

## Program Oriented Payment parameters

Program Oriented Payment (POP) is a new payment system that supports different types of incentive approaches. Incentive programs are created or modified using configuration parameters. The parameters provide:

- flexibility
  - a variety of goals can be defined
- consistency
  - the same goals and programs can address many communities and environment

The parameters also serve to define a program's virtual team, the qualified providers that, as a team, treat a POP program's patient, helping the patient attain the patient goal.

### Parameters of a program

The parameters are used to define any POP program. The parameters are in the most common order of definition when designing a program.

<i>Parameter</i>	<i>Purpose</i>
<a href="#">Patient identification</a>	Medical criteria used to identify a qualified patient
<a href="#">Patient goal</a>	An intermediate result that is a target that a provider tries to achieve for the patient
<a href="#">Provider goal</a>	A set of aspirations that define what a provider must achieve or exceed to be successful; determines qualification for an incentive
<a href="#">Qualified Specialties</a>	A set of specialties used to satisfy the needs of the program
<a href="#">Vendor eligibility</a>	Participation requirements for registration in a program
<a href="#">Provider role</a>	A specialty or need defined by a patient's health issue
<a href="#">Cost attribution</a>	A formula used to assign cost to a program
<a href="#">Incentive design</a>	A set of qualified items, i.e. diagnosis codes, patient attributes, etc., that define a program's scope
<a href="#">Payment formula</a>	A set of numbers used to calculate the incentive amount

### Patient identification

Medical terms used to identify patients who belong in this program. Similar to normal disease management patient selection criteria, the difference being that payment software is being configured and stratification criteria is not specified.

The POP methodology focuses on a single condition. If there is another stratum, that definition is used to create another separate POP incentive program.

For example:

**Diabetes:**

((The presence of two or more claims in the past with a 250.xx ICD9) OR (presence of two prescription fills for diabetic medication) OR (PCP referral stating that the patient has diabetes))  
AND NOT (statement by PCP saying the patient doesn't have Diabetes)

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## Patient goal

A statement that defines what a program is designed to achieve in the terms of a single patient. For example:

- **Diabetes:** A retinal examination (payment code) annually, A HbA1c laboratory measurement every two weeks (payment code), and that the HbA1c value be  $\leq 7\%$  (A laboratory value)
- **Sepsis:** For a patient admitted to the hospital with a condition associated with Sepsis (diagnosis codes), the patient never experiences MCC (Major Complications or Comorbidity) or MV (Mechanical Ventilation). These are both DRG billing codes
- **CHF:** For a patient with Functional Class III or IV CHF that, unless contraindicated, the be on a ACE inhibitor (NDC or RXNorm code in pharmacy data) and Spironolactone (NDCA OR RXNorm code in pharmacy data) and that their weight not fluctuate more than 5% around a target value specified by the PCP
- **ED utilization management:** For a population of patients, who are frequent users of the Emergency department, reduce ED utilization management below 1 visit per 6 months.

The patient goal is an intermediate goal. The actual goal of the health plan or health system will usually be overall quality improvement or cost reduction. For a POP program, a goal is defined that is reasonably within the control of the provider to achieve.

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## Provider goal

The definition of what outcomes a provider must attain to receive an incentive.

Quality improvement programs most often use the [Patient Goal](#). For example, a diabetic quality improvement program might have a provider goal where an incentive is paid when the Patient Goal is met in 60% of patients.

For capability or service compliance programs such as Patient Centered Medical Home (PCMH), the goal may be defined as meeting a standard without reference to the patient goal.

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## Qualified Specialties

A set of specialties used to satisfy the needs of the program. Participating providers identified with one or more of the specialties are eligible for to join the team.

Every participating POP provider who contributes to meeting the program's provider goal is rewarded.

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## Vendor eligibility

A set of eligibility criteria used to determine if a vendor (who manages a provider's billings) receives payments from a POP program. These are administrative criteria such as

- Valid contract with the health plan that is using POP
- Participation in a network that is using POP for incentives
- Acceptance of the specific rules of that apply to POP

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## Provider role

A description of the function a sub group of providers serve. This description is attached to a set of specialties within the [Qualified Specialties](#) parameter.

The purpose of the role is to create payment schedules that recognize the relative contribution of the role.

The main component is a term, usually the name of a specialty, that identifies what aspect of a patient's care a virtual team member (provider) addresses

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## Cost attribution

A formula that connects patients identified with a condition to the associated claim cost. The formula mainly addresses provider payments and includes associated pharmacy costs if the data is available.

Cost attribution contributes to projection of future expenditures using program simulation against historical data and also to calculate costs incurred during operation of a program. In this way, program performance is tracked without delayed report generation.

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## Incentive Design

A set of qualified items, i.e. diagnosis codes, patient attributes, etc., that define a program's scope.

For example, a "Fee For Service" (FFS) benefit plan would use a statement identifying the diagnosis or payment code combinations that an acceptable claim must have.

A “Per Member Per Month” (PMPM) plan would use other attributes relating to vendor, provider, or patient or may contain criteria relating to encounter diagnosis or procedure codes

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## Payment formula

A set of numbers, paired to a [Provider role](#), which is used to calculate an incentive amount.

There are two incentive payment options: FFS or PMPM. Each has its own formula(s):

- FFS
  - a conversion factor applied to the associated “Relative Value Unit” (RVU) value, OR
  - a specific fee schedule table for the procedure(s) present in the claim
- PMPM
  - a payment amount per member cared for

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