Large hospitals reportedly use secret deals to hinder competition

On its front page, the [Wall Street Journal](http://mailview.bulletinhealthcare.com/mailview.aspx?m=2018091902ama&r=6144171-fdfb&l=036-40f&t=c) (9/18, A1, Mathews, Subscription Publication) reports that hospital giants use a series of secret agreements to protect themselves and stop efforts to lower health care costs. In some instances, hospitals can require that they be included in all health plans in their area, or prevent rivals which charge less from being included. Alternatively, they could obscure prices from consumers or limit attempts to audit claims. The article says U.S. health care spending is higher than other developed countries’, and the problem is not that Americans are consuming more health care, but that what they pay for is increasingly more expensive.

The Duke Endowment sent me to the Kings Fund College in London to study the National Health Service. Met with the counterpart of Sec. HHS in the US and about a dozen of the undersecretaries over a week and saw firsthand how they chased their tail and justified their "book". Spent the next week in the boondocks in Hereford in the west of England with family docs, specialists, health depts. and hospitals. They used the "book" as a doorstop, and did what needed to be done for patients as best they could with restrictions from London. The Univ of New Mexico in 1977 sent me to study the health care delivery system in China, Hong Kong (still a colony) and the Phillipines. So I have some bone fides to write the Act in addition to practicing in the trenches in Siler City for 46 years, initiating federal legislation with Sen. Helms for the tobacco allotment buyout, state legislation for lowering legal limit of blood alcohol from .10 to .08, and encouraging testing for HIV/AIDS and establishing Drug Courts. Served 5 years on the NC Humanities Council and 2 in the Duke Medicine and Society  Program on Death and Dying, 5 years on the NC Driver's License Review Board as Chairman of Physicians, two years as state chair for CME for the NC Academy of Family Physicians and 35 years as chair of CME for Chatham Hospital Thursday Morning Intellectual Society, and multiple stints as Chief of the Medical Staff and Chief of Obstetrics including directing the first nurse midwifery service in NC, Head of Ethics Committee, Death Review, Credentials, and Medicine and Pediatrics and Emergency Services. I have given the annual address to the Institute Of Medicine on our society’s response to HIV, and lectured at the Institute of Government and to Bar Associations about DWI. Addressed conclaves in Bratislava, Czecheslovakia and Montreal, Canada on metronidazole and trichomoniasis.

The ACA won't even need to be repealed as it will atrophy from disuse as it is replaced by The Medical Care Restoration Act. Legislation designed to improve function can be brief; the Act is 4 pages. (Legislation designed to protect corrupt special interests is convoluted and obtuse, as Nancy Pelosi famously described ACA, "We'll have to pass it to see what it says", all 2000 pages.)

The Medical Care Restoration Act is Conservative, Voluntary, and Universal. The Act controls costs by removing the Hassel Factor, returning the non-monetary rewards to practicing medicine, and facilitating the value efforts of many physician sponsored programs such as Cornerstone. The Act returns the decision making to the Dr./Pt. relationship and ends 'defensive medicine, protects patients and taxpayers, and returns learning and caring for the patient to the practice of medicine, simplifying the payment process.

Medical Care Restoration Act, a Conservative Voluntary Universal Health Care initiative is permissive legislation, and all existing payment or health related functions will be allowed to thrive or atrophy as experience dictates.

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. The Primary Care Physician must be an individual. Persons not having a Primary Care Physician as defined in this act will not be required to be seen in any Emergency Department.

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, hereby established by this act, as follows:

I, full name, address, and social security number, do hereby request, and I, full name, address, and social security number, do hereby agree to serve as Primary Care Physician for, full name, address and social security number, beginning, date.

Either party may rescind this agreement without cause by notifying the Federal Agency for Medical Payment as follows:

I, full name, address, 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.

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.

The primary care relationship may be terminated at any time for cause. Such termination returns both parties to the starting point of the schedule for terminations without cause. Death of the primary care physician or 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 (Fraud and Abuse Protection 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 Primary Care Physician and the Federal Agency for Medical Payment shall maintain a list of all patients cared for by the PCP, and FAMP shall pay the Primary Care Physician $40 for each patient on the list for all or any part of each month. 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.  The PCP may 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.  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 on 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 to FAMP in dollars U.S.  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). Email visits, telemedicine, and whatever technology allows suitable medical care to be delivered to benefit the patient.

All of these charges will be submitted by the provider to the primary care physician for approval, disapproval or modification 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 80% 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. Recognizing the capability for payment to be almost immediate if done electronically debiting the FAMP account and crediting the account of the provider, THE CHARGE SHOULD LEAVE THE ELECTRONIC SYSTEM AND PASS THROUGH THE BRAIN OF THE PCP OR DESIGNEE AND BE REENTERED IN ORDER TO ESTABLISH RESPONSIBILITY FOR THE NUMBER OF DOLLARS SPENT AS BEING SOLELY THE RESPONSIBILITY/AUTHORITY OF THE PCP.

Other third-party payers 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 the dollar amount of the 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.

Federal Agency for Medical Payment shall receive bills approved by Primary Care Physicians and patients and pay them with funds appropriated by Congress to the US Treasury. FAMP will establish Fraud and Abuse Protection (FAP) composed of physicians with at least 25 years experience practicing direct patient care medicine. It shall be the responsibility of FAP to investigate all charges of fraud and abuse from whatever source. (WE HAVE 55+ YEARS EXPERIENCE SINCE MEDICARE WAS STARTED, A SOUND FOUNDATION FOR GUIDANCE FOR 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. These may be compared to those for which a value has already been established,

All clinical records shall be available to a single investigating physician (OR DESIGNATED AGENT) from FAP, and 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 Primary Care Physician shall receive a 6 inch 5 pointed plastic or metal GOLD STAR. This GOLD STAR may be displayed or not wherever 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 appropriate.

(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 up to $20,000 are levied, and/or the physician and/or patient 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.

THERAPEUTIC MISADVENTURE

Replace “Consent” forms with “Request” forms.

Participating physicians and hospitals and other institutions/providers shall have the option to declare a Therapeutic Misadventure whenever they become aware any patient has been inadvertently harmed by medical care, OR when they reasonably become aware of harm from any medical or surgical act, or the omission of any action. Once a Therapeutic Misadventure has been declared, all subsequent medical care delivered to that patient as a result of that TM, shall be at the expense of all participating physicians, hospitals or other institutions/providers and none shall be liable to be sued for malpractice arising out of that TM. Whoever declares the THERAPEUTIC MISADVENTURE, physician or hospital or other institution/provider shall request an investigation by a physician from FAP of the institution or individual to determine whether or not the misadventure was human error of whatever type that could be avoided by changed behavior, or whether or not the cause was system error that could be avoided by changes in the system, or whether the TM was unavoidable. FAP will determine who, if anyone, will compensate the injured patient for lost wages and pain and suffering that arise from the declared Therapeutic Misadventure. The amount of such payment, if any, if not agreed upon by the parties involved, may be adjudicated by civil litigation. FAP may require changes or education or make any of the 6 determinations for care as have been established for charges.

CONFIDENTIALITY IS AUTOMATICALLY COMPROMISED BY INVESTIGATION WHERE CLINICAL RECORDS MUST JUSTIFY CHARGES AND APPROPRIATENESS.

80% 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 20% patient responsibility leaves room for market 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 Providers, physicians, pharmacists, hospitals, et. al. 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 FAP. (It is ok to be charitable about the balance, but dismissing part of the balance must, in fact, be charitable.)

The $40 per patient per month fee is also arbitrary but not irrational and may move in either direction as experience dictates.