

Robert Wood Johnson Foundation Payment Reform Evaluation Project
Program Oriented Payment (POP) Demonstration Project
Physicians Choice Foundation

Autumn 2012 Site Report

Context

The Physicians Choice Foundation (PCF) is the lead organization for the Program Oriented Payment (POP) Demonstration Project in Salem, Oregon, which is being shaped by state, federal, and local forces. At the state level, major changes are happening in Oregon's health care system. Faced with a \$3.5 billion shortfall in Oregon's state budget,¹ the Governor and Legislative Assembly are transforming the state's health system as one strategy to close the gap.

In 2011 the Oregon Legislative Assembly authorized House Bill (HB) 3650, Health Systems Transformation, which is built on the State's existing infrastructure for public health insurance. In 2009 the Oregon State Legislature had passed HB 2009, which created two new state entities, the Oregon Health Authority (OHA) and the Oregon Health Policy Board (OHPB).² The OHA oversees the public health insurance plans for Medicaid enrollees, public employees, school district employees, and the state's high risk pool and premium subsidy programs, or a total of 800,000–900,000 covered lives. Governed by the nine-member OHPB, the OHA gives Oregon greater purchasing and market power to achieve its mission of improving the health of Oregonians by reducing costs and improving quality, the delivery of preventive care, and health care access.³

The other key elements of the HB 3650 system transformation are community care organizations (CCOs) and global budgets. Oregonians covered by OHA insurance will receive care through CCOs, health care organizations offering coordinated preventive and therapeutic care through primary care medical homes, which will contribute to quality care at lower cost.⁴ Oregon State's current system of funding health care -- through separate budgets for hospital, ambulatory, mental health and other care categories -- will be replaced by a new system that pools all money into a global budget dispersed by the OHA to CCOs. In February 2012 the Oregon legislature passed Senate Bill (SB) 1580 authorizing the OHA to create CCOs to replace the State's Medicaid and other contracts with managed care systems.⁵ The

¹ Source: <http://health.oregon.gov/OHA/docs/fed-hlth-ref-or.pdf>

² Source: <http://www.leg.state.or.us/09reg/measpdf/hb2000.dir/hb2009.en.pdf>

³ Source: http://www.oregon.gov/OHA/about_us.shtml

⁴ Source: <http://www.wvphealthauthority.org/images/pdf/2011-health-care-transformation.pdf>

⁵ Source: <http://gov.oregonlive.com/bill/2012/SB1580/>

reform is significant because the Oregon and Medicaid reforms are the one of a few with global budgets in the U.S.⁶

Federal aid was needed for the plan to work. Under the agreement with the Centers for Medicare & Medicaid Services (CMS) in May 2012, Oregon will receive \$1.9 billion to launch the Medicaid reforms, contingent on reducing Medicaid cost growth per capita by two percent and improving health outcomes by the end of two years.⁷ Over the past five years, Oregon's Medicaid costs have increased annually about six percent, which implies the growth rate must be lowered to four percent. In July 2012 thirteen CCO contracts in 33 counties were approved, and began operating on September 1, 2012.⁸ One of the CCOs, Willamette Valley Community Health, LLC, serves the Salem area.⁹

The passage of HB 3650 and SB 1580 has been attributed to the Governor's leadership, the State's urgent need to solve its huge budget deficit, and a state history of cooperation and collaboration in health care and other policy sectors, as well as an innovative and pioneering culture. The next major reform in Oregon will be a health insurance exchange, which is being developed in response to the federal Affordable Care Act (ACA).

At the local level, the features of the health care system in Marion and Polk Counties (the region around Salem, Oregon) also have shaped the Project. Like Oregon as a whole, the local medical community has a history of collaboration to solve health care problems. Physicians Choice Foundation(PCF) is a consensus-building organization created by local health care leaders to work collaboratively on system improvements that no single organization could accomplish by itself (PCF is a not-for-profit, tax exempt organization under Section 501(c)(3) of the IRS code).¹⁰ The local health care system is composed mainly of over 500 independent physicians in small offices; no large, integrated delivery systems dominate the area. There are several community hospitals, and providers have experience with managed health plans. There is a shortage of primary and specialty physicians in the area. Local leaders (key informants) share

⁶ <http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2012/May/May-7-2012/Oregon-Gets-Nod-for-Medicaid-Global-Budget.aspx>

⁷ Washington Post: <http://www.washingtonpost.com/blogs/wonkblog/wp/2012/09/19/interview-gov-john-kitzhaber-on-oregons-1-9-billion-medicaid-experiment/>

The Commonwealth Fund: <http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2012/May/May-7-2012/Oregon-Gets-Nod-for-Medicaid-Global-Budget.aspx>

⁸ Source: <https://cco.health.oregon.gov/Pages/Home.aspx>

⁹ Source: <http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx>. CCO participating organizations include ATRIO Health Plans, Catholic Community Services, Capitol Dental Care, Marion County, Mid-Valley Behavioral Care Network, WVP Health Authority, Northwest Human Services, Polk County, Salem Clinic, P.C., Salem Health/Salem Hospital, Santiam Memorial Hospital, Silverton Health, West Valley Hospital, and Yakima Valley Farm Workers Clinic. Local organizations may join or leave the CCO over time. Regence Blue Cross Blue Shield of Oregon, Health Net, and PacificSource Health Plan have left the CCO.

¹⁰ Source: PCF proposal to the Robert Wood Johnson Foundation

a perception that local health care is lower cost and better quality than at the national level, and that the area has a reputation for innovative, “cutting edge” health care.

Finally, the Marion-Polk County medical offices do not share a common electronic information system. However, about half of the physicians use a community information system that is operated by the WVP Health Authority, a stakeholder in this project. Another quarter of physicians have their own separate electronic medical records systems that are not linked to WVP’s system. A local multi-stakeholder committee, SACHIE (Salem Area Community Health Information Exchange), is developing an information system to connect the medical community but is making slow progress.¹¹The birth of Salem’s CCO, which is mandated legally to coordinate care across participating health care organizations, may speed up the development of a community-wide data warehouse and electronic medical record.

Objective

The goal of the project is to improve the quality and efficiency of health care in Marion and Polk Counties by paying a virtual provider team when a minimum percentage of patients achieve all clinical targets for a specific condition.

Approach

POP’s approach for achieving its objective is presented in the following three sections: POP leadership; description of the POP approach; and POP implementation.

POP leadership. Within this historical and local context, the Robert Wood Johnson Foundation (RWJF) funded the Physicians Choice Foundation’s (PCF) payment reform project known locally as the Program Oriented Payment (POP) Demonstration Project (hereafter referred to as the ‘POP Project’). PCF is implementing the project mainly in collaboration with the local independent physicians association, WVP Health Authority (formerly Mid-Valley Independent Physicians Association) and its subsidiary, Marion-Polk Community (Medicaid) Health Plan, and Performance Health Technology (PH Tech). PH Tech a private, for-profit firm offering health plan benefits administration to over 700,000 individuals¹² and is leading the design and development of the project’s payment strategy.¹³ The RWJF provided PCF with a one-year award from May 2011 to April 2012, and approved an extension of the project to April 2013.

¹¹ The State of Oregon, under the Federal Health Information Exchange Cooperative Agreement Program, is working on a statewide health information exchange, as all states are.

¹² PH Tech provides claims administration for 788,000 lives; about 60,000 of those receive care through the MVP independent practice association.

¹³ Source: <http://www2.phtech.com/>

Program Oriented Payment Approach. The POP Demonstration Project has developed a payment reform approach that blends the concepts of pay for performance with value-based health insurance, or paying extra for health services that generate better clinical results based on scientific evidence, ultimately to improve the quality and efficiency of local health care.¹⁴ The POP Program focuses on conditions that have the highest costs and has three key features:

- (1) **Accountability.** The main goal of the POP project is accountability: to modify the existing fee for service (FFS) payment, where insurers reimburse providers automatically for patient care, with additional payment that rewards providers when their patients have better clinical outcomes. The POP payment scheme does not have algorithms that pay contingent on reducing cost; payment is contingent only on achieving better clinical outcomes.
- (2) **Programs (condition-specific services).** Payment reform is condition-specific.¹⁵ The payment protocol for a specific medical condition is called a “program.” Programs are grouped into “families” for conditions that commonly co-occur in patients (for example, diabetes, congestive heart failure [CHF], and chronic obstructive pulmonary disease [COPD] are a family of three programs).
- (3) **Virtual provider teams.** Payment for better results goes to the virtual team caring for a patient, not just the patient’s physician. The team is “virtual” partly because care is delivered through the small independent practices in the Marion-Polk Counties. Patients with chronic conditions usually receive care from a ‘virtual team’ of providers in several medical practices, rather than from providers co-located in a single, large integrated delivery system.

The key stakeholders viewed the intent of the POP Project as a “Proof of Concept:” that is, the main purpose is to demonstrate if it is actually feasible to design, develop and implement POP’s payment strategy and improve quality while reducing costs. If the concept works in Marion-Polk Counties, the payment approach may appeal broadly to similar U.S. markets composed of small independent practices.

Program oriented payment for a condition works basically as follows, using a simplified version of the program for diabetes as an example; actual programs are more complex. The major components of POP are described more fully below and include patient identification; patient goal (clinical targets); provider goal (thresholds); program payment; program payment to virtual team; and patient severity:

¹⁴ Our interviews with key informants indicate the POP’s pay-for-performance strategy draws from the PROMETHEUS Payment Model, which pays providers for evidence-based care (source: Health Care Incentives Improvement Institute). For more information see: <http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/02/prometheus-payment/what-is->

¹⁵ The POP Project’s condition-specific approach is in stark contrast to the State of Oregon’s reforms which, for example, propose changing the delivery of health care for all types of conditions through patient-centered medical homes to improve health care and save costs.

Patient Identification. Patients who have diabetes are identified based on clinical criteria, such as claims with diabetes diagnosis codes, prescriptions for diabetes medication, or physician referral for diabetes.

Patient Goal (clinical targets). Patient goals are predetermined clinical targets based on the condition of interest. For diabetes, as an example, goals might include receiving a retinal examination and an HbA1c laboratory test, and having HbA1c level ≤ 7 . Goals are all-or-nothing: all three targets must be achieved to receive credit. Conceptually, the patient goal is thought to be an “intermediate outcome” that, if met, will in turn achieve the ultimate “system goal,” such as reduced hospital admissions and readmissions. The POP Project develops the goals based on the evidence and in consultation with an expert clinician for the program’s condition. A program does not specify the treatment(s) that providers must offer to eligible patients.¹⁶

Provider Goal (thresholds). Program payments start when a provider surpasses a performance threshold for the program’s patients. For example, payments may begin when 60% of the provider’s patients with diabetes have achieved the patient goal.

Program Payment. When the provider goal is achieved under capitation, the program payment is paid per member per month (PMPM). For example, if a provider has 50 patients with diabetes and the PMPM is \$30, the provider’s monthly program payment is \$1,500.

When the provider goal is achieved under fee for service (FFS) insurance, program payment is composed of two parts. First, each program has a list of procedure codes that qualify for payment. Codes qualify for payment based on evidence that the procedure contributes to better clinical results, a feature similar to value-based insurance. In patients with diabetes, for example, office management (office codes 99202-99380) is associated with better diabetes control. Second, for qualifying codes, a program computes the payment by multiplying the code’s relative value unit (RVU) by the program’s conversion factor (Payment = RVU * Program Conversion Factor). For example, if a provider submits a claim with code 99214, which has a RVU of 3.08 and a \$10 conversion factor, the program payment is \$30.80 for that claim.

Program payments are projected to be budget neutral or potentially cost-saving. The basic calculations behind program payments are as follows for hypothetical Condition A:

¹⁶ For patients covered by the Oregon Health Plan (Medicaid), however, a patient with a diagnosis code must receive a treatment(s) that is authorized by Medicaid for that code or payment is not made. [Sources: <http://www.oregon.gov/OHA/OHPR/HERC/Current-Prioritized-List.shtml> http://www.oregon.gov/OHA/OHPR/HERC/docs/L/Jan12List_Rev010512.pdf]

- (1) In 2011 Condition A had total payments of \$3,000,000. By achieving the patient goal (see above), hospitalizations and emergency room visits are expected to decline by 15%, for a projected savings of \$450,000.
- (2) Part of the savings, 20%, is reserved for program payments, or \$90,000 ($90,000 = 450,000 * .20$). The remainder of the savings is shared with providers through the established contractual shared savings agreements.
- (3) For Condition A, office management CPT codes 99202-99380 qualify for program payments. In 2011 the CPT codes had payments of \$66,666 and total RVU of 2,222. By dividing the two numbers, the usual average payment (or 'conversion factor') for the codes is \$30 ($30 = 66,666 / 2,222$).
- (4) Because providers earn more money by using the above CPT codes for program patients, providers are expected to use the codes more frequently, such as an increase of 20%, which increases the codes' projected RVUs to 2,666 ($2,666 = 2,222 + (2,222 * .20)$). Drawing from (2) above, the program conversion factor is computed as \$33.76 ($33.76 = 90,000 / 2,666$).
- (5) The combined conversion factor for a qualifying CPT code is calculated by adding the usual and program conversion factors, or \$63.76 ($63.76 = 30 + 33.76$).
- (6) Similar calculations are performed for capitation health insurance. For example, if the program projects making 3,333 PMPM payments, the PMPM payment is \$27 ($27 = 90,000 / 3,333$) for qualifying patients in the practices with Condition A.
- (7) For Condition A, program payments to Provider A begin when 60% of Provider A's patients achieve the patient goal. Because all providers are unlikely to reach the 60% threshold, program payments will likely be less than the budgeted \$90,000.
- (8) If a patient has multiple chronic conditions in the same family, POP pays only for the program with the highest incentive, if the provider fulfills the quality goals for that program. Payment still occurs if the provider has not fulfilled the program goals for the patient's other chronic conditions.
- (9) Program oriented payments also exist for care processes, such as transitions of care.¹⁷ For example, a provider or virtual team may receive double the fee if a patient is seen within 24 hours of hospital discharge for certain conditions.

Program Payment to Virtual Team. Once the program payment is computed under capitation or FFS, the payment is distributed to the patient's virtual team, which is defined based on three factors. First, each program defines the provider specialties eligible to be team members. For example, for diabetes the eligible team members are a primary care provider (PCP), a diabetic nurse practitioner, nutritionist, endocrinologist and a case manager. Second, the eligible members of a patient's virtual team are identified by the provider identification numbers in a patient's claims, through provider

¹⁷ POP includes care transitions because the CCO has launched initiatives to improve care transitions at hospital discharge.

referral or other mechanisms. Third, the payment is distributed to virtual team members based on their contribution to patient care. If the PCP refers the patient to a specialty provider(s), the primary care provider also receives program payments if the specialty providers achieve the patient and provider goals. The POP method for distributing payments to virtual team members will be developed in collaboration with community providers. Although payments are distributed only at the end of the budget cycle, providers may view their total payments in real time on a secure web site.

Patient Severity. Given the program payments, providers may have an incentive to “dump” patients with greater condition severity or comorbid conditions and who therefore may not reach the Patient Goal. Patient “dumping” may be reduced – but probably not eliminated -- through two mechanisms. First, providers may exclude patients from a program. However, the program payments are based on the number of patients a provider chooses to include, and including more patients may yield a larger incentive once the targets are met. This design may create an incentive to include more patients with complex needs.¹⁸ Second, new programs will be created for more-complex patients. For example, a new program might be created for patients with diabetes and CHF that contains different patient goals and payment formulas consistent with the patients’ increased clinical complexity.¹⁹

POP Implementation. Oregon’s health care reforms initially slowed POP’s implementation in the first year of RWJF funding (May 2011-April 2012) but are now speeding up rollout. The start-up of the RWJF POP demonstration project overlapped precisely with Oregon’s statewide launch of CCOs, including the CCO in the Salem region. The health care organizations in a CCO are required by state contract to collaborate and provide coordinated care to enrolled patients. With state and federal approval of the CCOs early in 2012, the health care organizations in the Salem region’s CCO were on a tight timeline -- about six months -- to build linkages for physical, mental and dental health care, and to build working relationships between hospitals and practice-based physicians and other providers. The goal was to create a new “we” – Willamette Valley Community Health, LLC – a coordinated health care system offering better care at lower cost, as mandated by state law, for enrolled patients in the Salem area. The work was challenging because the local market had few incentives historically for competing

¹⁸ In POP the financial incentive is paid to the provider when a given percentage of the provider’s patients achieve the quality goal (e.g., 60%). Thus, the remaining 40% of the patients could include those with greater condition severity or comorbid conditions, which may dampen patient dumping.

¹⁹ Key informants argue their program approach for addressing severity of illness is better than mathematical formulas that adjust payment based on severity because the latter does not address accountability for achieving patient goals.

organizations to collaborate.²⁰ With organizations engaged fully in CCO-building, forging new relationships and learning how to work together, payment reform received much less attention.

However, House Bill 3650 (Section 5) requires explicitly that CCOs have alternative payment methodologies that:

- “Reimburse providers on the basis of health outcomes and quality measures instead of volume of care;
- Hold organizations and providers responsible for the efficient delivery of quality care; [and]
- Reward good performance...”

Given the legal mandate for payment reform and that CCO contracts started September 1, 2012, local attention shifted to payment reform in summer 2012. Because POP is responsive to the HB 3650 payment requirements, in July 2012 the CEO of WVP Health Authority approved the implementation of POP before September 1, mainly to secure some control over payment reform before the WVP Health Authority was subsumed within the CCO. The WVP Health Authority launched a small-scale POP pilot initiative for CHF, COPD and diabetes. The CCO’s plan to adopt POP and fulfill the HB 3650 mandate was submitted to the HCA for approval in September 2012.

With a sense of relief and excitement, POP leadership launched POP for CHF, COPD and diabetes in autumn 2012. Key steps of POP implementation are the following:²¹

- 1) Providers are educated about POP, how it will support their practices, and why POP is required for the CCO. PH Tech and WVP hosted a dinner for over 50 local physicians to share information about POP and build support for POP in the physician community. The dinner included a formal slide presentation about POP and a question-and-answer period to learn about physicians’ viewpoints.²² In addition, a blog was created to disseminate information about POP to providers, and POP information was published in the medical society’s newsletter.
- 2) Providers are recruited through outreach by POP leaders, and are registered to participate in POP.
- 3) Participating providers review and modify the design of each program.²³

²⁰ Key informants report that due to the provider shortage in most specialties, there is little competition for patients among providers and health care organizations in the Salem area.

²¹ Patients do not participate in POP implementation. However, POP leaders intend to invite patients to participate in POP in the future. In addition, CCO legislation requires that patients and the general public participate in CCO governance, which another mechanism for increasing patient participation in POP.

²² The dinner was mentioned by all key informants and seemed to mark a turning point in physician engagement in the project.

²³ Each program is designed presently through three steps: 1) program goals are developed based on the evidence and in consultation with an expert clinician for the program’s condition; 2) medical directors of health plans in the CCO review the program; and 3) a workgroup of primary care physicians review the program, particularly whether the patient goals will be too onerous for practices to satisfy. A program is expected to be modified at each step.

- 4) POP budgets are developed for each condition.
- 5) Patients with a severe disease and significant comorbidity are identified based on claims data and are enrolled in the program.
- 6) Eligible and potentially eligible providers who care for these patients are identified through claims and notified about their program status. If the provider is not currently participating in POP, the provider is invited to participate in POP.
- 7) Patients who meet the clinical criteria of the program, but lack a claim history (newly enrolled to plan), can be enrolled through the standard PHTECH online authorization management tools that are currently available in Marion and Polk counties. The CCO medical director will review such requests, and enrollment occurs when the standards are met.
- 8) Health care of enrolled patients is tracked.
- 9) Claims are adjudicated to determine whether providers qualify for incentive payments.
- 10) Incentives are paid and savings are calculated.

Steps 4 and 5 are performed on a regular basis to ensure that patients who could benefit are identified to the plan and the providers who care for them. The steps assume that the design of a program is flexible and will vary across communities based on local health problems and provider practices.²⁴ The steps also assume that providers are more likely to participate if providers can shape the features of a program. On January 1, 2013, POP began tracking claims for the CHF, COPD and diabetes programs in the CCO, with payment of incentives starting after July 1, 2013. POP metrics require collecting clinical quality data, and POP is presently finishing those data collection protocols.

Logic Model

The POP Project is expected to achieve its goal of increasing accountable care at lower cost for the following reasons:

- Financial rewards change provider behavior, improve quality and lower costs. Providers receive extra payments only when most patients with the target condition achieve a set of clinical benchmarks, and that achieving all benchmarks in the set causes lower health care costs.
- Providers may have little knowledge of the evidence-based guidelines for a condition. Extra payment increases the likelihood that providers' awareness and knowledge of the evidence will increase, and speeds up the diffusion of knowledge into practice.
- The treatments (CPT codes) that qualify for program payments contribute to achieving the patient goal.

²⁴ The POP computer software is ready to implement. If a community develops a customized version of a program for a chronic condition(s), POP software can be modified readily to support those changes. POP is using agile software development [http://en.wikipedia.org/wiki/Agile_software_development], which is a flexible approach to developing computer code as POP parameters are defined in real time during CCO rollout.

- Providers have flexibility in choosing treatments to achieve the patient goal for a program. One assumption is that providers will choose low cost treatments to achieve the patient goal. POP's critical feature is to incentivize providers to reach the patient goal, and not to dictate what treatments should be provided.²⁵
- Program patients will receive care from virtual teams composed of providers who produce better clinical results. Program patients have chronic conditions and receive care from different specialty providers across several small practices, creating a virtual care team. Because program payments are shared by the virtual team, a provider has a financial incentive to refer patients to specialists who are more effective in achieving patient goals. Over time, the program payments may change provider referral patterns, creating virtual teams composed of providers who are effective in coordinating care to achieve a program's quality benchmarks. In doing so, POP incentives reward collaboration, which is the hallmark of CCOs.
- Because a physician shortage exists and patient demand for care is high in the counties, patients may experience long delays in appointments, which increases unmet patient needs. Providers may see POP program patients in a timelier manner because of the extra payments, which may improve their clinical results.

Facilitators and Barriers

The facilitators and barriers are presented in no particular order of importance.

Facilitators

- History of collaboration and innovation in Oregon and particularly in Salem.
- The leadership of PCF, PH Tech and WVP Health Authority.
- After the legislation was passed authorizing CCOs, the State of Oregon actually followed through and implemented the CCOs. Health care organizations in Salem are "actually" participating in the local CCO.
- The Oregon legislature and the federal government mandate that CCOs are required to have alternative payment methods that pay providers based on quality and that reduce cost growth, which created a receptive environment in the Salem area for implementing POP.
- Local physicians and other providers contribute to the development of each program, which increases the likelihood that providers will participate in POP.
- PH Tech routinely collects much of the medical claims data for operating POP.
- Funding from the Robert Wood Johnson Foundation raised awareness and credibility of the project.
- WVP Health Authority has a successful track record in managing payment withholds in the counties, which may increase provider participation in the POP Project.

²⁵ A related assumption is that health care is inefficient because medical practices do not target resources to achieve a patient goal(s) in day-to-day practice.

- POP is also part of PH Tech’s own goals, and PH Tech has invested substantial resources to develop the POP computer software.
- Providers in the community already use a Web interface to track their claim payments, which makes provider adoption of POP easier.

Barriers

- The Oregon legislature’s and the federal government’s authorization of CCOs focused the energy and attention of virtually all health care organizations in the Salem area on developing the CCO, and there was little time and capacity remaining for developing and implementing POP.
- Local providers also were overwhelmed by other health care reforms, including patient-centered medical home initiatives, payer incentive programs, meaningful use of health information technology, and the switch from ICD-9 to ICD-10 coding, with no guidelines for combining and integrating them to improve medical practice. The other reforms also reduced their time and energy for POP.
- Turnover occurred when one of the POP leaders who was instrumental in building and maintaining cohesive relations between the independent practice association and the local medical society left the organization. A goal is to maintain continuity in these close relations and, in turn, to link them with new relationships that are forming within the CCO.
- POP Project is more efficient when providers submit all data electronically, which is not feasible yet.
- POP is complicated, and communicating to medical practices how it works is challenging. Key informants reported their initial communication efforts to recruit physicians were unproductive and almost doomed the project. POP leaders learned from their mistakes and improved their communication, marketing and recruitment strategies in the second year of the project.

Evaluation and Sustainability

POP is designed to be “self-evaluating.” The POP database is a rich source of information about provider treatments, quality goals and incentive payments. The success of POP will be apparent from the percentage of providers reaching their quality goals and the amount of incentives paid to providers. PCF and PH Tech also will conduct a survey of provider participants to find out their perceptions of POP.

In principle, POP should be self-sustaining because POP operates within existing budgets and does not require “new” dollars. POP is portable to other communities and is scalable to handle small and large provider and patient populations. If POP works in Salem, other communities may adapt POP to achieve their quality and cost goals.

Lessons Learned

The POP Project is just now being implemented in the field. At this point in its history, the main lesson learned is that context can be both a facilitator and a barrier. On one hand, Oregon's legislature mandated the statewide rollout of community care organizations with alternative payment methods – a fortuitous requirement that POP fulfilled and that paved the way for POP rollout. On the other hand, efforts to achieve the larger, more immediate and pressing goal of quickly implementing CCOs slowed the implementation of payment reform in the Salem area. Viewed as a barrier, context can dictate the timeline for implementing payment reform, and POP implementation took longer than expected, largely because the local health care system was overwhelmed and grappling with Oregon's statewide reforms.

A related lesson learned is that development of the POP computer software is, in fact, feasible but has taken more time and cost to accomplish than expected. PH Tech has the medical claims required for POP operations, but at least in the short run, participating clinics will be asked to submit clinical information, which is absent in claims. POP is aware that other local reforms and projects in the Salem area also are asking clinics to report clinical information. A goal is to reduce the clinics' reporting burden by "harmonizing" or blending POP's data requests with the other projects into a common set of clinical indicators.

Most lessons learned will be discovered as POP is implemented in the following months. POP implementation may yield insights that address the following questions:

- Are payment reforms more successful when they are implemented partly to address legal requirements? A related question is whether collaboration among health care organizations is more successful when mandated by law versus when organizations coordinate care voluntarily.
- A central challenge to implementing POP is human: will providers buy-in to the project? In principle, POP's flexibility to satisfy local practice patterns and active provider participation in the design of POP's programs may increase provider participation.
- CCOs offer a coordinated health care system offering better care at lower cost, as mandated by state law. Will the Salem-area CCO be successful in creating collaboration among health care organizations marketplace based on competition between health care organizations?
- Providers may be more willing to participate in payment reform when the payment amounts offset their costs of implementing the project. How much will POP's payments cover the provider costs of achieving the patient goals for a given chronic condition? Will providers participate in POP if the costs of achieving the patient goals are substantially greater than the POP payment?
- Are larger payment incentives that target the sickest, highest-cost patients more effective in controlling the level and growth of health care costs than much smaller payment incentives targeting large populations of healthy and sick patients?

- And, finally, will POP actually work? Will providers achieve patient goals? Is it possible to identify virtual teams? Will providers in virtual teams receive payment incentives? Will cost growth decline in the Salem area?