**SHIFT THE PARADIGM**

(From the Medical Model to an Enterprise Model)

**Systemic Problems:**

While America is number ONE in cost per capita and thirty-eighth in quality, statistically, Americans spend more money on their health care than anything else but food. But the consumption of the health-care dollar is predominately not paid for by the consumer. The middlemen, so to speak, make the forces of free enterprise moot. Consumers are bystanders in the relationship between purchase and quality because they do not directly pay for the product. This phenomenon is called monopsony. The consumer is not the buyer. But the buyer is almost singly dominant. This is the reverse of monopoly, where the seller has the last say. This is not Microsoft at work. It is the federal and state Medicare and Medicaid programs that buy upward of seventy five percent of all health-care service products.

Under the Obama nation, government will be the purchaser of last resort for all Americans. Ingeniously, the insurance industry (Blue Cross and Blue Shield) convinced the federal government in 1966 when Medicare and Medicaid were enacted, that the only fair and equitable manner to fund and pay for health care for the elderly and disabled was to pay reimbursable costs including a markup for overhead and return on equity. Most of the providers, in those days, were not-for-profit hospitals and sole practitioner doctors. This method lasted until 1989, when it was changed, in terms of payment, for hospital care and the emerging continuum of services for the elderly population. DRGs (diagnosis-related groupings) set a price for a diagnostic group without regard to what it costs the hospital. This political maneuver has turned the tables on the providers and forced them to look at cost and economize. The same method is now being embraced for all facets of health care: DRGs for inpatient care, OPUs for outpatient care, RUGs for long-term care, RVUs for physician care, RUGs for nursing-home care, and RIUs for rehabilitative care.

**PATIENT PROTECTION AND AFFORDABLE CARE ACT**

***(i.e., Obama Care)***

Affordable—Not . . . Protecting the elderly and disabled—Not

**Projected Cost =**

$465 Billion for State Exchanges

$434 Billion Medicaid Increases

$176 Billion Demonstration Projects and

Enforcement

**$1.075 Trillion Annul Cost**

**Projected Funding =**

$414 Billion Medicare Cuts

$349 Billion Provider Taxes

$210 Billion Medicare Withholding Taxes and Surtaxes

$107 Billion Pharmacy, Hospital Taxes

$ 68 Billion Fines and Penalties

$150 Billion Cadillac Insurance Taxes

$ 13 Billion Downsizing Medical Savings Accounts

$ 20 Billion Taxes on Devices

$ 15 Billion Reductions in Tax Deduction for Medical Expenses

$ 3 Billion Taxes on Tanning Salons

$1.218 Trillion Annual Taxes and Reductions

in Benefits

Projected, in theory is for the next decade but those types of forecasts are rarely in the ballpark when realty sets in . . . i.e. Medicare in its inception was to be costing in the millions not

billions as is true of Part D medication coverage that will exceed$700 billion per year as the Boomers come on stream. Payment for the beneficiaries to the providers continues using the antiquated and treatment-based pay for diagnosis and per diem basis. Paying for income not outcome, paying on input data not output data.

**Financial Problems:**

1. Currently paying for income of providers not outcome for wellness and better health.
2. Chronic diseases continue to rise (1 int 4 Americans has a least 1 and half up to 4 chronic diseases.
3. Costs for treatment, prescription drugs and warehousing the elderly is at $2.7 trillion dollars per year and growing.
4. Providers aren’t accountable for quality, costs and outcomes.
5. Providers aren’t paid for prevention of chronic illnesses.
6. Providers aren’t paid for preserving the life expectancy of their patients.
7. Current Obama ACA not sustainable – costs to the beneficiary is preventing the benefits to flow to the insured and uninsured.

**Objectives SHIFT:**

1. Pay for treatable health and mental problems based the underlying root causes of chronic disease and catastrophic illnesses. Use a simplified method of process mapping problems and causes in the care plan using 11 body systems triaged down to problems and interventions for treatment and payment versus 77,000 diagnoses codes only used for payment.
2. How we pay drives practice in hospital, physician offices, nursing homes, home care, hospice care and it determines how the government regulators control cost and enforcement. Vertical payment is used with no continuum of data nor outcomes when horizontal payment by episode would track treatment, cost and outcome.
3. What this means is we have no accountability for a predetermined outcome just a method of paying income. Hospitals get per diems based on diagnosis codes (groupings of average length of stays for DRG’s) A stroke gets a standard payment for 4.5 days regardless of length of stay with outliers justifies higher payments. Doctors are encouraged to get the patient out as soon as possible to a nursing home or their home care agency. Nursing homes, home care agencies, assisted living, are paid average per day rates. All of these are subject to regulatory review for medical necessity and denials of payment. What is needed of course is a method of payment that horizontally tracks the solving of medical and mental problems (outcomes) to justify payment and supports cost management for efficiency and effectiveness of the plan of care.
4. How can we shift the paradigm from the medical model of vertical payment with no accountability for quality and cost to an enterprise model that pays for outcomes and not just income? The first step is to build the paradigm that health care is a privilege not a right … the healthy active beneficiary should not have to pay for the unhealthy beneficiary that only contributes to cost not benefits.

**SHIFT Procedures:**

1. We call this Self=Health using personal health care as the foundation of determining payment into a trust fund savings account managed by newly formed Mutual Health Care Companies … a standard 6% (for sake of an example) withholding from every employed Americans gross salary that populates the savings (health investment) account. As the fund grows with its return on investment from the Mutual investments the claims are processed for qualified expenditures for treatment, or prevention or preservation of personal health habits.
2. Under the health care Enterprise Model the providers compete for the beneficiaries business based on pricing, cost and outcome for each episode specified in the plan of care. This makes the beneficiary the decision maker on quality of the outcome being paid for and the underlying cost of producing that outcome.
3. SHIFT the paradigm stands for Self=Health Insurance Funding Trust
4. Accountability for quality assurance is administers by the State insurance agency using maximum standards of care in a reinforcement procedure of survey and post payment review of random claims subject to backup documentation.
5. Accountability for pricing using process cost accounting and episodic computer modeling to connect the providers to a continuum of care.
6. The Self Health funding trusts will be backed by reinsurance for catastrophic occurrences and risk pools based on age with the responsibility for rates based on individual health profiles and internalized incentives for staying healthy and fit. Those with chronic illnesses will be able to qualify for being in a high-risk pool for payment.
7. Incentives for saving – preexisting illnesses are covered, no deductibles, no coinsurance no limitations on maximum coverage (those with not enough funded can borrow from the high risk pool), no denials of claims except for nonqualified items.
8. Incentives for SHIFT prevention services and preservation education are included in the plan. Those with better health profiles will either get tax deductions or better rates or the providers.

**SHITT Outcomes:**

1. Savings for overall administrative costs – shift to use of problem root cause analysis in the care plans and shift the use of diagnoses based on symptoms to the 11 body systems for care planning, problem approaches, interventions, goals and outcome measurements.
2. Savings for the providers costs – reduced paperwork to support the documentation of care plans and use of body systems and problem triggers using standardized software modeling programs provided by the Mutual Health Care Companies networked with all providers in the continuum.
3. Implementation over a ten-year period (say 2020 to 2030 for building the savings accounts through withholding from employed members to be fully funded by 2031. From 2031 to 2041 all health care claim and reimbursement will be run through the Mutual SHIFT Insurance system. Resulting in incremental tweaking for the first decade and real time usage in the second decade of shifting the paradigm.
4. From day one the driver for Shifting the paradigm will be payment of claims to the providers … examples of this working in the past was the requirement for cost reporting and electronic billing … both of which were not a priority to the providers until they couldn’t get paid if they didn’t comply.
5. Privatizing the shift to pay for outcome will internalize the moral and economic incentives making Americans healthier, wealthier and wiser for the Grater Good. It begins the concept of privatizing certain government functions to eliminate regulatory redundancy with the States and economizing on savings from better care, prevention and preservation of the quality of life and avoid the need for Medicaid as now structured. It will also savesthe current system from sinking the Baby Boomer ship with denials, high deductibles, coinsurance and shifting high costs to the State Medicaid programs. Under SHIFT the indigent and unemployed will be covered under the Medicare catastrophic pool based on age and the spend down rule for coverage will be rescinded.

**Conclusion:**

SHIFT mission statement: To share in the benefits of better health for each individual and taxpayer and “ask not what you can get but what you can give to a healthier, wealthier, wiser America and its greater good”.

SHIFT is budget neutral and administratively simple … it will take the Republicans and Democrats to work together at the Federal and State levels to collaborate on saving the country from the sinking ship of pay as you go Medicare for all mentality. It requires privatizing solution where it has to be solved … at the root of the problem … unhealthy Americans not internalizing their responsibility for righting the ship and the healthy to continue to work on prevention and health preservation for the greater good.