What Public Policies Pertaining to Payment of Care for Medically Complex Patients Would *Both* Improve Outcomes and Help to Lower Per Capita Spending by 10% by 2019?

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Introductory Observation

- Better tertiary prevention for the severely ill may offer the best combination of technical and political characteristics of available policies to improve outcomes and lower per capita spending by >10% by 2019.

Summary of Preponderance of Relevant Evidence

A. Ambulatory care: Intensify both primary care and primary care management of specialist care for patients at predicted highest risk of near-term ER and unplanned hospital use

B. Hospital care: Mainstream continuous study, redesign, and rapid testing of "double or triple aim" care pathways/protocols for hospital care episodes

C. Apply compelling economic incentives from major payer(s) - and technical assistance - to providers to lower per capita spending and improve outcomes via A + B

Transforming Evidence into Federal Policies: General Rules

- Keep the policy concept(s) simple
- Make provider incentives large enough to be irresistible
- Help likely service volume losers to find socially-valuable sources of new revenue
- Minimize concentration of losers within Congressional districts

Proposed Policy Solutions

1. CMS uses variable patient cost-sharing to encourage highest risk beneficiaries to preferentially use primary care teams and hospitals that accept powerful positive and negative payment incentives to improve outcomes & lower total per capita spending
2. Federal tax policy incentivizes (a) non CMS-sponsored health plans to do likewise and (b) competitive pricing of provider services
3. Require public and private payer pro-rata support for expert peer assistance to enable providers to attain the double-aim - or to “re-purpose” their expertise and non-depreciated capital investments
4. In allocating CER funds, prioritize care delivery innovations targeting the double aims