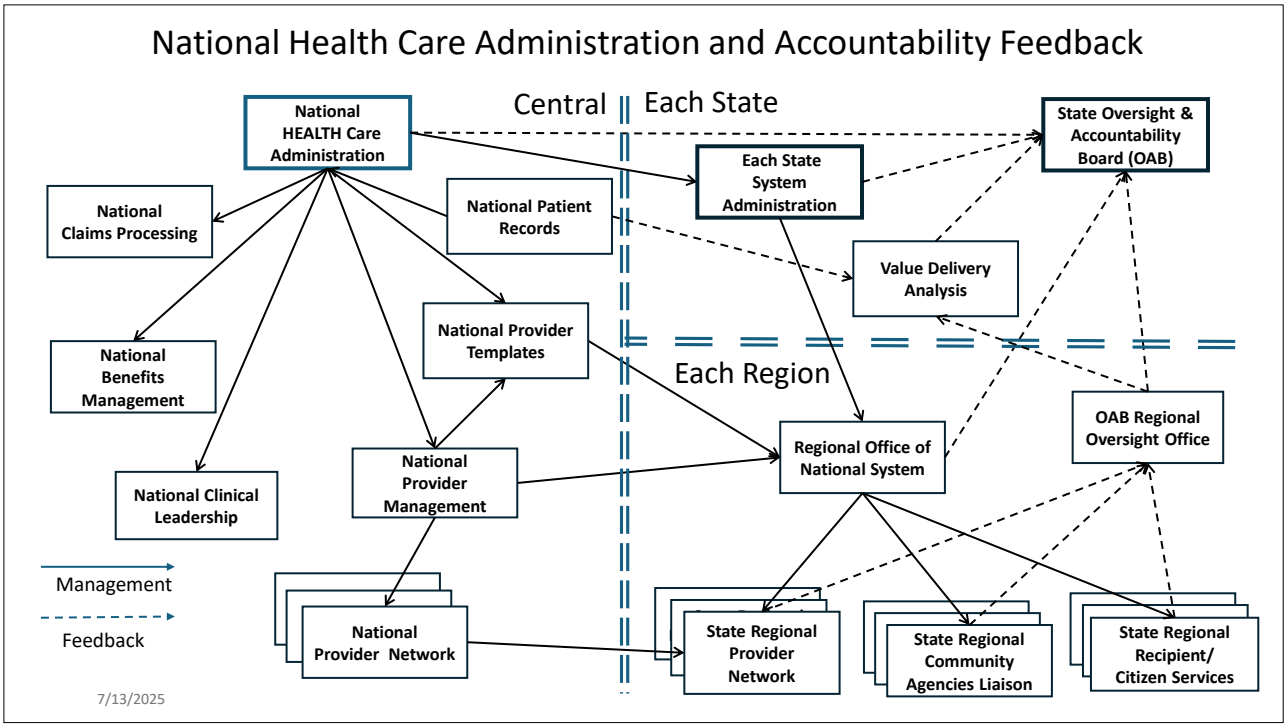
- Traceable funding
- Appropriate compensation
- Value delivered
- Performance oversight and reporting
- Participation of conflicts of interest
- Management of private payer offerings

3 Part 3, Single Payer System 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 (O& A) organization in each state, with the Federal office that is the center of operations in each region. The solid arrows represent the organization hierarchy. The dashed arrows represent the flow of accountability information through the Overview and Accountability organizations in each state. 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. However, much also comes from labs, scans, psychotherapy, 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 O&A 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, O&A, 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 and 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.

It might also include strategic planning, and initiation and technical support for clinical studies or trials. Clinical trials and studies and c may require independent funding as “private” funding, from and independent budget under Health and Human Services. (See Section 2.2.6.3)

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 for cutting costs and the availability of quality care. However, see the state responsibility for accountability of the proposed, nation-wide system (see Sections 2.2.6, and 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 agency (O&A)

O&A 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 O&A over the health care system.

3.1.2.2 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.

3.1.2.3 State Administration 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.

3.1.3 Each region

3.1.3.1 OAB Regional Oversight Office

This branch activity of the OAB is likely located in the national system each regional 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 and 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

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.

3.2.6.1 Oversight and Accountability agencies (O&A)

O&A agencies should apply value delivery analysis to evaluation by management and funding sources regarding their value delivered for the investment. However, this accountability is of most importance to the recipients and families that are affected 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 providers along the way.

These systems should become the basis for a grater scope of accountability of state and Federal systems as result of their independent, non-partisan role in holding legislators and Congress accountable to the general public for representing their interests, rather than the interests of profiteers and exploitation of less advantaged customers and employees.

3.2.7 Customer and Community Services and Complaints

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.

The regopma; office is also responsible for addressing complaints and investigation and resolution of recipient rights complaints. These must also be reviewed by the associated O&A office.

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.

3.2.8 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.

4.1.1.1 Expected Benefits

The following sections highlight a number of cost savings and expected service benefits, listed by different interest groups.

4.1.1.1.1 Single Payer, Federal Savings

- Federal savings from elimination of health care insurance companies from management of benefits and payments, provider contract management, company overhead, operating costs and profits.
- Reduction in health care service claims from better Health care: early intervention, timely care, shorter, less intense episodes, shorter recovery
- Other savings will result from better health care outcomes
- Potential reduced federal funding of other Federal poverty-based programs due to reduction of People in poverty, including persons suffering mental illness.
- Reduction in seriously mentally ill in long-term care (warehousing).
- Reduced mentally ill inmates in Federal prisons.
- Reduced CMS administration/oversight for each State share of Medicaid and ACA budgets.
- Revenue from the deductibles on benefits that are assessed based on a graduated scale of recipient ability to pay.
- Recognition and improved response to potential pandemics
- Include Federal employees, including Congress and Administration as national system recipients and their families. Will also provide importance of good health care to everyone.

4.1.1.1.2 Improved Health Care Leadership

Leadership is not confined to national system managers, but it includes leaders in particular health care roles and community relationships, advocates, state and federal government, and so on. National collaboration facilitated by Oversight and Accountability organizations.

- Participation by leaders throughout the system engaged with Industry and professional associations.
- Attention to strategic opportunities
- Insights for better treatments based on analyses of patient records for diagnoses, medications, treatment practices, patient history and outcomes
- Identification of long-term medication side effects and conflicts,
- Efficient formation and effective management of clinical trials
- Improved epidemiological analyses for trends and emerging epidemics

4.1.1.1.3 State Benefits

- Reduction of poverty and mentally ill populations impact on many associated state agencies such as welfare, social services and criminal justice
- State Oversight and Accountability agencies of Federal health care system (replaces other, state funded, oversight and complaint-resolution organizations.
- Reduced school suicides, bullying, violence, drop-outs through childhood, psychotherapy interventions
- Elimination of most of the Medicaid-match, state budget.
- Elimination of government employee health insurance costs
- Reduction in criminal justice, state and local, due to reduction in mental health, criminal behavior, and domestic violence through better mental health interventions and treatment (psychotherapy)
- Reduction of Jail and prison, health care costs (only some states use Medicaid).
- Reduction in jail and prison costs due to reduction in mentally ill inmates, through early, peace officer, intervention, improved treatment and rehabilitation.
- Reduction in shootings, domestic abuse and trauma through early intervention for psychotherapy, medications if appropriate, and rehabilitation, before the disturbed thinking becomes a more serious behavioral problem.
-

4.1.1.1.4 Benefits to Health Care Recipients

- Health care that is Equitable, Quality, Affordable, Accessible and Accountable, with attention to Strategic Priorities.
- Recognition and improved response to potential pandemics

- Psychotherapy for poverty despair, along with non-health related, economic recovery, assistance will result in a significant improvement in health and quality of life, and reduced poverty population (and restoration of the “middle class.”
- Elimination of employer-paid health insurance will eliminate job-change or loss, health risks.
- Crisis/emergency response teams that have health information, nationwide, support of mental health professionals, for more peaceful outcomes.
- Medicare recipients will have coverage that is extended for long-term care, so they still have a benefit from their somewhat lifelong contributions to the Medicare fund.
- Elimination of Medicaid personal debt.
- Health care coverage premiums and deductibles will be adjusted to be affordable wo that everyone can afford proper health without a consequential risk of a health and economic crisis.
- Health care that is always there and accessible.
- Cost of employer health insurance will become employee income.
- No longer need to coordinate care between your treating professionals regarding medications, treatment, and diagnostic reports (consolidated patient records).
- Faster and easier for you to access your patient records.
- Remote monitoring and home support to allow people to live at home, with family, or live independently rather than in long-term care with restricted of transportation and social relationships, and loss of quality of life.

4.1.1.1.5 Employer Benefits

- Elimination of employer-paid employee health insurance bill, along with insurance company and union negotiations.
- Elimination of health care insurance costs improves international competition.
- Reduced employee absences due to illness
- Health care intervention for employees with personal and family-member mental heath concerns.

4.1.1.1.6 Provider Benefits

- Reduced clerical workload due to only one payer, one benefits package, one set of portals, and one provider network.
- Authorized professionals have rapied access to consolidated, nation-wide, patient records.
- One set of system interfaces and one-contractor set of contract terms to reduce complexity and administrative support.

- Reduced clerical workload caused by multiple insurance companies with different portals and supporting systems, ,different benefit restrictions, cost-cutting schemes, claim payment and patient record systems.
- Appropriate compensation for quality services delivered, support personnel job satisfaction and less turnover.
- Compensation for professional collaboration and consultation promotes better care and sharing of knowledge.

4.1.1.1.7 General Indirect benefits to society

- No more 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 and despair.
- Fewer, if any health care bankruptcies
- An end to health care deductibles as financial barriers to recovery
- No health care economic risks due to a recession or job loss
- Epidemiology analyses of population or trends, outcomes, risks, epidemics
- Efficient formation and effective management of clinical studies
- Recognition and improved response to potential pandemics
- Reduction in shootings, domestic abuse and trauma through timely intervention in behavioral health disturbances

4.1.1.1.8 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.

4.1.1.1.9 Indirect Costs

As a country, we need to find effective ways to reduce the pain of economic disruptions on the less fortunate and middle class citizens that suffer through these periods of personal chaos, while bankers and billionaires find way to get richer. This health care transformation is an opportunity to learn and adopt practices and supports to make these painful experience into opportunities for a better live. We did something very important with the GIBill, after WW2.

- 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.

4.1.2 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 people to be recipients of health care services. These segments of the population are identified as those people 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 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.

4.1.3.3.1 Transformation Workforce (Program requirements)

4.1.3.3.2 New Administration Workforce (each phase)

4.1.3.3.3 Upgrading Existing Health Care Personnel (each pase)

4.1.3.3.4 Development of a Psychotherapy National Workforce)

- Psychotherapy professionals
- School Teachers
- School intervention professionals
- Mental heath providers
- Health Caregivers
- Law enforcement
- Incarceration staff
- Welfare staff

4.1.3.4 Development of a New Psychotherapy Culture

- Recruiting programs
- Professional education programs,
- Training for teachers
- Training for health care workers
- Training for criminal justice professionals
- Training for welfare workers
- Interventions for persons in poverty and other large groups of people in despair by failed systems such as mental illnesses, personal trauma, aging, and children challenged by a narrow minded education system that fails to prepare them for lives as adults in a complex world.

4.1.3.5 Development-contractor RFPs

RFPs (Requests for Proposals) 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.

4.1.3.6 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.

4.1.3.7 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.

4.1.3.7.1 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.

4.1.3.7.2 User/web interfaces (Portals)

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.

4.1.3.7.3 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.

4.1.3.7.4 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 it 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.

4.1.3.7.5 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, psychotherapy 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.

4.1.3.7.6 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.

4.1.3.7.7 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.

4.1.3.7.8 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.

4.1.3.7.9 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.

4.1.3.7.10 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.

Medicaid and Medicare

- 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.
- Alternative Affordability AdjustmentsThere 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 may 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.

Subsidies, Premiums and Enhanced Care

- 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 health care qualifications and insurance company closures, system transformation, retraining, , 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 O&A 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 O&A 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 qualification 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 inconsistent 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.
-

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 people 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.
- This deployment will add long-term care to the former recipients of Medicare. This should be noted as the assignment of the Medicare fund, their long-term investment is Medicare, but Medicare is now replaced by the National health care system. The subsidy/cost adjustment should reflect an adjustment for equity/affordability.
- Incarcerated persons may be included at the discretion of the state or Federal administration. But the cost, the continuity of care and benefit of psychotherapy 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)
- **State Hospitals**

Existing state hospitals, for persons with serious mental illness, should be treated as long-term care facilities owned by the state, but for persons with incurable, violent behaviors. They must be upgraded in terms of national, health care objectives and coverage, but they also might be

transformed to function as community, general hospitals in “health care deserts.” This is an opportunity for the state to address the need for hospitals in “health care deserts,” generally low income and rural areas.

- Congress should consider funding the cost of establishment of state hospitals in states with significant “health care deserts.” These may include long-term care services, but long-term care for seriously mentally ill persons should diminish under the new system as a result of a focus on recovery and psychotherapy,
- Transformation of State hospitals should be included in Phase 4, effectively in the deployment of Medicaid long-term care services.

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 psychotherapy 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, psychotherapy 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 Employer-Paid Coverage, Uninsured, 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.
- Some or all of these recipients may be added individually, as they become no longer covered by their insurance company. Some may require outreach of the regional offices.

This phase may lead to the phase-out of 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.
-

4.2.6 Phase 6, Provide populations in non-Governmental 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, hospital 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.
- Psychotherapy 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 psychotherapy. 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 psychotherapy, potentially complemented with medications, to heal the brain and effectively re-program the brain to restore healthy thinking. Here is a more recent video discussing advances in the use of psychotherapy to achieve dramatic improvement in mental disturbances including serious mental illnesses.

How to build up mental health with Tom Insel, MD

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 (e.g., 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 techniques for health care. OMG works on system modeling, interoperability and integration standards as primary objectives.

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

   - 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 politics, and political problem solving.

5.11 Trigger Points: Inside the Mission to Stop Mass Shootings in America

Mare Follman is a journalist, reporting on various efforts to understand and reduce mass shootings in America, starting with a study in the 1970s, leading to efforts to intervene with persons who exhibit potential threats and averting the potential threats. This has resulted in red flag laws to recognize behavior of people who hac early symptoms of potential, violent behavior and intervene. This has been somewhat effective, but of course, the root causes of the mental distress, most likely occurred much earlier. Causes of PSD emerge long after the trauma of military combat. Psychotherapy may be a major factor in prevention of violence if there is timely intervention.