The Banner Health Network, an AIP and Banner Health partnership, present the

Banner Health Network
Pioneer ACO - Physician Toolkit

This BHN Pioneer ACO Physician Toolkit has been developed to provide you with information you should be aware of regarding what the Pioneer ACO model is and how it will work operationally. The Physician Toolkit provides resources and talking points for Physicians, Office Managers, Billing Departments, Office Staff and your Medicare Patients. Components of the Toolkit can be used separately and provided to the appropriate staff or as a whole. Medicare Patients should only receive the section “FAQ’s from a Medicare Beneficiary Perspective”.

The Table of Contents has been color coded to assist in directing individuals to sections specifically relevant to them. However, we encourage you and your staff to review the entire resource to familiarize yourself with this new and exciting clinical partnership.
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EXECUTIVE SUMMARY

A Call To Action - The Development of the Banner Health Network (BHN)

The current health care system is too costly and unsustainable. Providers currently operate under a volume-based, fee-for-service model, which means the more care and services they provide the more they are rewarded, regardless of the clinical outcome. To ensure continued success physicians and hospitals will need to partner to lead the transformation to a value-based model of population health management. This call to action is the catalyst for the development of Banner Health Network (BHN).

This new model of clinical and business alignment will allow BHN participants to align a comprehensive network of providers (hospitals, primary care and specialty physicians, post-acute, home long-term care, ancillary providers, pharmacy, public health agencies, hospice, and wellness programs) with payers. BHN and its providers will have accountability for managing and improving the health and coordination of patient care for the beneficiaries within a defined population – Commercial, Medicare and Medicaid. Many value-based clinical activities that physicians provide, or would like to provide, today are not “billable codes” or not linked to appropriate levels of reimbursement. Therefore they are sub-optimized or not provided at all. Physicians who do not participate in new models such as this will be subject to the inevitable downward reimbursement under the traditional pay-for-volume methodology and will become influenced BY the market as opposed to influencing the market through leadership and transformation. This new model will provide the opportunity to reward physicians for providing the high quality and patient-centered care they were trained to provide.

Who Is Banner Health Network?
The Banner Health Network is an Arizona patient care and business partnership between Arizona Integrated Physicians (AIP), Banner Medical Group (BMG), Banner Physician Hospital Organization (BPHO), and Banner Health. BHN currently has more than 2,000 private practice and employed physicians located in the Phoenix metro area. It is anticipated that BHN will be serving more than 200,000 members during 2012. By 2015, it is believed that between 500,000 – 750,000 individuals in Arizona will be served by BHN.

Why should providers participate with Banner Health Network?

- Opportunities to improve reimbursement, compared with the traditional fee-for-service reimbursement model for providing cost-effective, evidence-based health care.
- Movement of CMS and virtually all insurance plans from transaction-based, fee-for-service reimbursement methodologies to outcomes-based incentive reimbursements tied to the health of the covered population.
- Early adoption of these new models will enable the providers to be much better positioned for other similar arrangements and influence how those models function.
- Focusing more on population health management, quality improvements, access, patient satisfaction, which are all features of this model should prove to be rewarding to the patient population served within this model and allow providers to be better positioned to retain and grow their patient base.
- Rewards providers for providing quality care.
- Physicians will have a voice in the development and implementation of changes in how clinical care is provided.
- We will work proactively with your practice to provide more efficient outcomes and improve the patient care experience.
**What is the Pioneer ACO Model initiative?**

The Pioneer ACO Model (Pioneer ACO Model) is a new initiative launched by the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI - Innovation Center). The Pioneer ACO Model is designed to test how moving experienced organizations of aligned physicians and hospitals more rapidly to population-based payment arrangements can achieve cost savings, which will improve health outcomes for Medicare beneficiaries.

**How will payments to the Pioneer ACO work?**

CMMI developed a target per capita expenditure level (benchmark) based on previous CMS expenditures on the group of beneficiaries aligned to the ACO. At the end of each year, participating ACOs will be evaluated against this benchmark, and rewarded with a portion of the savings or held accountable for increased expenditures.

**How are physicians paid?**

Medicare will continue to pay providers directly and at the same Medicare reimbursement rates that exist today. There is no change in the claims submission process for traditional Medicare Fee-For-Service claims; continue to send claims using your existing processes for paper or electronic claims submission.

**How are providers rewarded for providing cost effective, quality care?**

Unlike today, participating providers in the Pioneer ACO will be eligible for an upside, shared-savings based on cost effective care and quality measures. If the BHN Pioneer ACO provide more efficient care as a result of improved care coordination the savings resulting from that efficiency will be shared between CMS and BHN and subsequently to the individual providers impacting that care.

**What is my financial risk?**

In the first year of operations there is no individual provider downside risk. All downside risk will be held or absorbed at the BHN or individual network entity levels (AIP, BMG, BPHO or Banner Health).

**How will I know if a Medicare beneficiary is a BHN Pioneer ACO member?**

Generally, CMMI has attributed all traditional Medicare Fee-For-Service patients into the BHN Pioneer ACO, therefore you should assume all traditional Medicare beneficiaries are attributed to the ACO.

**Can I refer outside of the BHN Pioneer ACO network?**

Medicare Beneficiaries have the option to receive services from providers outside of the ACO at any time, and ACOs are forbidden from restricting which providers a beneficiary may seek care from. The foundation of the ACO model is to enhance care coordination across the continuum, therefore referring within the BHN network is the preferred model as the BHN network includes a provider network that has been built on integration and care coordination processes to optimize the patient experiences as they move through the continuum to facilitate continuity of care and ensure appropriate access into programs such as disease and case management. The Medicare Fee-For-Service benefits remain the same and there are no prior authorization requirements to receive services.

**How will patients be affected by the Pioneer ACO Model?**

Pioneer ACOs are designed to provide CMS beneficiaries with higher quality, more seamless healthcare, by the Pioneer ACO facilitating coordination between healthcare providers, resulting in better care for patients aligned with the ACO.
How can providers participate with Banner Health Network?
Providers must be a part of one of the networks that compose Banner Health Network – AIP, BPHO or BMG. BHN is anticipating significantly expanding the provider network for 2013.

Which Payors are contracted with Banner Health Network?
Currently, BHN is contracted with CMMI for a Pioneer ACO, Health Net for commercial and senior products and Aetna for a narrow network commercial product. Additionally, BHN is in discussions with all the major health plans in Phoenix to develop additional attribution, ACO and value based partnerships and contracts.

What can Physicians do to ensure the success of the ACO Model with BHN?
The primary objective of an Accountable Care Organization (ACO) is to improve the total cost, quality and satisfaction of a defined population – in the Pioneer ACO model the target population are Medicare beneficiaries. In order to accomplish these commendable goals numerous changes to the existing approach to care delivery must be implemented. While change to the health system is complex the following are some fundamental approaches that BHN is taking to influence transformation in care delivery and ways in which you, as a physician partner of BHN, can help lead this change.

- Optimize Efficacious Use of Diagnostic Testing.
- Transition from Reactive to Proactive Care.
- Actively “Manage” High Risk Patients.
- Optimize “Same Day Care” Appointment Access.
- Actively Engage ACO Beneficiaries.
- Assume All Your Medicare Beneficiaries are BHN ACO Members for Efficient Management.
- Refer to High Quality / Cost Effective BHN Specialists, Ancillary Providers and Hospitals.
- Practice to the Height of Your License.
- Proactively Identify BHN ACO Beneficiaries
- For Specialists, Actively Communicate With PCP’s and Refer / Direct Patient Back to PCP for Continued Care Coordination.
- For Specialists this is an Opportunity to Differentiate Yourself on Quality, Cost and Service

Please see full details in the document attached. This knowledge will assist you in preparing for the inevitable changes in the way health care is delivered and how together, we can lead this transformation.
ACO & Banner Health Network Overview

ACO & Banner Health Network (BHN) FAQs

What is an ACO?
Accountable Care Organizations (ACOs) bring doctors, nurses, hospitals and other care providers together to share responsibility for keeping patients healthy. The goal of ACOs is to work to measurably improve the total cost, quality and satisfaction of a defined patient population’s care.

Why create an ACO?
Today, our healthcare system focuses on caring for the sick and rewards healthcare providers within their silos of care, i.e., physician offices, hospitals, nursing homes, etc. This reality contributes to inefficiency, waste and poor care coordination. ACOs are widely viewed as a way to transform healthcare to address these concerns simultaneously. In an ACO, providers will no longer be rewarded for the volume of care provided - they will instead be paid based on their ability to provide preventive care and keep people healthy.

How are ACOs paid?
When doctors, hospitals, nurses and other care providers efficiently deliver the right care, in the right setting at the right time, patients benefit and overall costs are reduced. For example, if the ACO works proactively with a heart failure patient to manage medications and recommends lifestyle changes that improve their condition, they can prevent serious complications that require expensive surgeries and long hospital stays. The savings generated from these care improvements can then be shared by the ACO and the payer. The incentives are shifted to promote the value rather than volume.

What can patients expect from ACOs?
ACOs put the patient at the center of care. In these models, patients are partners working with a designated care team to manage and improve their health. Patients are assisted in navigating the healthcare system so they get the right care, from the right provider at the right time.

How can you expect to build accountability in the patient population?
Building accountability is critical for success in the ACO model, and is intended to enhance the patient’s engagement in their care and overall health. We are measuring the success of these efforts in the context of improving the care experience, so approaches will be customized to ensure they are complete and satisfying to the patient. ACOs are focused on providing patients the appropriate health information they need and a convenient way to access care so that they are motivated to take their own actions to ensure wellness.

How will ACOs reduce spending?
Studies have shown that up to 30 percent of the total funds spent on healthcare are “wasted dollars” – spent on unnecessary and duplicative tests, treating complications that could have been avoided, and treating patients in expensive settings such as the hospital. ACOs are expected to eliminate the waste and unnecessary spending and increase the preventive and other care that will keep patients well. This is accomplished through realignment of incentives, rewarding value instead of volume, increasing the level of clinical integration and interdependency of providers across the care continuum, investing in technology and the application of evidence based clinical protocols.

Is an ACO a Health Maintenance Organization (HMO), managed care or an insurance company?
No. An ACO is a group of doctors, hospitals, and other health care providers who work together to provide better, more coordinated care. Doctors and hospitals in an ACO communicate with beneficiaries and with each other to ensure patients get the care they need when they are sick, and the support needed to stay healthy and well.
An ACO isn’t an HMO, managed care or insurance company. Unlike HMOs, managed care, or some insurance plans, a Medicare ACO can’t tell beneficiaries which health care providers to see and can’t change your Medicare benefits. If a doctor participates in a Medicare ACO, Medicare beneficiaries have the right to choose any doctor or hospital who accepts Medicare at any time. Commercial ACO’s may differ in that they will often be restricted to the network of providers that participate in that specific ACO product.

**What is Banner Health Network (BHN)?**

The Banner Health Network is a partnership between Banner Health and its aligned and integrated physician groups’ version of an Accountable Care Organization. It is a network of providers and payers (Medicare, Medicaid, Commercial, etc.) who together have accountability for managing and improving the health of a defined group or population.

**Who is Banner Health Network?**

The Banner Health Network is an Arizona patient care and business partnership between Arizona Integrated Physicians (AIP), Banner Medical Group (BMG), Banner Physician Hospital Organization (BPHO), and Banner Health. BHN currently has more than 2,000 private practice and employed physicians located in the Phoenix metro area. It is anticipated that BHN will be serving more than 200,000 members during 2012. From a financial perspective, BHN could encompass up to 15 – 20% of Banner Health’s operations in 2012. By 2015, it is believed that between 500,000 – 750,000 individuals in Arizona will be served by BHN. Banner Health also plans to launch this network strategy with a defined set of providers in several of our Western Region Markets. Today the network is comprised as follows:

**Arizona Integrated Physicians**: AIP is a physician-owned organization comprised of more than 600 physicians, including approximately 150 primary care physicians and 450 specialty care physicians. AIP was founded in 1994 and has evolved to become a nationally recognized leader in implementing comprehensive quality and care management programs, pay-for-performance models, outcome improvement measures and tiered provider reimbursement models tied to quality measures and patient outcomes. As a physician-owned and governed organization, AIP is dedicated to becoming a virtual medical group and clinically integrated physician network that enhances the viability and sustainability of independent physicians.

**Banner Medical Group**: BMG is a group of primary care and specialty physicians who are aligned with Banner through an employed model. These physicians may practice in smaller clinics or in large, multi-specialty practices. Currently, nearly 800 physicians are aligned or employed by Banner Medical Group (BMG). The Banner Medical Group will be a prominent component of the Banner Health Network. The anticipation is that BMG physicians will be located in our Banner Health Centers to ensure convenient locations for Banner Health Network members or other consumers to receive care and health management.

**Banner Health**: Banner Health is a non-profit health system, which operates 23 hospitals, as well as other specialized facilities, in seven western states. The health system is headquartered in Phoenix, Arizona and is one of the largest employers in the state of Arizona. Banner also operates in a number of other states including Colorado, Nebraska, Wyoming, Nevada, California and Alaska. Across the entire enterprise, Banner Health employs over 36,000 employees. The organization provides emergency care, hospital care, ambulatory care, hospice, long-term/home care, outpatient surgery centers, labs, and rehabilitation services.

**BPHO**: BPHO is a taxable, nonprofit corporation formed in 1989 to engage in risk-based joint contracting with payers on behalf of a network comprised of Banner hospitals in the Phoenix metropolitan area and over 900 primary care and specialist physicians. With over 20 years of organizational experience in managing population health with specific expertise in managing the health for Medicare, Medicaid and commercial patients, BPHO has established administrative capabilities (network development, provider relations, quality management, utilization management, medical economics, credentialing,
etc.) and clinical programs focused on managing both acute episodes and chronic diseases. To date, the BPHO is responsible for over 20,000 Medicare Advantage members in three different Medicare Advantage arrangements.

**Why Banner Health Network?**
The current health care system is too costly and unsustainable because of escalating cost and declining reimbursement for care provided. Providers currently predominately operate under a volume-based, fee-for-service model, which means the more care and services they provide, the more they are rewarded. In order to ensure our continued success, however, providers must shift to a new value-based model of population health management, while also balancing the present volume-based model.

Operating under this new model will essentially allow the BHN participants to align a comprehensive network of providers (hospitals, primary care and specialty physicians, post-acute, home long-term care, ancillary providers, pharmacy, public health agencies, hospice and wellness programs) with payers who together have accountability for managing and improving the health and close coordination of patient care of the members within a defined group or population. As leaders in transforming to value-based care BHN will be influencers of reimbursement model changes as opposed to being influenced by rate reductions, which is the only option if providers do not drive enhanced value.

**Why should providers participate with Banner Health Network?**
There are a number of reasons a provider should consider becoming part of the Banner Health Network including:

- Opportunities to improve reimbursement, compared with the traditional Medicare reimbursement model for providing cost-effective, evidence-based health care.
- Movement of CMS and virtually all insurance plans from transaction-based, fee-for-service reimbursement methodologies to outcomes-based incentive reimbursements tied to the health of the covered population.
- Early adoption of these new models will enable the providers to be much better positioned for other similar arrangements and influence how those models function.
- Focusing more on population health management, quality improvements, access, patient satisfaction, which are all features of this model should prove to be rewarding to the patient population served within this model and allow providers to be better positioned to retain and grow their patient base.
- **Rewards providers for providing quality care.**
- Physicians will have a voice in the development and implementation of changes in how clinical care is provided.
- We will work proactively with your practice to provide more efficient outcomes and improve the patient care experience.

**How can providers participate with Banner Health Network?**
Providers must be a part of one of the networks that compose Banner Health Network – AIP, BPHO or BMG. BHN will be participating with various payors including commercial, Medicare Advantage, AHCCCS and Medicare. To participate in products sponsored or partnered by BHN you must be a contracted provider of AIP, BPHO or BMG. The initial Medicare Pioneer ACO network for 2012 was submitted to CMS as a subset of the entire BHN physician network based upon several criteria and a willingness of the provider to participate. The Pioneer ACO models allows for additional providers to be added on an annual calendar year basis. BHN is anticipating significantly expanding the provider network for 2013.

**What Payors are Banner Health Network contracted with?**
In addition to current contracts with Medicare for the Pioneer ACO, BHN has contracts with Health Net and Aetna. Additionally, Banner Health Network is in discussion with all the major health plans in Phoenix. It is anticipated by 2015 more than 500,000 members will be served by Banner Health Network.

**For more information about Banner Health Network please contact:**
Provider Relations
East Valley 480-684-7070, AIP West Valley 623-215-9430
Pioneer ACO Overview

Banner Health Network’s Pioneer Accountable Care Organization FAQs

What is an ACO?
An ACO is a recognized legal entity under State law comprised of a group of ACO participants (providers of services and suppliers) that have established a mechanism for shared governance and work together to coordinate care for Medicare fee-for-service beneficiaries. ACOs enter into an agreement with CMS to be accountable for the quality, cost, and overall care of traditional fee-for-service Medicare beneficiaries who may be aligned with it.

What is the Pioneer ACO Model initiative?
The Pioneer ACO Model (Pioneer ACO Model) is a new initiative launched by the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI - Innovation Center). The Pioneer ACO Model is designed to test how moving experienced organizations more rapidly to population-based payment arrangements working in coordination with private payers can achieve cost savings across the ACO, which will improve health outcomes for Medicare beneficiaries.

The first two years of the Pioneer ACO Model are a shared savings payment arrangement with ACO’s. Starting in year three of the initiative, those organizations that have shown savings over the first two years will be eligible to move to a population-based (capitation) payment arrangement that can continue through optional years four and five.

Pioneer ACOs are required to develop similar outcomes-based payment arrangements with other payers by the end of the second year, and fully commit their business and care models to offering seamless, high quality care.

How will payments to the Pioneer ACO work? What are population-based payments?
The Innovation Center will develop a target per capita expenditure level (benchmark) based on previous CMS expenditures on the group of beneficiaries aligned to the ACO. This benchmark will be adjusted based on a combination of the average growth percentage for a reference population and the absolute dollar growth for that reference population. At the end of each of the first two years, participating ACOs would be judged against this benchmark, and rewarded with a portion of the savings or held accountable for increased expenditures. The per capita expenditure would have to be outside of threshold of at least 1 percent to trigger payments or obligations.

In year three, Pioneer ACOs will be able to transition into a population-based payment arrangement. Population-based payment is a capitation-based per-beneficiary per month payment amount intended to replace a significant portion of the ACO’s fee-for-service (FFS) payment with a prospective payment.

How will patients be affected by the Pioneer ACO Model?
Pioneer ACOs are designed to provide CMS beneficiaries with higher quality, more seamless healthcare. By encouraging integration amongst healthcare providers on an accelerated risk track, the Pioneer ACO Model facilitates coordination between healthcare providers, resulting in better care for beneficiaries aligned with ACOs.

Are patients required to participate in the Pioneer ACO Model?
Under prospective alignment, Pioneer ACOs will notify their aligned beneficiaries regarding the initiative at the start of the first performance period. Beneficiaries have the option to receive services from providers outside the ACO at any time, and ACOs are forbidden from restricting which providers a beneficiary may seek care from. Beneficiaries participating in the initiative may also contact 1-800-Medicare with questions or concerns, and will be surveyed by CMS to ensure they are receiving high quality care. In addition, beneficiaries are permitted to opt out of data sharing with the Pioneer ACO. Beneficiary notification procedures may be modified under retrospective alignment.
How are patients aligned ("attributed") to the BHN Pioneer ACO?
Under prospective alignment, CMS will identify the Pioneer ACO’s beneficiary population through three years of fee-for-service, primary care claims before the performance period, align those beneficiaries with the ACO, and measure the ACO’s success or failure with that pre-identified set of beneficiaries.
**BHN Pioneer ACO Contracting and Reimbursement FAQs**

**How do I participate in the BHN Pioneer ACO?**
Providers must be a part of one of the networks that compose Banner Health Network – AIP, BPHO or BMG. The initial Medicare Pioneer ACO network for 2012 was submitted to CMS as a subset of the entire BHN physician network based upon several criteria and a willingness of the provider to participate. The Pioneer ACO models allows for additional providers to be added on an annual calendar year basis. BHN is anticipating significantly expanding the provider network for 2013. If you are not participating in 2012 and are interested in participating for the 2013 contract year please contact Provider relations at East Valley 480-684-7070 or AIP West Valley 623-215-9430.

**Can I participate in more than one Medicare ACO?**
According to CMS and CMMI regulations Primary Care Physicians can only participate in ONE Medicare ACO. This includes Pioneer and/or Medicare Shared Savings Program (MKSSP) ACO’s. The primary reason for this exclusivity to a single ACO is the methodology for the assignment or attributed lives to the PCP and affiliated ACO. Specialty Care Physicians (Specialists) may participate in as many Medicare ACO’s as they choose.

**As a PCP, once I agree to participate in a Medicare ACO can I opt to terminate participation and join a different one?**
According to CMS and CMMI regulations a PCP can only participate in a single Medicare ACO at a time. During a contract year a PCP may choose to terminate participation in that ACO by providing written notice of termination pursuant to the terms of their agreement with the BHN affiliated network. However, because of the methodology of attributing Medicare beneficiaries to a Medicare ACO the Medicare beneficiary will remain aligned or attributed to the current ACO until the end of the contract year and the PCP will not be eligible to participate in another Medicare ACO until the beginning of the next contract year.

**Can I terminate my participation?**
During a contract year a PCP may choose to terminate participation in the BHN Pioneer ACO by providing written notice of termination pursuant to the terms of your agreement with the BHN affiliated network. However, because of the methodology of attributing Medicare beneficiaries to a Medicare ACO the Medicare beneficiary will remain aligned or attributed to the BHN Pioneer ACO until the end of the contract year.

**How are physicians paid?**
For the first two years of the Pioneer ACO model Medicare will continue to pay providers directly at the same Medicare reimbursement rates that exist today. For years three to five when reimbursement to BHN transitions to a population-based payment methodology the reimbursement rates and methodology is expected to change to reflect the approach to population health and a focus on rewarding outcome and quality. Providers will be communicated in advance of the reimbursement methodology so that they can make informed decisions.

**How are providers rewarded for providing cost effective, quality care?**
Unlike the current Medicare FFS model, participating providers in the BHN Pioneer ACO will be eligible for additional reimbursement - a shared-savings based on cost effective care and quality measures. Therefore, if the BHN Pioneer ACO provides more efficient care as a result of improved care coordination the savings resulting from that efficiency will be shared between CMS and BHN and subsequently to the individual providers impacting that care.
When would physicians receive any bonus payments should they be earned?
CMMI will complete their reconciliation 90 days following the end of the contract year and then BHN would have to complete its analysis of performance across the networks. It is anticipated that any bonus payments would be made by the end of April for the preceding calendar year’s performance.

What is my financial risk?
In the first year of operations there is no individual provider downside risk. All downside risk will be held or absorbed at the BHN or individual network entity levels (AIP, BMG, BPHO or Banner Health). The BHN Board and its Participants (AIP, BMG, BPHO and Banner Health) will determine how future financial exposure will be managed beyond year 1 once BHN has additional experience in the new Pioneer ACO model.

Where do I submit claims?
The claims submission process for the BHN Pioneer ACO is the same as for traditional Medicare Fee-For-Service claims. Please continue to send claims using your existing processes for paper or electronic claims submission.
BHN Pioneer ACO Operational FAQs

Where do I submit claims?
The claims submission process for the BHN Pioneer ACO is the same as for traditional Medicare Fee-For-Service claims. Please continue to send claims using your existing processes for paper or electronic claims submission.

What is “Opt-Out”?
In the Pioneer ACO the term “Opt-Out” refers to the ability for a Medicare beneficiary to elect to “opt-out” of data sharing. This data sharing is making available to the providers within the ACO their specific medical and pharmacy claims history to ensure that the providers have access to the relevant clinical information to effectively manage the beneficiary’s care. Even if a beneficiary elects to “opt-out” of data sharing that beneficiary is still considered an attributed beneficiary of the ACO and the ACO is financially responsible for the management of his/her care and cannot “opt-out” of the ACO.

Where do I send the Opt-Out of Information Sharing form?
The completed Opt-Out form can be mailed directly to BHN at the following address:
Banner Health Network
P.O. Box 1427
Mesa, AZ 85211-1427

How will I know if a Medicare beneficiary is a BHN Pioneer ACO member?
Primary Care Physicians – Generally speaking, the Center for Medicare & Medicaid Innovation (CMMI) has attributed all traditional Medicare Fee-For-Service patients for participating PCP’s into the BHN Pioneer ACO, therefore you should assume all traditional Medicare beneficiaries are attributed to the ACO. BHN will provide your practice with a list of Medicare Beneficiaries attributed to your practice by January 31, 2012. This list of members will be valid until December 31, 2012. Additionally, a listing of attributed beneficiaries will be available on the BHN website (www.bannerhealthnetwork.com). BHN is also working to create additional tools to enhance the identification of BHN Pioneer ACO beneficiaries at the point of care.

Specialist Physicians - BHN will provide your practice with a list of Medicare Beneficiaries attributed to Banner Health Network by January 31, 2012. This list of members will be valid until December 31, 2012. Additionally, a listing of attributed beneficiaries will be available on the BHN website. BHN is also working to create additional tools to enhance the identification of BHN Pioneer ACO beneficiaries at the point of care.

Hospitals – A database of attributed members of the BHN Pioneer ACO will be created to assist in identifying BHN Pioneer ACO beneficiaries that are hospitalized to assist in transition of care.

What is the effective date of the BHN Pioneer ACO?
The start of the performance period is January 1, 2012.

What is the BHN Pioneer ACO network?
The Banner Health Network is an Arizona patient care and business partnership between Arizona Integrated Physicians (AIP), Banner Medical Group (BMG), Banner Physician Hospital Organization (BPHO), and Banner Health. BHN currently has more than 2,000 employed and private physicians located in the Phoenix metro area. A full listing of all BHN participating physicians is available on the BHN website (www.bannerhealthnetwork.com).

Can I refer outside of the BHN Pioneer ACO network?
Medicare Beneficiaries have the option to receive services from providers outside of the ACO at any time, and ACOs are forbidden from restricting which providers a beneficiary may seek care from. With that said, the advantage of an ACO is the availability of coordinated care. The foundation of the ACO model is to enhance care coordination across the continuum, therefore referring within the BHN network is the preferred model as the BHN network includes a provider network that
has been built on integration and care coordination processes to optimize the patient experiences as they move through the continuum to facilitate continuity of care and ensure appropriate access into programs such as disease and case management.

**Are there any prior authorization requirements?**
The Medicare Fee-For-Service benefits remain the same and there are no prior authorization requirements to receive services.

**How do I refer a Pioneer ACO member to Case Management or Disease Management?**
The referral process for Case Management or Disease Management is the same as it is for Banner MediSun. Contact BHN for referral forms to Case Management or Disease Management at phone number (480) 684-7751, fax number 480-684-7852 or visit the BHN website to access the forms (www.bannerhealthnetwork.com).
FAQs from a Medicare Beneficiary Perspective

If my doctor’s in an ACO, can I still see whatever doctor I want?
Absolutely—if your doctor participates in an ACO, you can see any healthcare provider who accepts Medicare. Nobody—not your doctor, not your hospital—can tell you who you have to see.

Is an ACO a Health Maintenance Organization (HMO), managed care or an insurance company?
No. An ACO is a group of doctors, hospitals, and other health care providers who work together to provide you with better, more coordinated care. Doctors and hospitals in an ACO communicate with you and with each other to make sure that you get the care you need when you are sick, and the support you need to stay healthy and well. An ACO isn’t an HMO, managed care or insurance company. Unlike HMOs, managed care, or some insurance plans, an ACO can’t tell you which health care providers to see and can’t change your Medicare benefits. If your doctor participates in a Medicare ACO, you always have the right to choose any doctor or hospital who accepts Medicare at any time.

How do I know if my doctor is in an ACO? What should I expect if my doctor is in an ACO?
If your doctor chooses to participate in an ACO, you will be notified. This notification might be a letter, written information provided to you when you see your doctor, a sign posted in a hospital, or it might be a conversation with your doctor the next time you go to see him or her.

If you aren’t sure if your doctor or healthcare provider is participating in a Medicare ACO, ask him or her. For general information on ACOs, call 1-800-MEDICARE (1-800-633-4227) 24 hours a day 7/days a week. TTY users should call 1-877-486-2048.

Over time, if you see a doctor participating in an ACO, you may notice that:
- You don’t have to fill out as many medical forms that ask for the same information;
- The health care providers that you see all know what is going on with your health because they communicate with each other;
- You don’t have to have the same medical tests done over and over because your results are shared among your health care team;
- The providers participating in the ACO will become partners with you in making care decisions.

Here are things that won’t change because your doctor is part of an ACO:
- What you pay, your Medicare benefits, or the cost of your coverage should not increase;
- Your right to choose any hospital or doctor that accepts Medicare, at any time, will not change even if that hospital or doctor is not part of an ACO;
- Some ACOs may hire people to help check on your care. They may call you after an appointment or a procedure to make sure you understand how to take your medicines or schedule follow up visits. They will also share information with your doctor to make sure you get the right care.

What rights do I have if my doctor is in an ACO?
You will continue to receive the same rights enjoyed by all people with Medicare. To help you to get the best-coordinated care, Medicare will share information about your medical information with your doctor’s ACO, including medical conditions, prescriptions, and visits to the doctor. This is important to help the ACO keep up with your medical needs and track how well the ACO is doing to keep you healthy and helping you get the right care.

Your privacy is very important to us, so you may choose to have your name and other personal information removed from the information that Medicare shares with your doctor by doing one of these things:
- Calling 1-800-MEDICARE (TTY users should call 1-877-486-2048); or
- Signing a form available in your doctor or other healthcare provider’s office, which you may also receive in the mail from your doctor.
If you receive a letter from your doctor, unless you take one of these steps, your medical information will be shared automatically starting 30 days from the date you are notified.

Medicare won’t share information about anyone who has ever received treatment for alcohol or substance abuse without written permission. If you have received treatment for alcohol or substance abuse and want Medicare to share that information with your doctor’s Medicare ACO complete the “Alcohol or Substance Abuse Medical Data Sharing Form” and mail it in.

Starting in 2013, Medicare will also be following up with people with Medicare to ask about your experiences as a patient of a doctor who is participating in a Medicare ACO. As time gets closer, you will get a letter to let you know the survey is genuine. Medicare will use your feedback to help make sure you get high quality care.

**Who can read my medical information? And will it be protected?**
The group of doctors, hospitals, and other health care providers working together in the ACO will be able to read your medical records, along with other office staff authorized to help coordinate your care. The privacy and security of your medical information is protected by Federal law. Contact your doctor’s office for more information about how they protect your medical information, or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.

**How will an ACO lead to better care for me?**
When your health care providers have access to your health information and are able to share that information with one another, they can give you better, more coordinated care. Each of your health care providers will not only know about the health issues that they have treated, they will have a more complete picture of your health through communicating with your other health care providers.

If your health care providers are participating in an ACO, over time, you should see better more coordinated health care where you are the center of care and your satisfaction is a goal of the ACO.

**Where can I find more information about ACOs?**
For more information about ACOs, you can do the following:
- Visit www.cms.gov/ACO/
- Visit www.Medicare.gov/ACO
- Talk to your doctor.
- Call 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048
- Visit www.bannerhealthnetwork.com
- Call Banner Health Network 1-855-874-2400.
Key Talking Points - Pioneer ACO Highlights

What is Banner Health Network (BHN)?
The Banner Health Network is a clinical and business partnership between Banner Health and its aligned and integrated physician groups’ including Arizona Integrated Physicians (AIP), Banner PHO (BPHO), and Banner Medical Group (BMG). BHN is an ACO.

What is an ACO?
Accountable Care Organizations (ACOs) bring doctors, nurses, hospitals and other care providers together to share responsibility for keeping patients healthy, by improving the total cost, quality and satisfaction of a defined patient population’s care.

Why should providers participate with Banner Health Network?
There are a number of reasons a provider should consider becoming part of the Banner Health Network including, opportunities to influence and improve reimbursement rates, the movement to an outcomes-based reimbursement model, focus on population health management, and rewards for providers providing quality and efficient care.

What Payors is Banner Health Network contracted with?
Currently, BHN is contracted with CMMI for a Pioneer ACO, Health Net for commercial and senior products and Aetna for a narrow network commercial product. Additionally, BHN is in discussions with all the major health plans in Phoenix to develop additional attribution, ACO and value based partnerships and contracts.

What is the Pioneer ACO Model initiative?
The Pioneer ACO Model is a new initiative launched by the Centers for Medicare & Medicaid Innovation (CMMI) designed to test how moving experienced organizations more rapidly to population-based payment arrangements working in coordination with private payers can achieve cost savings across the ACO, which will improve health outcomes for Medicare beneficiaries.

What can patients expect from the BHN Pioneer ACO Model?
ACOs put the patient at the center of care. In these models, patients are partners working with a designated care team to manage and improve their health. Patients are assisted in navigating the healthcare system so they get the right care, from the right provider at the right time.

How will payments to the Pioneer ACO work?
CMMI developed a target per capita expenditure level (benchmark) based on previous CMS expenditures on the group of beneficiaries aligned to the ACO. At the end of each of the year, participating ACOs will be evaluated against this benchmark, and rewarded with a portion of the savings or held accountable for increased expenditures.

How are physicians paid?
Medicare will continue to pay providers directly and at the same Medicare reimbursement rates that exist today.
How are providers rewarded for providing cost effective, quality care?
Unlike today, participating providers in the Pioneer ACO will be eligible for an upside, shared-savings based on cost effective care and quality measures. If the BHN Pioneer ACO provide more efficient care as a result of improved care coordination the savings resulting from that efficiency will be shared between CMS and BHN and subsequently to the individual providers impacting that care.

What is my financial risk?
In the first year of operations there is no individual provider downside risk. All downside risk will be held or absorbed at the BHN or individual network entity levels (AIP, BPHO or Banner Health).

How will I know if a Medicare beneficiary is a BHN Pioneer ACO member?
Generally, CMMI has attributed all traditional Medicare Fee-For-Service patients into the BHN Pioneer ACO, therefore you should assume all traditional Medicare beneficiaries are attributed to the ACO.

Can I refer outside of the BHN Pioneer ACO network?
Medicare Beneficiaries have the option to receive services from providers outside of the ACO at any time, and ACOs are forbidden from restricting which providers a beneficiary may seek care from. The foundation of the ACO model is to enhance care coordination across the continuum, therefore referring within the BHN network is the preferred model as the BHN network includes a provider network that has been built on integration and care coordination processes to optimize the patient experiences as they move through the continuum to facilitate continuity of care and ensure appropriate access into programs such as disease and case management.

Are there any prior authorization requirements?
The Medicare Fee-For-Service benefits remain the same and there are no prior authorization requirements to receive services.

Where do I submit claims?
There is no change in the claims submission process for traditional Medicare Fee-For-Service claims; continue to send claims using your existing processes for paper or electronic claims submission.

How will patients be affected by the Pioneer ACO Model?
Pioneer ACOs are designed to provide CMS beneficiaries with higher quality, more seamless healthcare, by Pioneer ACO Model facilitating coordination between healthcare providers, resulting in better care for patients aligned with ACO.

How can providers participate with Banner Health Network?
Providers must be a part of one of the networks that compose Banner Health Network – AIP, BPHO or BMG, in which a subset of providers was submitted to CMS for participation. BHN is anticipating significantly expanding the provider network for 2013.
BHN Pioneer ACO Keys to Success – Physician Perspective

The primary objective of an Accountable Care Organization (ACO) is to improve the total cost, quality and satisfaction of a defined population – in the Pioneer ACO model the target population are Medicare beneficiaries. In order to accomplish these commendable goals numerous changes to the existing approach to care delivery must be implemented. While change to the health system is complex the following are some fundamental approaches that BHN is taking to influence transformation in care delivery and ways in which you, as a physician partner of BHN, can help lead this change.

All Providers

- **Optimize Efficacious Use of Diagnostic Testing.** Prior to ordering diagnostic tests ask yourself: (1) “Will test results impact how I will manage the patient?” and (2) “Was this test already performed by another provider and results are otherwise available?”

- **Transition from Reactive to Proactive Care.** A critical success factor in an ACO is to transition from treating sickness to promoting and encouraging health and wellness. This includes optimizing the use of preventative treatments to defend against or minimize the onset of chronic disease, actively managing chronic illnesses through disease and care management, and integrating all members of the care team and patient across the continuum to efficiently utilize resources.

Primary Care Providers (PCP’s)

- **Actively “Manage” High Risk Patients.** 15% of Medicare beneficiaries consume 85% of the health care dollar. It is critical to the success of an ACO that “high risk” patients and those with multiple chronic conditions are actively managed and proactively identified. BHN will assist PCP’s in identifying attributed beneficiaries that are at high risk or have multiple chronic conditions through the use of historical claim information and risk assessments. Additionally, PCP’s should identify these patients and ensure that they are referred to BHN Disease and Case Management program as an additional resource.

- **Optimize “Same Day Care” Appointment Access.** In an effort to maximize the PCP – Patient relationship it is vitally important to ensure availability of same day appointments (especially for all high risk beneficiaries). This will decrease emergency room visits and potentially unnecessary hospitalizations as well as increase the level of health for patients.

- **Engage ACO Beneficiaries.** It is critically important that all PCP’s reach out to their attributed Medicare beneficiaries so that they are educated as to the benefits of being a part of the BHN Medicare Pioneer ACO and how to get the most of the integrated care model. BHN and your affiliated provider network (AIP, BPHO and BMG) will be assisting you in communicating and educating your attributed Medicare beneficiaries.

- **Assume All Your Medicare Beneficiaries are BHN ACO Members.** Due to the complexity in actively identifying which Medicare beneficiaries are attributed to BHN and since CMMI is using an attribution model to align beneficiaries it is safe to assume that as a PCP, ALL of your Medicare beneficiaries are attributed to the BHN ACO. Detailed attribution rosters will be provided to all ACO participating BHN PCP’s.

- **Refer to High Quality / Cost Effective BHN Specialists, Ancillary Providers and Hospitals.** It is critical to the success of an accountable care model to utilize specialists, ancillary providers and hospitals that are aligned with the clinical integration model of BHN. Providers affiliated with BHN have committed to utilizing evidenced based clinical protocols, sharing information across the care continuum and focus on providing coordinated care. Medicare beneficiaries may elect to go to any provider that they so choose, however it is important for you as a PCP to inform the beneficiary of the benefit of utilizing a BHN affiliated provider for their care. BHN will assist you with the information necessary to identify quality and cost effective providers as well as ensure you have tools and talking points to facilitate dialogue with your patients.
• **Operate at the Height of Your License.** Accountable Care places new demands on the role of the PCP. This will require more time and resources being invested with patients. In order to accomplish this it is imperative that physicians focus on operating at the full height of their license and delegate to other members of the care team clinical and administrative functions that do not necessarily require the physician. BHN and its’ affiliated networks will be working closely with the PCP’s to identify ways and provide tools in which you can more effectively operate at the height of your license.

**Specialty Care Providers (SCP’s)**

• **Actively “Manage” High Risk Patients.** 15% of Medicare beneficiaries consume 85% of the health care dollar. It is critical to the success of an ACO that “high risk” patients and those with multiple chronic conditions are actively managed and proactively identified. BHN will assist SCP’s in identifying attributed beneficiaries that are at high risk or have multiple chronic conditions through the use of historical claim information and risk assessments. Additionally, SCP’s should identify these patients and ensure that they are referred to BHN Disease and Case Management program as an additional resource.

• **Proactively Identify BHN ACO Beneficiaries.** BHN will provide to all contracted SPC’s a listing of all BHN attributed Pioneer ACO Medicare beneficiaries in January 2012. This roster of beneficiaries will generally remain the same throughout 2012 due to the nature of assignment and attribution. Additionally, BHN is working to assist SPC offices with additional ways to identify BHN Pioneer ACO beneficiaries and providers and will be updated on these resources as soon as they are identified. It is important that the BHN Pioneer ACO beneficiaries are identified proactively to ensure optimal referral into the BHN disease and case management programs and to integrate the care of the beneficiaries into the BHN care coordination model. Active communication between the SPC and attributed PCP is vitally important.

• **Actively Communicate With PCP’s.** The key to success of an ACO to improve total cost, quality and satisfaction is to ensure timely and relevant communication between the treating SPC and the PCP. This includes communication regarding the clinical findings, treatment provided, and suggested clinical management. BHN will be providing additional tools to enhance communication and sharing of clinical information between BHN providers.

• **Refer / Direct Patient Back to PCP for Continued Care Coordination.** One of the foundational responsibilities of the PCP is to manage, coordinate and assist the patient in optimizing their health across the complex care continuum. It is critically important that SPC’s actively redirect patients back to the PCP for ongoing management and clinical coordination. It should be determined by the PCP with consultation from the SPC on the required frequency of continued SPC care as opposed to automatic sequencing of follow-up appointments.

• **An Opportunity to Differentiate Yourself on Quality, Cost and Service.** As health care continues to evolve from a volume based fee for service model to one of value built on cost effectiveness and optimal quality the level of interdependency between PCP’s and SPC’s will continue to be more important. During this time of transformation it is an ideal opportunity for SPC’s to differentiate themselves through their individual and practice level’s commitment as a clinical and business partner with affiliated PCP’s, BHN, and the affiliated provider networks of AIP, BMG and BPHO in providing a high level of quality, cost effectiveness and service to beneficiaries.