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# Pay for Performance in California's Workers' Compensation Medical Treatment System

An Assessment of Options,  
Challenges, and Potential Benefits

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Prepared for the Commission for Health and Safety and Workers' Compensation



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## Summary

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### Purpose

Over the past few years, nonoccupational group health-insurance programs and health plans have implemented initiatives to improve the quality and efficiency of care through incentive programs, typically called “pay for performance,” or P4P. In addition, Medicare program administrators are evaluating how P4P incentives might be incorporated into Medicare payment systems. This paper assesses the options, challenges, and potential benefits of adopting P4P incentives for physician services in California’s WC program.

### What Is Pay for Performance?

Existing P4P programs reward health-care providers based on their performance on a set of specified measures related to one or more of the following:

- quality
- efficiency
- administrative processes (e.g., timely submission of reports)
- IT adoption (e.g., electronic billing)
- patient satisfaction.

A nationally prominent example is the program sponsored by Integrated Healthcare Association (IHA), a collaborative, statewide initiative that a leadership group of California employers, health plans, and physician organizations developed to stimulate improvement in patient satisfaction and clinical quality. The program involves seven health plans and 225 physician groups representing 35,000 California physicians who are eligible to receive bonus payments for individually attaining evidence-based performance goals in three areas: clinical measures, patient experiences, and investment in IT. In addition, the California Office of the Patient Advocate (OPA) reports physician-group scores on patient-experience measures (see OPA, 2006). IHA recently announced that it is adding efficiency measures for episode-based and population-based group efficiency, efficiency by clinical area, and generic-drug prescribing (IHA, 2007).

## **Why Consider Pay for Performance for Workers' Compensation Medical Care?**

Recent changes in the WC medical treatment system have created an environment that might both support and benefit from P4P initiatives. Recent statutory changes establish evidence-based treatment guidelines as presumptively correct care, require that injured workers of employers with medical provider networks use network providers throughout the course of their treatment, and authorize a new physician fee schedule.

- The medical provider networks create greater opportunity to measure performance and use both financial and nonfinancial incentives to reward providers who deliver high-quality care efficiently.
- Physicians who practice in accordance with the medical treatment guidelines could benefit from more targeted utilization review (UR) and reduced administrative burden.
- The new fee schedule creates an opportunity to align financial incentives with improved processes of care and to pay explicitly for such services as work-related disability-management activities.

In addition, the California Division of Workers' Compensation (DWC) has implemented a new data-collection system for medical services that has the potential to consolidate physician data across payers and to provide comparative data on both physicians and medical networks.

Currently, there is a high level of contention and distrust among the various stakeholders in the WC system. If properly structured to obtain the commitment and involvement of all interested parties, a P4P mechanism could be an effective vehicle for identifying common goals and improving communication and understanding among stakeholders.

## **What Are the Lessons Learned from Group Health Programs?**

Relatively little is known, either from the literature or from conversations with individual program administrators, about the impact of group health P4P programs or the best way to design these programs. Substantial experimentation and refinement are occurring as programs mature and evolve, and few have been rigorously evaluated. Nevertheless, group health P4P programs have provided valuable lessons for program implementation that may be transferable to WC. Key lessons include the following:

- Physician buy-in to the P4P program is essential. Payers must interact with and engage providers from the beginning of program development by, for example, involving physicians in the measure selection and development processes.
- All aspects of the P4P program, and most especially the measures, must be pilot-tested to work out the "bugs" and allow physicians to become familiar with any additional reporting requirements before the data are used for payment.
- P4P programs take more time and resources than initially anticipated to support the data-collection and evaluation processes. One solution is to start small and gradually build the infrastructure to support the program.

## What Are the Key Design Components of a Pay-for-Performance Program?

The following are the most important questions that must be answered during the design and planning stages of a P4P program:

- Priority goals and objectives
  - What should be the goals and objectives for a WC P4P program?
  - Should a P4P program focus on rewarding top performance or encouraging quality improvement?
  - Should a P4P program be mandatory or voluntary?
- Measures
  - What are appropriate measures for a P4P program?
  - How should the initial performance areas subject to P4P be identified?
  - What is the level of accountability for measurement and reward?
  - How is care attributed to providers?
- Data infrastructure
  - Should data be collected individually by each payer or pooled across payers?
  - What organization or organizations should perform the data-collection and performance-assessment functions?
- Reward structure
  - What should be the structure of the reward?
  - What are the criteria for receiving the financial reward?
  - How is the reward financed? What data and data infrastructure could support a WC P4P program?
  - What nonfinancial rewards could be included in a P4P program?

While an array of options might be considered in answering each of these questions, the design for a P4P program must take into account a number of obstacles. These include the complexity of the current system; the lack of clinical performance measures for common WC conditions; the absence of an established, central data-collection system and ongoing performance-monitoring system to facilitate evaluation; and the involvement of multiple payers and many physicians who treat only a few injured workers each year. For this reason, a P4P program should start with relatively straightforward measurement and reward structures, but it should include flexibility for enhancements over time as the measurement and data-collection systems mature.

## What Are Potential Models for Workers' Compensation?

For illustrative purposes, Table S.1 summarizes the key features to two potential mandatory systems and one collective, voluntary system among payers.

- Model 1 is a mandatory P4P program that would require minimal changes to the existing system. We describe the system as mandatory because it would be implemented by establishing fees through California's Official Medical Fee Schedule (OMFS) (see DWC, 2007a) for specific activities, such as timely filing of reports or documenting specific

**Table S.1**  
**Comparison of Three Potential Workers' Compensation Pay-for-Performance Models**

Characteristic	Model 1	Model 2	Model 3
Type	Mandatory	Mandatory	Voluntary
Performance measures	Performing specific activities	Meeting relative or absolute thresholds for a set of performance measures	Core set of measures collectively determined
Data-collection infrastructure	Current billing system	WC information system (WCIS)	California Workers' Compensation Institute (CWCI) or independent organization
Reward structure	Explicit fees for work-related disability-management activities	Higher fees for "gold-star" physicians	Negotiated between payers and participating physicians
Source of funding	Employers or payers	Employers or payers	Negotiated between payer and participating physicians

disability-management activities. Payers would be required to pay these fees unless they negotiated an alternative arrangement with the participating physician.

- Model 2 is a mandatory P4P program that would add more administrative processes to the system but would facilitate the development of a broader set of performance measures over time. The system would be mandatory for physicians: All physicians providing services relevant to the selected measures would have their performance measured automatically and would not be given the choice to participate. Data for performance measurement would be collected through the WCIS (see DWC, 2007b), and uniformly determined rewards would apply to high performers. Payers would be required to pay the resulting financial reward unless they negotiated an alternative arrangement with the participating physician. Unlike the simpler fee-for-service (FFS) model, this structure would provide an opportunity for pooling data and providing report cards at the medical-group or network level when there are enough observations. Payers would also be able to supplement the financial reward structure with additional financial or nonfinancial rewards, such as reduced UR.
- Model 3 is a voluntary program modeled after the IHA P4P program, in which multiple payers voluntarily join together to create a collaborative. The payers involved in the collaborative would use a standardized set of core measures, with individual payers determining their reward structure and having the option to use additional measures as desired. Data for the core set of measures would be pooled to increase the sample size for individual physicians.

We do not discuss a voluntary individual-payer model, because payers have the capability to negotiate P4P contractual arrangements with providers without additional policy development, and the particulars of such arrangements would be specific to the payer and providers. However, individual-payer programs may be the most feasible to implement in the short run and could serve as pilot tests for broader programs.

## Next Steps

There are challenges to implementing a WC P4P, including a lack of clinical measures for WC conditions, multiple payers, and the many physicians who treat only a few WC patients. This paper offers three models that we believe might be able to surmount these problems, provided that the stakeholders have the commitment and trust to work through the design issues and allow the P4P program to evolve over time. Given the current WC environment and amount of change that has occurred in the medical treatment system over the past few years, the various stakeholders need to confirm their willingness to undertake a collective P4P initiative. Thus, a critical next step is to expand the discussion to include representatives of the various stakeholder constituencies to gauge the level of interest and commitment in a P4P initiative, define the program's goals and objectives, and determine whether there are any "idea champions" to promote the P4P concept. If there is sufficient interest, a structure could then be established for further collaborative work on design options and issues. If there is no interest in a collective effort, there may nevertheless be interest in pilot projects to ascertain whether a P4P program would be a cost-effective way to improve the quality and/or efficiency of medical care. Further, there may be interest in workshops and joint educational activities on ways in which individual employers or payers could incorporate P4P principles into their relationships with physicians.

While the current California WC environment poses challenges to advancing the P4P concept, this is an opportune time for DWC to put mechanisms in place to measure and reward physician performance. The opportunities include the following:

- Data collection has been initiated for WCIS. There is an opportunity to consider how the medical data collected through WCIS can be turned into useful information to support performance evaluation. The critical decision is whether WCIS will support monitoring and evaluation at the system level only or whether it will be structured to also support measures of performance at the individual, group, or medical provider–network level.
- DWC has begun work to modify the physician fee schedule. As the goals for the new fee-schedule structure are established, consideration should be given to how to align the financial incentives inherent in the fee schedule with value-based care.

P4P alone will not be sufficient to drive improvements to value-based medical care provided to injured workers; rather, it should be considered as part of a multipronged set of strategies designed to increase the efficient delivery of high-quality care that enables a rapid and sustained return to work.