

# Health system transformation: Aligning incentives for high quality, efficient, and high value care

*Susan Nedza, MD, MBA, FACEP*

A number of factors have converged to focus attention on the need for a paradigm shift in how we view the relationship between the individual and the health care system. This shift requires that the Centers for Medicare and Medicaid Services (CMS) focus not only on sickness or chronic illnesses, but also focus on rewarding health promotion and prevention. CMS has embarked on an agency-wide effort to transform Medicare and Medicaid programs to support health care systems that are safe, effective, efficient, patient-centered, timely, and equitable. In order to achieve this vision, CMS is committed to transforming our programs so that physicians and others are rewarded for providing high-quality and efficient care based on the needs of the individual patient.

## **The Environment**

A recent Commonwealth Fund study<sup>1</sup> looked at the gaps in quality in the US health care system in spite of growing expenditures per person. The study also reported that 75% of Americans believe the US health care system must

undergo fundamental change or be completely rebuilt. Forty-two percent of respondents felt that over the last 2 years, they had experienced care that was poorly coordinated, inefficient, or unsafe; 39% of individuals also reported serious problems accessing physicians.

Health care spending is now over \$2 trillion annually and represents approximately 16% of the gross domestic product of the United States. Future funding of the program as it is now configured is unsustainable based on the growing complexity of services, the aging population, increased utilization of technology and imaging, and the number of individuals with complex, comorbid conditions. The economic competitiveness of the United States is dependent on our ability to control the growth in health care expenditures.

In 2007, the Physician Fee Schedule is scheduled to be adjusted by -5.1% based on the Sustainable Growth Rate (SGR) Formula. This scheduled adjustment is due to increases in the complexity of service, volume of outpatient procedures, increasing imaging costs, and increasing expenditures on Part B drugs. The current formula is recognized as flawed, and Congress may use the opportunity to link physician payment to participation to qual-

ity, efficiency, and achieving good patient outcomes.

## **The CMS Strategy**

Medicare (and Medicaid) is moving to a Value Based Purchasing model. This includes a number of strategies:

- It will shift payment policy from paying for volume of services.
- It will define quality, access, and efficiency locally.
- It will pay for quality care for a specific beneficiary.
- It will reward systems and health care professionals who efficiently provide service (quality and process management).
- It will utilize IT innovation, traditional administrative data, and focused initiatives to enable this change.

## **Medicare Value Based Purchasing**

Value based purchasing (VBP) is about defining/rewarding health care professionals for the value of their contribution to delivering quality and efficient care. Care should be linked to better health outcomes.

VBP is not just about physician level measures, documentation, or compliance. It should be considered within the context of providing care—not simply as an audit function. It is not about what a

---

Doctor Nedza serves as the Chief Medical Officer, Region V for the Centers for Medicare and Medicaid Services. Please send any comments to [susan.nedza@cms.hhs.gov](mailto:susan.nedza@cms.hhs.gov).

---

physician can control, but the component of value that the physician brings to a given episode of care, or to managing chronic disease. It goes well beyond competency, which is within the scope of the medical specialty certifying boards and licensure agencies.

### **Cornerstones of Value Based Purchasing**

Use of certified health information technology to connect the system will enable local transparency and energize care coordination and local information gathering. The Department of Health and Human Services (DHHS),<sup>2</sup> under the leadership of Secretary Michael Leavitt has committed to recognizing interoperable systems, to setting standards, and to providing transparent information to consumers of health care in order to support their decision-making.

### **Measuring and Publishing Quality Data**

CMS will expand efforts to continue to increase measurement across all sites of care (office, hospital, long term care). The number of measures reported on Hospital Compare will expand to 21, including measures of 30-day mortality, patient experience of care, and surgical measures.<sup>3</sup> Physician performance as a part of the hospital care team is also being measured through this effort.

The Physician Voluntary Reporting Program<sup>4</sup> provides an opportunity for physicians to test how they would submit quality data to CMS through administrative or billing data. Practices that choose to participate will have an opportunity to prepare for possible requirements of pay for participation that may be linked to a change in the proposed SGR adjustment. The program also al-

lows a practice to begin to implement care process changes that enable quality improvement and efficiency.

### **Measuring and Publishing Pricing Data**

CMS is studying the use of episode groupers that will allow us to determine payment based on an episode of care. Agreement on procedures and services to be included in these episodes is being reached. This agreement will allow local competition on services (joint replacement, heart failure care, etc). With price information, purchasers of health care and consumers will have information available upon which to make decisions related to the cost of care.

What will enable this locally? Currently, the Ambulatory Quality Alliance and the Agency for Healthcare Quality and Research are supporting 6 pilot programs<sup>5</sup> including the Wisconsin Collaborative for Healthcare Quality (WCHQ)<sup>6</sup> to build Quality Price Information Collaboratives (QPICs). DHHS will support expansion to other communities next year that will commit to collaboration and will publish all-payer data for consumers in the areas of quality and efficiency.

### **Create Positive Incentives**

CMS is actively engaged in a number of demonstration projects that will inform policy decisions regarding payment for high value care.

The Physician Group Demonstration Project<sup>7</sup> is evaluating incentives regarding quality and care coordination in group practices. The Marshfield Clinic is one of the sites of the demonstration.<sup>8</sup>

The Premier Demonstration Project<sup>9</sup> recently reported pre-

liminary findings. Participating organizations will be rewarded or penalized based on a given set of measurement bundles for care associated with hip and knee replacement, acute MI, community-acquired pneumonia, CHF, and coronary artery bypass grafts. The preliminary results confirm the ability of organizations to provide high-quality care at lower cost.

The Section 646 Demonstration<sup>10</sup> or Physician Hospital Collaboration Demonstration project will examine the effects of gain-sharing arrangements between hospitals and physicians. Aimed at improving the quality of care in a health delivery system, the demonstration will determine if gain-sharing is an effective means of aligning financial incentives to enhance quality and efficiency of care across an entire system of care. It is a transformational effort that will align physician and hospital incentives.

The demonstration requires tracking patients for an entire episode of care, which generally extends well beyond a hospitalization, to determine the impact of hospital-physician collaborations on preventing short and longer-term complications, duplication of services, coordination of care across settings, and other quality improvements that hold great promise for eliminating preventable complications and unnecessary costs.

### **Conclusion**

There is an economic and moral imperative to improve our current model of fragmented, inefficient health care delivery, which does not reward quality and is often disconnected from patient outcomes. Physician engagement and leadership are crucial to these efforts. We must focus on the value

---

to the individual for whom CMS has the duty to pay for quality efficient care, and for whom the physician has a duty to provide the same type of care that must drive transformation.

### References

1. Commonwealth Fund. Available at: [www.cmwf.org/usr\\_doc/Commission\\_whynotthebest\\_951.pdf](http://www.cmwf.org/usr_doc/Commission_whynotthebest_951.pdf). Accessed November 27, 2006.
2. Health and Human Services. Available at: [www.hhs.gov/transparency/brochure.pdf](http://www.hhs.gov/transparency/brochure.pdf). Accessed November 27, 2006.
3. HospitalCompare.com. Available at: [www.hospitalcompare.com](http://www.hospitalcompare.com). Accessed November 27, 2006.
4. Centers for Medicare and Medicaid Services. Available at: [www.cms.hhs.gov/PVRP/01\\_Overview.asp](http://www.cms.hhs.gov/PVRP/01_Overview.asp). Accessed November 27, 2006.
5. Ambulatory Care Quality Alliance. Available at: [www.ambulatoryqualityalliance.org/files/AQA\\_pilotFINAL.Doc](http://www.ambulatoryqualityalliance.org/files/AQA_pilotFINAL.Doc). Accessed November 27, 2006.
6. Wisconsin Health Care Quality Collaborative. Available at: [www.wiqualitycollaborative.org/](http://www.wiqualitycollaborative.org/). Accessed November 27, 2006.
7. Centers for Medicare and Medicaid Services. Available at: [www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PGP\\_Fact\\_Sheet.pdf](http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf). Accessed November 27, 2006.
8. Commonwealth Fund. Available at: [www.cmwf.org/publications/publications\\_show.htm?doc\\_id=402822#issue](http://www.cmwf.org/publications/publications_show.htm?doc_id=402822#issue). Accessed November 27, 2006.
9. Premier. Available at: [www.premierinc.com/p4p/press/quality-cost-methods-paper3.pdf](http://www.premierinc.com/p4p/press/quality-cost-methods-paper3.pdf). Accessed November 27, 2006.
10. Centers for Medicaid and Medicare Services. Available at: [www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PHCD\\_646\\_Fact\\_Sheet.pdf](http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PHCD_646_Fact_Sheet.pdf). Accessed November 27, 2006.

*Editor's Note: This article was submitted before Congress acted on December 8-9 to avert the scheduled 5 percent Medicare physician reimbursement cut. For a summary of the bill, go to <http://waysandmeans.house.gov/media/pdf/taxdocs/hr6408healthsummary.pdf>.*

# Wisconsin Medical Journal

The mission of the *Wisconsin Medical Journal* is to provide a vehicle for professional communication and continuing education of Wisconsin physicians.

The *Wisconsin Medical Journal* (ISSN 1098-1861) is the official publication of the Wisconsin Medical Society and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor is responsible for overseeing the production, business operation and contents of the *Wisconsin Medical Journal*. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *Wisconsin Medical Journal* nor the Society take responsibility. The *Wisconsin Medical Journal* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

For reprints of this article, contact the *Wisconsin Medical Journal* at 866.442.3800 or e-mail [wmj@wismed.org](mailto:wmj@wismed.org).

© 2006 Wisconsin Medical Society