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Gail R. Wilensky

on the road to a national performance measurement system

It's one thing to conceive of a pay-for-performance system in health care; it's quite another thing to set up the system so it will work.

In a previous Eye on Washington column, I described the current interest in pay for performance as a way of rewarding practitioners and institutions that "do it well, do it right, and do it efficiently, the first time around." Although pay-for-performance initiatives were excluded from the reconciliation package that came out of December's House-Senate conference, interest in pay-for-performance types of changes in payment remains strong.

The Current Challenge

For pay for performance to be implemented, however, a national system of performance measures first needs to be put in place. To this end, the Institute of Medicine recently released a report entitled *Performance Measurement: Accelerating Improvement*—the first in a series of reports that will result from the IOM's Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement project. The report focuses on an initial selection of measures that will meet the needs of a variety of stakeholders, and on establishment of the infrastructure that will guide the development of an evolving future set of measures.

There is a need for greater focus in these areas. Many organizations, both public and private, have been working on developing performance measures, and they have made substantial progress in developing measures that reflect areas of clinical care, organizational performance, and patient perceptions. The problem is that the multiplicity of organizations involved in this effort has led to duplicative measures in some areas and an absence of measures in others. Also, the voluntary nature of these organizational activities means that they are dependent on being entirely consensual, both in the development of measures and in their application.

The IOM's Proposed Solution

The IOM committee believes that strong federal leadership will be needed to effectively meet the challenges of establishing a national performance measurement system. Specifically, it has recommended the creation of a National Quality Coordination Board, which would be recognized as the lead organization for creating and maintaining the national system for performance measurement and public reporting. The NQCB would be formed as a structurally independent body that would provide protection from undue influence from either short-term political or major stakeholder interests. It also would need to carry substantive expertise drawn from the public and private sectors sufficient to assess and guide the further development of the measurement system and establish the requisite contract and standards-setting authority, financial adequacy, and external accountability.

The IOM committee also believes that the NQCB would eventually need to be funded at a level of approximately $100 million to $200 million per year, not counting additional funding for burdens that might be imposed on the Centers for Medicare and Medicaid Services under the performance measure-

ment and reporting system. This money would primarily be used to fund the development and testing of measures, probably through contracts with current stakeholders. It is unlikely, however, that this large an amount would be needed initially. Several members of the committee have guessed that the amount needed to start the process may be more in the neighborhood of $5 million.

Defining the NQCB

Several members of the IOM committee have attempted to give more definition to the makeup of the NQCB, outside the workings of the committee, to provide a better sense of how such a board might function. The ideas of these committee members are described below, but do not represent the recommendations of the IOM committee itself.

Board structure. The NQCB is envisioned as being housed with the Department of Health and Human Services, as part of the Office of the Secretary, and reporting directly to the HHS Secretary. The chair of the board probably should be a full-time position, appointed by the president and serving at the pleasure of the president. The rest of the board members could be part-time members, compensated on a per diem rate. The number needs to reflect a compromise between having enough individuals to reflect the broad interests of various stakeholders and being small enough to work effectively. An initial assessment to meet this trade-off might be the chair plus 10 other voting members.

To protect the NQCB from undue political influence, board members should be appointed by the president to six-year terms, staggered and renewable on a one-time basis. Appropriate ex-officio members of the board would include the director of the Agency of Health Care Research and Quality and the director of CMS. In general, the board membership needs to reflect perspectives of consumers, providers, business, purchasers, regulators, and researchers. As with the Medicare Payment Advisory Commission, not all of these interests can be reflected in a single set of board members at any one time.

Board duties. The basic duties of the board are to guide the development of the performance measurement system, making sure that its development is robust, comprehensive, and transparent, and to provide guidance to the various stakeholders, including the president and Congress, on how best to align the activities of performance measurement, quality improvement, and pay for performance with the national goals of improving the healthcare system.

Board reporting schedule. Like MedPAC, the board needs to issue annual reports outlining its activities and describing the nation's progress in meeting national goals. These reports need to include advice and recommendations on how to improve the measurement system, the pay-for-performance initiatives, and the quality improvement programs. The reports also should specify the measures themselves and how they are to be collected, validated, aggregated, and reported.

The Reach of Pay for Performance

It is most obvious to imagine the measurement system and the alignment of payment and performance measures being applied to Medicare, but it is hoped that the measures and alignment would also be applied to Medicaid and other federal health programs, such as the Veterans Health programs, TRICARE and other Department of Defense programs, and the Indian Health Service.

The development of such a measurement system will require an enormous amount of work over a number of years. Realistically, it is important to start with an initial set of measures that have already been developed by various stakeholders, such as the Ambulatory Care Quality Alliance and the Hospital Quality Alliance, along with measures derived from the Agency for Health Care Policy and Research's Consumer Assessment of Healthcare Providers and Systems project and the National Committee for Quality Assurance's Health Plan Employer Data and Information Set. We then should move forward with more comprehensive measures as they become available. ●

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