MEDICAL CARE REINVENTION ACT

Better Health Care for the Money

A legislative act proposed by Dr. John R. Dykers Jr., M.D.

No one is happy with the present health-care delivery system. However, changes, even if improvements, will cause dislocations in the lives and pocketbooks of providers and patients alike. It is an important goal of any changes that they be improvements and that those changes minimize dislocations and disruptions.

COMMENT

We all have a justifiable terror about a single-payer system because of our past experience with government. Everybody's money is nobody's money and the individual responsibility defined in this act is there for the purpose of trying to avoid as much of the inherent wastefulness of such a system as possible. Those of you who are wiser in the ways of government may conclude that this is a foolish hope, but this must be balanced by the terrible waste and dissatisfaction of all of us-- doctors, other providers, patients and payers-- with the present chaos and inefficiency and inequity of the present non-system.

Every day we are evolving fantastic new eyes with which to see and with which to learn about the pathophysiology of the human organism. We are constantly devising new ways to interrupt sickness to create wellness. We are all willing to pay for health care, or we should be. We should not be willing to pay for layers of functionaries who create impediments to health care by interfering with honest payment..

Determining the magnitude of the dollar penalty for being born with an unhealthy gene versus living in an unhealthy manner creates tricky dilemmas.

Medicine is practiced. A standard of perfect outcome is unrealistic. Physicians and hospitals --and all who care for patients-- must be encouraged by the system to learn from their mistakes. We are all ignorant, and can only be so. We should be expected to make the effort to push our ignorance out to the edges of human knowledge.

An Alexandrian cut through the Gordian knot of the current mess must be tempered with practical realism.

The primary problem is how money flows and why. This act will create a voluntary system so effective that it will be foolish for most people to remain outside the system. However, a few may wisely decide to do so. Those who unwisely decide to do so will have no barrier to subsequent entry.

Every adult wishing to be eligible to participate must choose a primary-care physician -- who may be any physician licensed to practice medicine in any of these United States and who is willing to accept for that person the role of primary-care physician as defined in this act. (NOTE: THIS ACT specifically does not limit that role to those groups of PHYSICIANS classically designated as PRIMARY-CARE physicians because some persons with previously diagnosed dominant illnesses who have a current dominant relationship with a physician in a more narrow specialty who nevertheless is able and willing to accept the primary-care role for a specific patient and who may refer that patient to a more classical PRIMARY-CARE physician as easily as the reverse might be true.) This Act encourages the physician who is an aloof "prima donna" to develop good "bedside" manners. It is a goal of this act to enhance the therapeutic effectiveness of the relationship that exists between every patient and their chosen physician. The Primary-Care Physician must be an individual.

Every person under age 18, who wishes to participate, similarly must have chosen for them by their parent or legal guardian, a primary-care physician.

If a patient and primary-care physician agree to enter into such a relationship, they shall jointly notify the FEDERAL AGENCY for MEDICAL PAYMENT (**FAMP**), hereby established by this act, as follows:

I, full name and social security number, do hereby request, and I, full name and social security number, do hereby agree to serve as primary care physician for, full name and social security number, beginning, date.

Either party may rescind this agreement without cause by notifying FAMP as follows:
I, full name and social security number, do hereby terminate my request/agreement to relate to, full name and social security number, as patient/primary care physician.

After a first termination without cause, a patient may enter into another primary-care agreement with a different primary-care physician but cannot terminate that agreement without cause for 60 days. A third agreement cannot be terminated for 6 months, a fourth for one year and a 5th and any subsequent agreement for two years. A physician may similarly terminate a first agreement with a patient at any time without cause, but second and subsequent agreements with the same patient must adhere to the same schedule as the patient schedule.
If at any time the primary-care role is more appropriately assumed by another physician, and it is mutually agreed by the current primary-care physician, the patient, and the succeeding primary-care physician, the change may be made, but the succeeding primary-care physician/patient relationship may not be unilaterally terminated without cause for two years.

(**NOTE**: The purpose of this RESTRICTION is to allow freedom of choice but to prevent PHYSICIAN/PATIENT manipulation, either "DOCTOR SHOPPING" or "CHURNING".)

The primary-care relationship may be terminated at any time for cause, primarily for death or geographic movement of either party, or for non-compliance, a special situation.. Termination for cause returns both parties to the starting point of the schedule for terminations without cause. (This enables a PATIENT to find a new PHYSICIAN without impairing freedom of choice.) Death of the primary-care physician returns the patient to the beginning of the choice process. Geographic relocation of either the physician or the patient that increases the travel requirements of the patient by more than 15 minutes returns the patient to the beginning of the choice process. Geographic relocation that decreases the travel requirement has no effect. Termination for non-compliance requires the referral of the patient for a hearing within 5 working days before a 3-doctor panel of physicians who are experienced practice inspectors (*FAPA as defined below*) and, the judgment of that panel must be rendered at that hearing and shall be binding. Any terminated patient shall have the right to appeal that decision to Federal Court, but is terminated pending judicial decision to the contrary.

(The PHYSICIAN already has economic disincentive to TERMINATE any patient . IF the TAXPAYER is paying for care, the taxpayer has a right to expect compliance. A PATIENT is always free to purchase care outside the program. The possibility of NONCOMPLIANCE is especially powerful if people want or need the taxpayer to pay for their medical care. In reality this will have largely been dealt with in the selection process: The patient will have shopped until they found a physician that suited them.)

The PCP and the FAMP shall maintain a list of all patients cared for by the PCP, and FAMP shall pay the Primary Care Physician (estimate $40+/-$10per month per patient) for each patient on the list for all or any part of each month. The PCP shall have the right to delegate functions to other qualified persons and may pay others to perform the PCP functions but will retain authority and responsibility for all such functions. The patient may pay to the physician a mutually agreeable incentive to fill that role and the physician may rebate to a patient all or part of list fee! (This allows the MARKET to have an effect on the selection of primary-care physician without being a dominant determinant. Over-served areas OR beginning practices might find ***rebates*** necessary AND private ***incentive payments*** could fairly restrict large practices.)

Physician charges for medical care, both primary and consultative, preventive care, acute illness, chronic disease management, surgery, diagnostic evaluation, mental health care, whatever effort is being made in behalf of the patient to most efficiently maintain or restore the patient to a reasonably obtainable functional level will be designated as "Professional services rendered" and will be documented by appropriate patient care records and will be billed in dollars U.S.

(The only CODES for SERVICES and FEES shall be a dollar sign AND the appropriate digits thereafter. AN entire industry has been created for CODING PROCEDURES. The cost of this industry is excessive and wasteful, AND the process is an invitation to fraud.)

Other categories of care covered by this act will include: Hospital care, (inpatient, outpatient, elective and emergency), Nursing home care (skilled, intermediate, domicile), Home care (nursing, aides, IV's, O2, tests, structural modifications,, whatever allows a patient to remain at home more efficiently than to be institutionalized), Medications (pills, shots, sprays, suppositories, creams, patches, ointment, gasses, by whatever means delivered), Therapeutic modalities (Physical therapy, chiropractic, massage therapy, acupuncture, electric shock therapy, whatever modality may be applied to the patient in an appropriate attempt at healing), Dental care and dentures, Podiatric care and special shoes and inserts, Optometrist and optician care and glasses and contact lenses, Audiology services and hearing aids, Durable and disposable medical equipment and supplies wherever used as permits improved function(beds, wheelchairs, walkers, canes, lifts, whatever most efficiently improves patient function and healing).
All of these charges will be submitted by the provider to the primary-care physician and approved or disapproved for payment by the primary-care physician based on the value of the goods and services to the patient. The approved bill amount shall be submitted to the FAMP and the provider shall be paid X% (ESTIMATE 65+/-10% TO START) of that amount. Payments by FAMP are made ONLY by the authority of the individual PCP. The patient shall be responsible for the unpaid portion of the charges.

Other third party payers (Medicaid, Medicare, private insurance or employer paid insurance, whatever form) may contract to pay all or a given part of the balance due, but they can't change the rules. Once a bill is approved by the primary care physician, that bill stands except as herein provided. Other third parties may elect to insure only certain categories, but whether or not a given service fits any category defined by a third party shall be at the sole discretion of the primary care physician.
(It is anticipated that both GOVERNMENT and PRIVATE THIRD-PARTY PAYERS will atrophy, and the PERCENTAGE of the bill paid by FAMP will increase over time, allowing those employed by present third parties time to adjust.)

FAMP shall establish a Fraud and Abuse Protection Army (FAPA) composed of physicians with at least 25 years experience practicing direct patient care medicine. It shall be the responsibility of FAPA to investigate all charges of fraud and abuse from whatever source.

(We have 40+ YEARS EXPERIENCE since MEDICARE was started, a sound foundation for safeguards to enhance VALUE RECEIVED.)
The value of new treatments should be judged on the basis of their improvement of patient care as compared to the best available previous care for which a value has already been established.

All clinical records shall be available to a single investigating physician (or designated agent) from FAPA. Such investigating physician shall make one of the following determinations:
(1) The care delivered was appropriate and was delivered at less than the expected cost and the PCP shall receive a GOLD STAR. This GOLD STAR may be displayed, or not, whereever and whenever the PCP shall choose.
(2) The care delivered was appropriate and the charges were appropriate and no further investigation or action is needed.
(3) The care was inappropriate and/or inadequate, and the charges inappropriate and/or excessive. Reeducation and/or refund are required.
(4) Care was foolish and/or charges were grossly excessive. Reeducation and refunds are required. Investigation of any or all of the bills and records of the PCP may be undertaken.

(5) A pattern of inappropriate care and/or overcharging is established and reeducation and/or refund are required and fines are levied, and/or the physician may be discharged from the program.
(6) A pattern of fraud exists and criminal charges are instituted. Patients and other providers colluding in such fraud shall also be prosecuted.

PCP shall have the right to require a second physician from FAPA review any determination of paragraphs 3 through 6. PCP may appeal any unresolved differences to the State Board of Medical Examiners. FAPA shall bring any fraud or other criminal charges to federal court.

THERAPEUTIC MISADVENTURE

Participating physicians and hospitals and other institutions/providers shall have the option to declare a Therapeutic Misadventure whenever they think they have inadvertently harmed a patient. Once a TM has been declared, all subsequent medical care delivered to that patient as a result of that TM, shall be at the expense of the physician, hospital or other institution/provider and none shall be liable to be sued for malpractice arising out of that TM. The physician or hospital or other institution/provider shall compensate the injured patient for lost wages and pain and suffering that arise from the declared TM, and the amount of such payment may be adjudicated by civil litigation. The declaration of a TM will automatically trigger an investigation mechanism of the institution to determine whether or not the misadventure was human error of whatever type that could be avoided by changed behavior or system error that could be avoided by changes in the system.

CONFIDENTIALITY is automatically compromised by investigation, where clinical records must justify charges.

X% payment is arbitrary but not irrational and may move in either direction. Our incentive for healthy lifestyles and good preventive care are motivated by our perception of the benefit of improved health versus the perceived suffering from leaving behind old habits. The % patient responsibility leaves room for market place forces to function without predominating. Federal budget constraints, employer wellness programs, third party insurers, individual wealth or poverty, PCP collection/forgiveness practices, charitable organization payments, other government programs, and any other payment sources should all be allowed to function and grow or atrophy as experience evolves. Health Care Delivery Units, physicians, pharmacists, hospitals, etc. may forgive any part or all of the patient responsibility on a case by case basis; however the service must be worth the total charge when being evaluated by FAPA. (It is ok to be charitable about the balance, but dismissing part of the balance must, in fact, be charitable.)

The $X per patient per month fee is also arbitrary, but not irrational, and may move in either direction as experience dictates.