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We will begin promptly.

Today's Presentation:

Starting VBC Success With an MSSP Application

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Advisor Live®: Starting VBC Success With an MSSP Application

April 27, 2017

Kathleen Harris, MPH, Sr. Director Government Operations, Banner Health Network

Seth Edwards, Principal, Population Health, Premier Inc.

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Logistics

AUDIO

Dial in to our operator assisted call, 800.616.4021

NOTES

Download today's slides from the event post at premierinc.com/events

QUESTIONS

Use the "Questions and Answers"

RECORDING

This webinar is being recorded.
View it later today on the event post at premierinc.com/events.

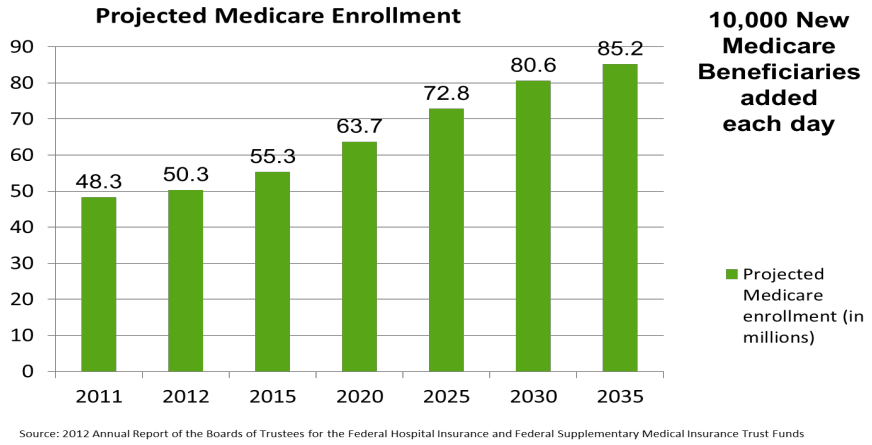
Today's Speakers

Kathleen Harris, MPH, Sr. Director Government Operations, Banner Health Network

Seth Edwards, Principal, Population Health, Premier Inc.

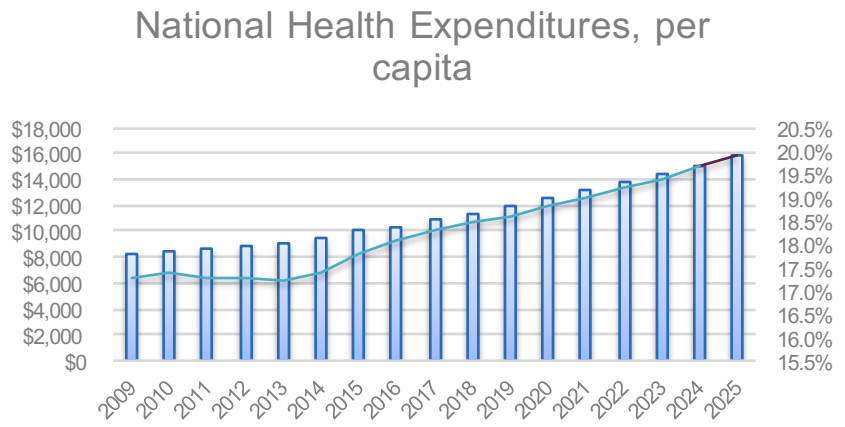
Market pressures pushing payers toward value-based payments

1. Aging Population

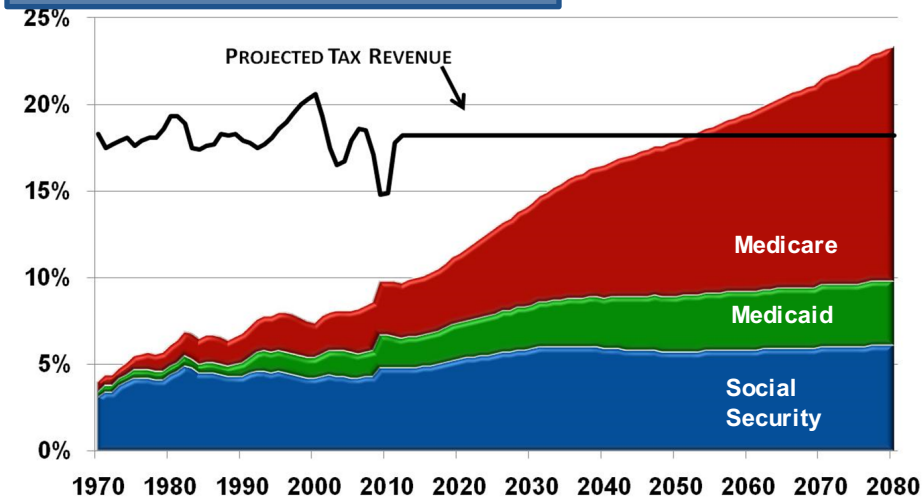


Source: 2012 Annual Report of the Boards of Trustees for the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

2. Significant Spend Increase

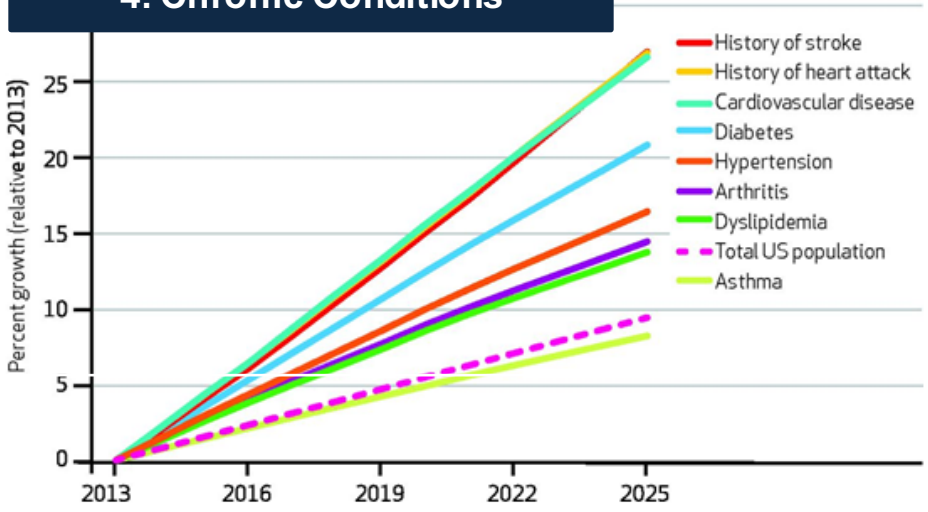


3. Not Fiscally Sustainable



SOURCE: CBO

4. Chronic Conditions



Value-based payment is here to stay…

HHS' Better Care. Smarter Spending. Healthier People initiative

Volume to Value

Track 1:
Value-based payments

2016	2018
85% of all Medicare payments	**90%** of all Medicare payments

Track 2:
Alternative payment models*

2016	2018
30% of all Medicare payments	**50%** of all Medicare payments

Focus Areas	Description
Incentives	▪ Promote value-based payment systems – Test new alternative payment models – Increase linkage of Medicaid, Medicare FFS, and other payments to value ▪ Bring proven payment models to scale
Care Delivery	▪ Encourage the integration and coordination of clinical care services ▪ Improve population health ▪ Promote patient engagement through shared decision making
Information	▪ Create transparency on cost and quality information ▪ Bring electronic health information to the point of care for meaningful use

MACRA reporting advantages

As an MIPS/APM, ACOs have beneficial scoring and simpler reporting requirements. As an ACO, you will report together as one group, reducing administrative and resource burden to report, with the following additional benefits for each category-

Quality -

- CMS will use the GPRO measures that are already reported for the MSSP 31 quality metrics for this category (50% of composite score).

Cost -

- This category is not included in the assessment of MSSP Track 1 ACOs in MIPS, as CMS believes ACO are already being judged on efficiency through the MSSP.

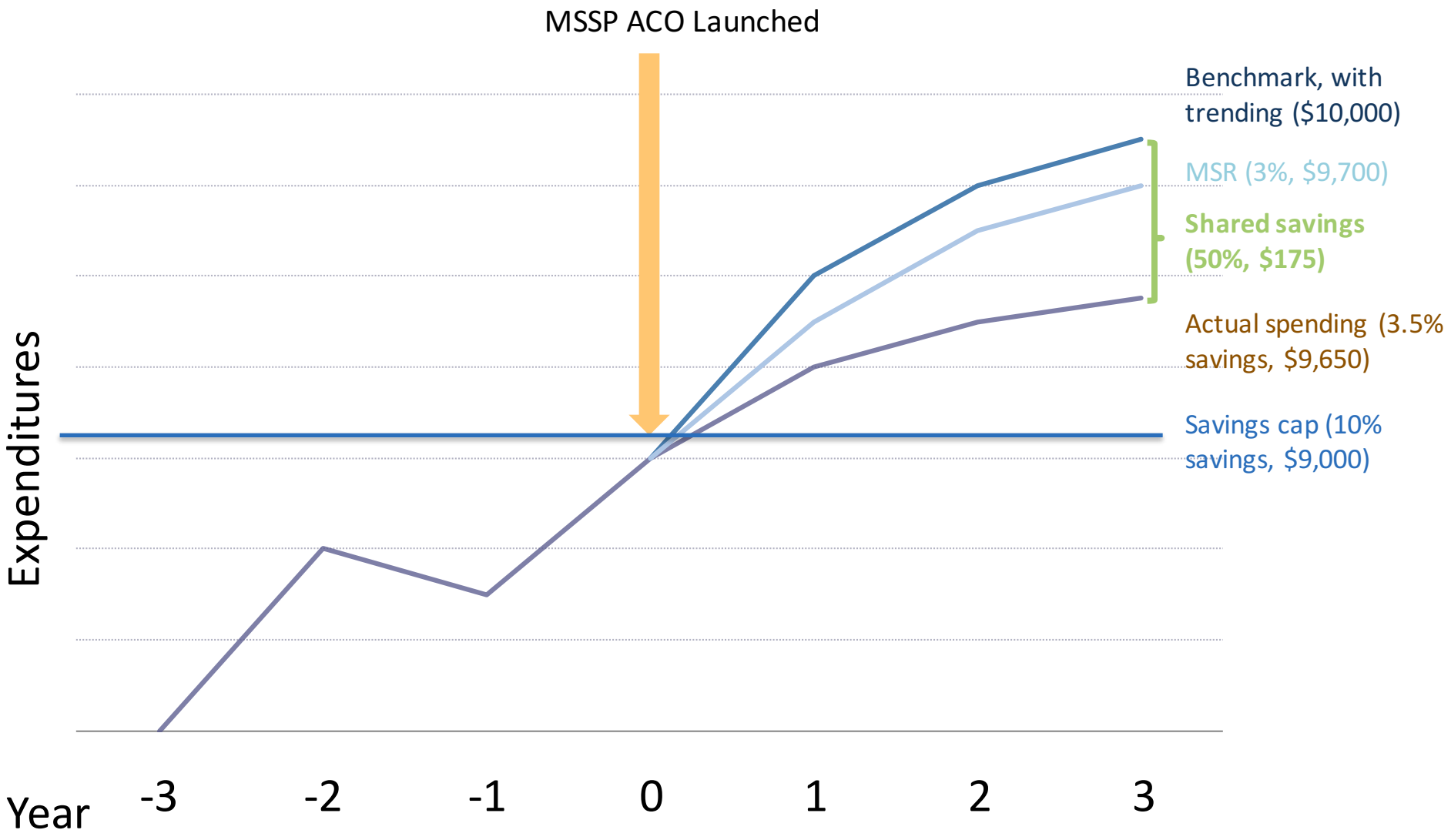
Improvement Activities -

- The ACO receives full credit for this category. (20% of composite score)

Advancing Care Information -

- Each ACO Participant TIN will report this category. These scores will be aggregated, and the ACO will receive weighted average of those scores (30% of composite)

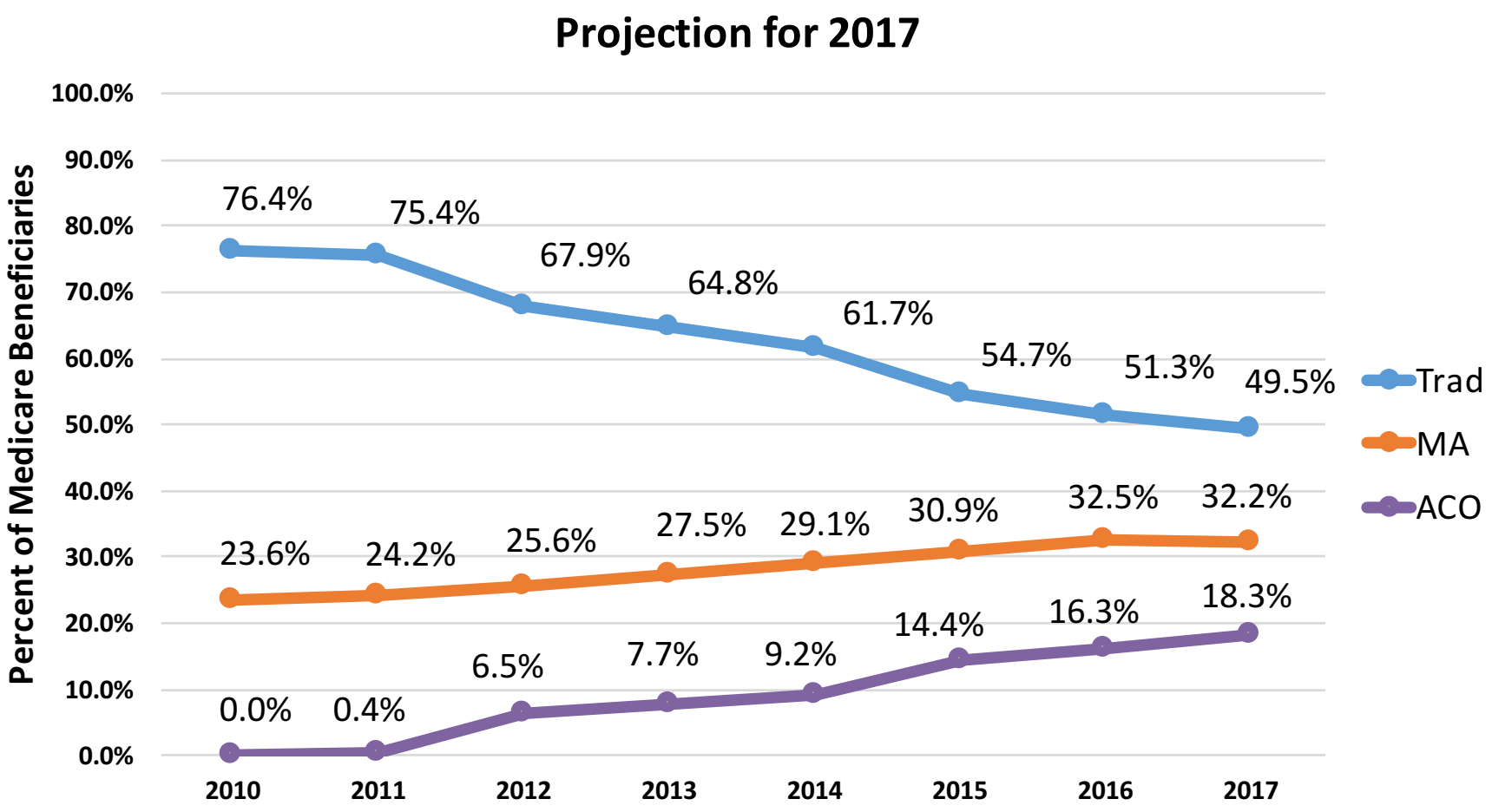
No downside risk but opportunities to gain shared savings



MSSP provides valuable claims data and legal waivers

- CMS provides Part A, B and D claims data for assigned beneficiaries
  - Opportunity for you can learn how to use claims data to manage a population
  - Patient specific leakage claims information to target specific areas for market share gain
- Broad CMS waivers around fraud / antitrust / civil monetary penalty
  - CMS ACOs deemed to be Clinically Integrated by FTC/DOJ for antitrust purposes
  - ACO's can provide start-up items and services provided within one year preceding submission of MSSP application, and other items throughout the agreement reasonably related to the purposes of the MSSP
  - ACOs can distribute shared savings to physicians and other participants
  - ACOs are able to provide free or below fair market value items and services to Medicare beneficiaries

Trend: Fee for service ↓ Population Health Management ↑



Sources:
https://innovation.cms.gov/Files/fact-sheet/nextgenaco-fs.pdf
http://www.markfarrah.com/healthcare-business-strategy/An-Analysis-of-2017-Medicare-Business-Competition.aspx
FFS 2015#: 38 (http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2015-03-Medicare.pdf) - 7.9M (the ACO population)= 30.1M
ACO 2016 #: 8.9M (http://www.hhs.gov/about/news/2016/01/11/new-hospitals-and-health-care-providers-join-successful-cutting-edge-federal-initiative.html)
MA 2015#: 17M (http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2015-03-Medicare.pdf)

Commercial plans moving to value-based payment

Key Themes from our 2016 Commercial Payer Session

Consistent message – Each payor stated that they are aggressively transitioning to value-based arrangements. Since 2015 each payor's has developed a VBP strategy and has begun to implement in selected markets.

Global Strategy

- ***Anthem*** – 50% shared savings/risk by 2018
- ***Aetna*** – 50% shared savings/risk by 2018
- ***Humana*** – 75% of MA under value-based (with and without shared risk) by 2017
- ***Cigna*** – 50% share savings/risk by 2018
- ***United*** – Committed to VBP but did not provide specifics. Presented a payment transition strategy, which included capitated payment models.

Focus/Goal

- ***Anthem*** – Collaboration / meet you where you are
- ***Aetna*** – Provider sponsored health plans, provider partnerships & JVs
- ***Humana*** – Focus is Medicare Advantage vs Medicare FFS/MSSP
- ***Cigna*** – Prefer to provide supporting tools, data, and services and moving to arrangements with CINs/IDNs
- ***United*** – Overall focus to AC arrangements for commercial, Medicaid, and Medicare (very few CIN arrangements)

Defensive strategy to avoid distruptors entering the market

Excellent opportunity to partner with physicians before a disruptor enters into your market and leaves the hospital / health system out of an ACO and viewed as a cost center (subcontractor).

Venture capital-backed firms

PRIVIA HEALTH

Aledade

Health plan employing PCPs

UnitedHealthcare

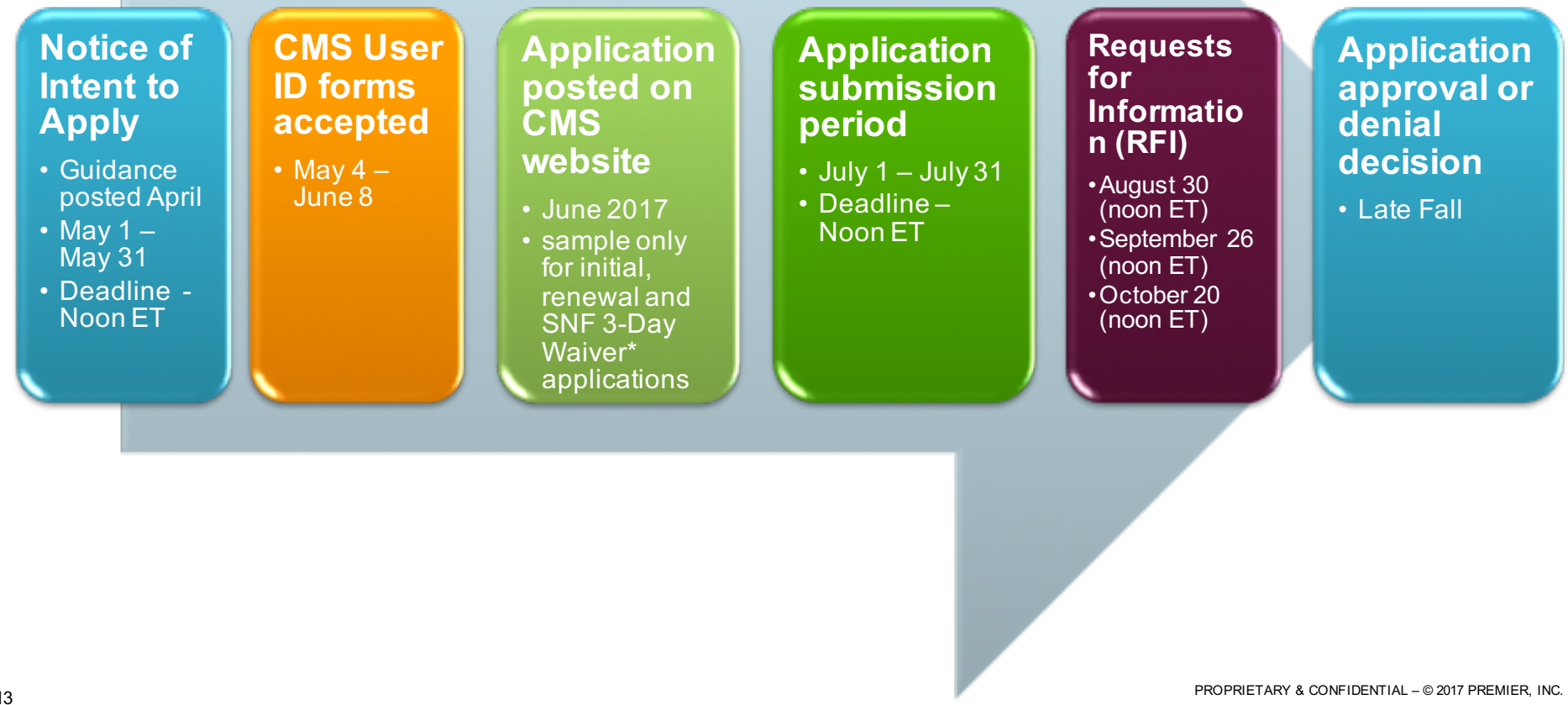
OPTUM®

UNIVERSAL AMERICAN

A Healthy Collaboration®

MSSP / Medicare ACO Track 1+
2018 application timeline

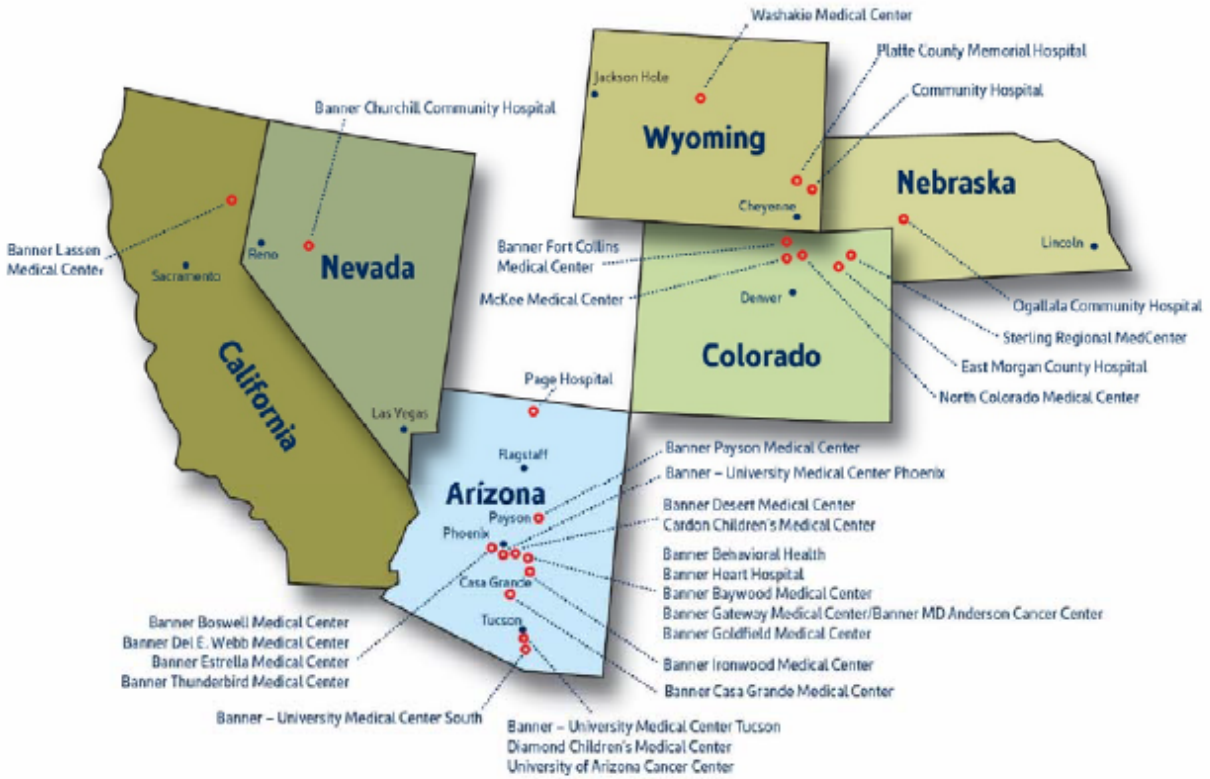
In order to apply, you must file a brief, non-binding, Notice of Intent to Apply by May 31 at noon ET.



Banner at a Glance

Banner Health®

- 28 Acute Care and Critical Access Hospitals
- Behavioral Hospital
- Banner Health Network
- Banner Network Colorado
- Banner Medical Group and Banner – University Medical Group with nearly 2,000 physicians and advanced practitioners and more than 200 Banner Health Centers and Clinics
- Banner Home Care and Hospice
- Outpatient Surgery
- Urgent Care
- Banner – University Medicine division
- $7 billion in revenue in 2015
- AA- bond rating
- $746 million in community benefits, including $62.9 million in charity, 2015



Banner Health Network Pioneer ACO Performance

	PY1 2012	PY2 2013	PY3 2014	PY4 2015	PY5 2016
Providers	448	907	1413	1857	931
Beneficiaries Jan 1	50,505	55,483	61,241	86,704	63,024
Percent Savings & Aggregate Savings	4.0% $19,098,858	2.8% $15,148,274	5.0% $29,047,735	5.5% $35,113,328	TBA
Quality Score	62.19%	81.18%	87.58%	95.23%	TBA
Shared Savings to BHN	$13,369,201	$9,038,408	$18,698.004	$24,578,369	TBA

Entering MSSP Can Feel Overwhelming

But It Doesn't Have To Be….

Photo credit: USA Today 3/26/27

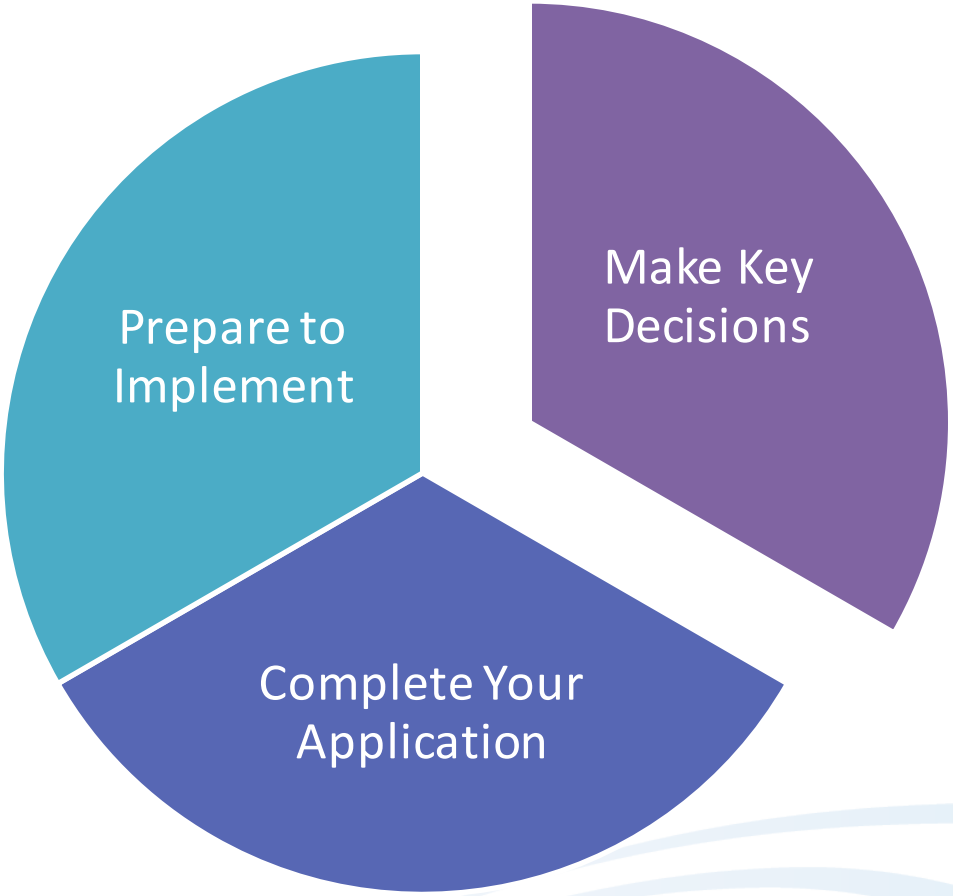
First Step

Submit your Notice of Intent to Apply (NOIA)!

- ❑ Open May 1
- ❑ Closes at 12:00 pm on May 31.
- ❑ It's non-binding.
- ❑ Appendix B of the 2018 NOIA Guidance document

1. Application type (new)
2. ACO Name and Address
3. ACO Tax ID number
4. Date of formation
5. Type of Legal Entity (i.e., LLC)
6. Tax Status (not/for profit)
7. ACO Type (i.e., Partnership)
8. Track selection (non-binding)
9. 3DW (Yes/No) (non-binding)
10. Primary contact
11. Secondary contact

Divide Your Work



Think About Your Structure

- Do you need to have a different legal structure? Consult a lawyer.
- Will you be one Tax ID number or one Tax ID number made up of many other Tax ID numbers?
- Will you be a large ACO or a small ACO – How will you get to minimum of 5,000 aligned beneficiaries?
- If this is a joint venture with another company, what is the division of duties? Get that clarified and in writing before you start.

Do You have a Solution for the Heavy Lifts?

- Do you have a **Compliance Program** already in place?
- Do you have a strong **HIPAA program**? It is one of the Application narratives. CMS will give you a lot of protected information and they are very serious about security. You will sign a Data Use Agreement (DUA).
- Do you have a strong **Electronic Health Record system** – and is it Certified? (Certified Electronic Health Record Technology = CEHRT) Will all providers share the same or will there be several systems? Will you connect them? Do you want to make this a requirement in their contract?
- Do you know how your **operations** will be set up? Decide on basic structure and who will attend meetings - you need this for your org chart.
- Do you have a **website** for your ACO? If not, get one (even a shell) set up. Also, reserve a URL for the Public Disclosure Page.

Plan Your Board

Why?

- You will need names for your Application.
- You need to find a Beneficiary now.
- You need to ensure that 75% of your Board is on your Participant List.

What?

- Decide who has voting rights.
- This can be your steering committee during the application process.
- Read the CMS requirements before you set this up.
- Consult your lawyer (Board Bylaws, Voting Rights, etc.)

The Most Important Piece….

The Providers on Your Participant List

- They are the core of this program.
- They serve the beneficiary.
- They are the community leaders.
- The practice name will go on our Public Disclosure Page (internet).
- CMS uses this list for everything.
- This is the list of providers that is used for MACRA/MIPS.
- They will be a large percentage of your Board.
- You must have them all identified and contracted before Application submission.

Is It A Network?

- Participant List for the Application is intended for Beneficiary Alignment, Benchmark Setting, and Quality Reporting (i.e., MIPS).
    - If you put a orthopedic surgeon on your List, could you properly manage those patients, considering the quality metrics that must be met?
    - If you put a specialist on your List, would you meet the Qualifying Participant threshold for Alternative Payment Model (APM)?
- MSSP aligned beneficiaries retain the Freedom of Choice right. You cannot require them to “stay in-network”.

Building Your ACO

What You Need for Application

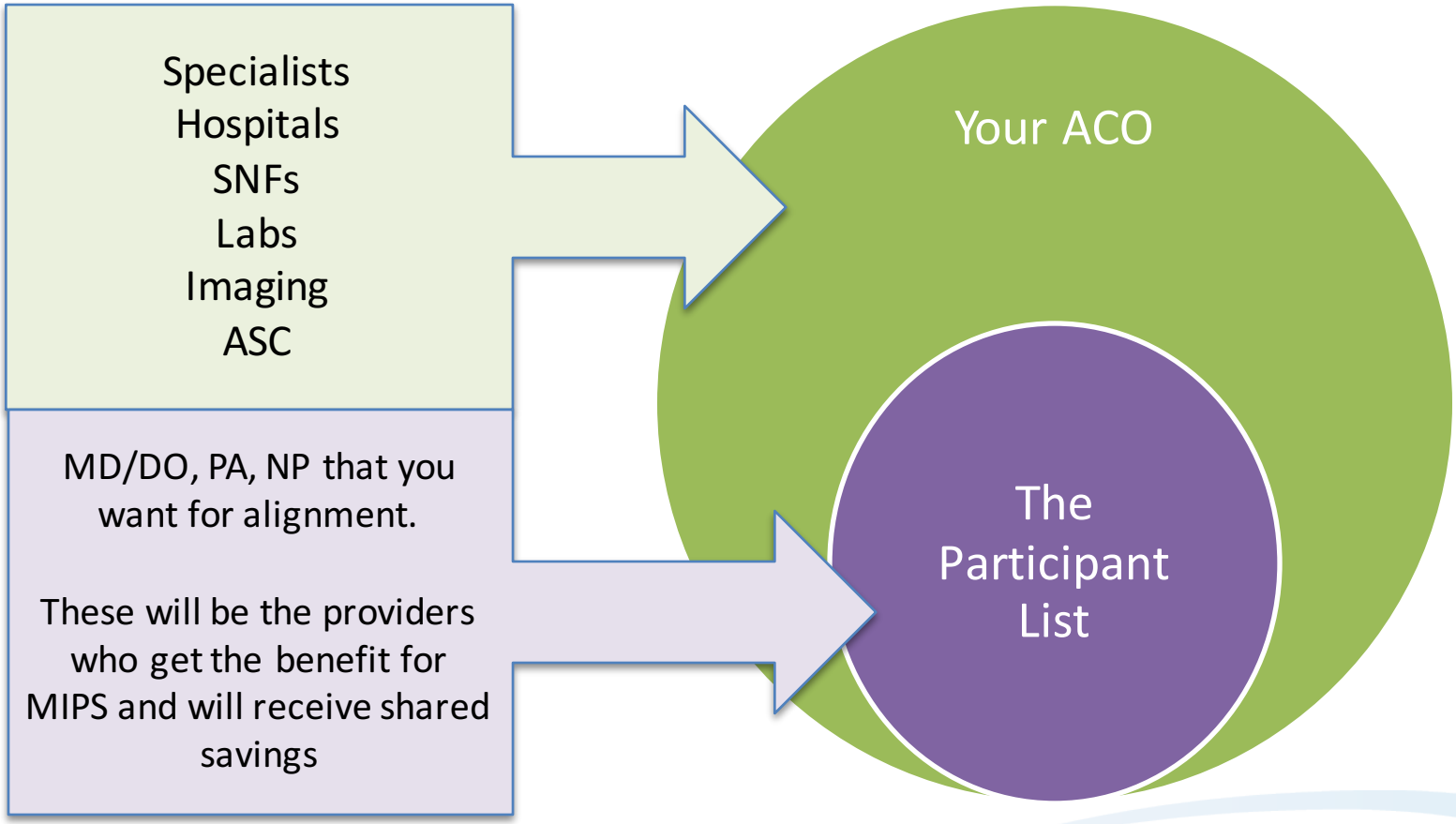
- Primary Care
- Specialists – if you choose
- Contract is for the entire Practice TIN. This is the "Participant"

- *If you are applying for Three Day Waiver, then you will need your SNFs contracted now.*

What You Need for Performance

- Specialists
- Hospitals
- Skilled Nursing Facilities
- Home Health
- Hospice
- Lab/Imaging
- Ambulatory Surgical Centers
- Other

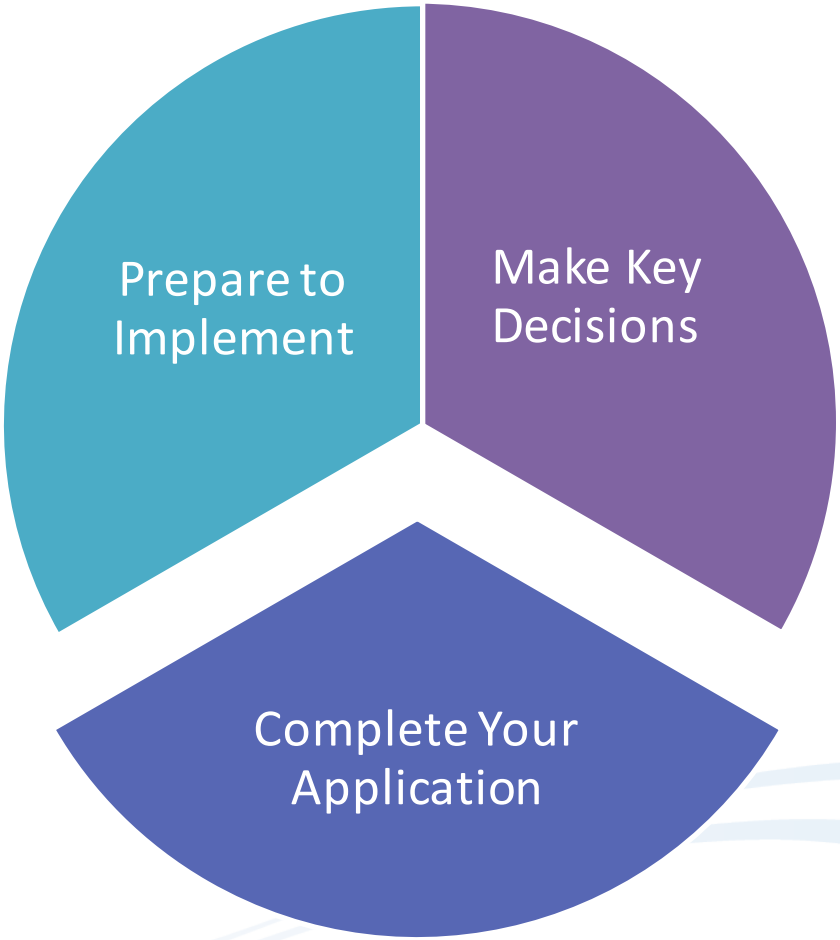
Example of Possible Structure



Here's Our Secret…..

- ✓ Partner with strong cardiology groups – this will take care of several of your quality measures.
- ✓ Partner with hospitals who understand that healthcare is changing – and who embrace it.
- ✓ Partner with SNFs and other post-acute providers that understand that healthcare is changing – and are willing to work with you on care transition and cost efficiency.

Divide Your Work



Important Dates

May 1-31, 2017:
- File NOIA

July 31, 2017:
- Submit Contracts
- Submit Application

NOIA and Application Cycle: Deadlines to Apply for January 1, 2018 Program Start Date

Notice of Intent to Apply (NOIA) Process	Deadlines[1]
NOIA Guidance Document Posted to this Website Under Step 1 Below (provides detailed information on the requirements for submitting a NOIA)	April 2017
NOIA Submission Period	May 1, 2017 – May 31, 2017
NOIA Deadline	May 31, 2017, at 12:00 p.m. (noon) Eastern Time (ET)
CMS System User ID Forms Submission Period (new users only)	May 4, 2017 – June 8, 2017

Application Process	Deadlines[1]
2018 Sample Applications Posted to the How to Apply Website (sample only application for initial, renewal, Skilled Nursing Facility (SNF) 3-Day Rule Waiver and Track 1+ Model applicants)	June 2017
Application Submission Period (for initial, renewal, SNF 3-Day Rule Waiver and Track 1+ Model applicants)	July 1, 2017 – July 31, 2017
Application Deadline (for initial, renewal, SNF 3-Day Rule Waiver and Track 1+ Model applicants)	July 31, 2017, at 12:00 p.m. (noon) ET
First Request for Information (RFI-1) Response Due from Applicants (see RFI Response Actions and Deadlines table below for details) 2	August 30, 2017, at 12:00 p.m. (noon) ET
Second Request for Information (RFI-2) Response Due from Applicants (see RFI Response Actions and Deadlines table below for details) 2	September 26, 2017, at 12:00 p.m. ET
Third Request for Information (RFI-3) Response Due from Applicants (see RFI Response Actions and Deadlines table below for details) 2	October 20, 2017, at 12:00 p.m. (noon) ET
Application Approval or Denial Decision Sent to Applicants **(all application types)**	Late Fall 2017
Reconsideration Review Deadline	15 Days from Notice of Denial

[1] All deadline dates are subject to change.

[2]See RFI Response Actions and Deadlines table below for details.

Timing…and How to Avoid all the Errors We Made or Almost Made

- Build your project plan with July 31, 2017 in mind.
  - Plan on submitting business day or two before.
  - Allow an hour or two for submission in case you have errors.
- Make sure you have file zip software (i.e., WinZip) for those uploading into HPMS because all files must be zipped.
- When contracting with providers, build in extra time for processing FQHCs, Sole Proprietors, and providers with recently-terminated TINs.
- Realize that the RFI periods give you some breathing room – time to fix some errors and to submit clarifications to reviewers.
- Realize that you don't need to do *everything* by July 31.
- But do not wait on getting your CMS ID and HPMS access!
  - Forms required by June 8, 2017.

Why PECOS Matters

PECOS: Provider Enrollment, Chain and Ownership System

- Encourage every contracted Participant to log onto their account and ensure that all currently employed providers are listed, and without errors.
- Ensure that your contract shows the *same* legal business name as what is in PECOS – or have the provider update PECOS.
- You will submit the Participant's TIN; CMS will pull the NPIs.
- If PECOS is not kept updated, then the Participant or the Provider/Supplier may be excluded from your Participant List.

Other Things To Do Now:

- Sign up for all CMS webinars
- Keep library of all CMS issued documents
- Get peer support – other ACOs or Premier
- Write your Participant contract
- Get CMS IDs and HPMS access for key people
- Set up your bank account (Form 588)
- Become familiar with quality metrics

Application Documents

- ✓ Form 588 (will be mailed)

- ✓ Attestation questions/answers
- ✓ Each Change Request with each Participant contract (separate entries)
- ✓ Contract template with the requirement checklist
- ✓ Org chart (per CMS specifications - Committees)
- ✓ Governing Body list of names and information
- ✓ Shared Savings plan
- ✓ HIPAA response
- ✓ Five clinical responses

Submitted through HPMS

Divide Your Work

After Application is Submitted

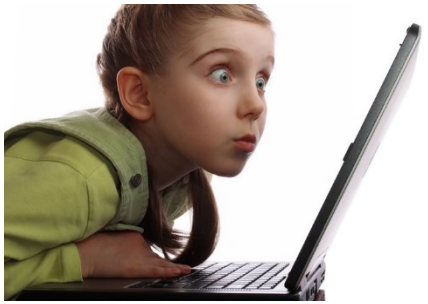
Start on getting CMS ID numbers for those who will sign your contract or work with data files.

Set up Public Disclosure Page.

Prepare to respond to all RFI errors. The expected turn around is about 5 working days.

Communicate to operational staff on what to expect; provide them with application responses and any CMS manual that is specific to their work.

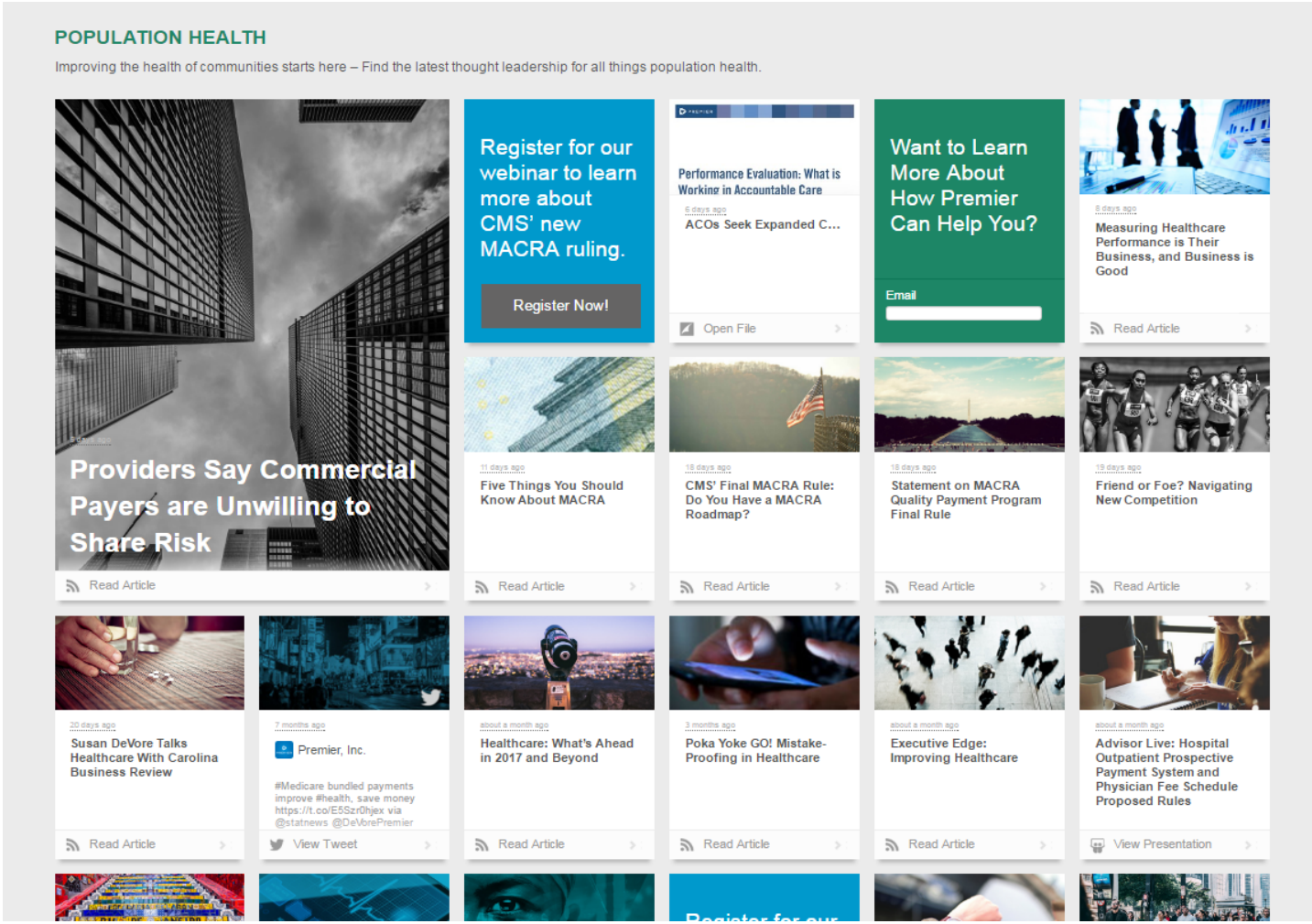
The Best Piece of Advice…



- When applying for a CMS ID number, watch your email *very carefully*.
- You will get a request to take a compliance training before they allow you to sign on.
- If you do not take this test *in the required time allotment*…you *may* have to start your application over.
- Remind staff to watch for this email and to respond as indicated in the email.

Want to learn more?

Visit: learn.premierinc.com



PREMIER

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