Who is the Consortium?

- First ACO created by nine rural CEOs in three states.
- Currently operating six ACO’s in nine states.
- Now setting up 41 state-wide Rural ACO’s for 2016
- Non-profit convenes, educates, and communicates with CMS.
- For-profit services organization provides simple, inexpensive, comprehensive, turn-key programs for transforming community health systems to prepare for and participate in new payment models.
- Our goal is to improve community health and gain more of the premium dollar to increase the profitability, market share and sustainability of rural health systems.

The Speed of Change is Increasing

Secretary Burwell’s historic announcement

“Our first goal is for 30% of all Medicare provider payments to be in alternative payment models that are tied to how well providers care for their patients, instead of how much care they provide – and to do it by 2016. Our goal would then be to get to 50% by 2018.

Our second goal is for virtually all Medicare fee-for-service payments to be tied to quality and value; at least 85% in 2016 and 90% in 2018.”

Only 36 percent of the 1,201,363 professionals who were eligible to participate in 2012 participated in PQRS, so how is that going to happen?
How will the Secretary Achieve Her Goal?

$114 Million in Grants

Steady Reduction of Current Payments

Democrats, Republicans and CMS Agree

0.5% increases for 5 years...

- 2015 PFS pays 4% bonus or 4% penalty in 2017 for top quartile performers on ACO-like quality measures and cost per beneficiary.
- By 2022, 36% of physician payments will be variable based on cost and quality

And that Puts the Target on Your Back

We have to find a way to participate in these programs, even though we don’t have to.

The greatest threat to the sustainability of rural healthcare systems are market forces that will force doctors and patients to choose high value providers and partners – and rural will be left behind.
Do You Want to be the Chef or the Lunch?

- 10,000 lives = $80 million in healthcare spending by your community.
- Payer profit is LIMITED to $12 million.
- You are lucky to make $500K.

Path to Sustainability

Your sustainability comes from gaining more of the premium dollar by saving payers money, and some day becoming the payer.

What is the Medicare Shared Savings Program?

- Transitional payment program
  - Requires formation of an Accountable Care Organization (ACO)
  - Providers become accountable for the cost and quality of care for a defined population.
  - Waivers and complete claims data files help participants to achieve goals.
  - If successful, Medicare shares up to 50% of savings.
  - If not successful, no penalty.
- ALL EXISTING REIMBURSEMENT STAYS THE SAME!
How Does “Shared Savings” Work?

- ACO’s Baseline Spending per Patient - based on previous 3 years, for all ACO participants

- ACO’s Year 1 Spending per Patient

- Saving s

- Quality Score

- Adjusted Shared Savings

All existing reimbursement stays the same!

Four Quality Domains

- At-Risk Populations
- Preventive Health
- Patient and Caregiver Experience
- Care Coordination and Patient Safety

Focus Care Coordination on “Top 10%” Patients to Achieve Savings

- Wellness Promotion
- Top 10%
- 8-10%
- 6-8%
- 4-6%
- 2-4%
- 0-2%

All existing reimbursement stays the same!
Create Meaningful Change

Chronic Obstructive Pulmonary Disease Discharge Rates
(Per 1000 Beneficiaries)

<table>
<thead>
<tr>
<th>Year</th>
<th>NRACO COPD</th>
<th>All ACOs COPD</th>
<th>NRACO Benchmark</th>
<th>All ACOs Benchmark</th>
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<tr>
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<td>3.00</td>
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<tr>
<td>2012</td>
<td>2.40</td>
<td>2.10</td>
<td>3.10</td>
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<tr>
<td>2013</td>
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<td>2.00</td>
<td>3.20</td>
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<tr>
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<td>3.40</td>
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<tr>
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<td>1.90</td>
<td>1.60</td>
<td>3.60</td>
<td>1.90</td>
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</tbody>
</table>

Build Market Share

Attributed Beneficiaries

<table>
<thead>
<tr>
<th>Year</th>
<th>2014-Q1</th>
<th>2014-Q2</th>
<th>2014-Q3</th>
<th>2014-Q4</th>
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<tbody>
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<td>1,100</td>
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<tr>
<td>2014-Q2</td>
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<td>2014-Q4</td>
<td>1,700</td>
<td>1,800</td>
<td>1,900</td>
<td>2,000</td>
</tr>
</tbody>
</table>

Take It Slow

• Control the rate of change
• Build market share at the same time
• Keep a close eye on the financials
What is the ACO Investment Model?
• Medicare pre-pays shared savings for two years
• Payments recovered from shared savings
• If no savings, no repayment as long as ACO complies with the program for 3 years.

AIM Pre-Payment
• An upfront, fixed payment: $250,000
• An upfront, variable payment: Assigned beneficiaries multiplied by $36.
• A monthly payment of varying amount depending on the size of the ACO: Assigned beneficiaries multiplied by $8, for up to 24 months or until it ceases participation
• If 5,000 beneficiaries are assigned, the ACO would get $250,000 + $180,000 up front ($430,000) plus $480,000 per year for 2 years = $1,390,000
• If 10,000 beneficiaries are assigned, the ACO would get $250,000 + $360,000 up front ($610,000) plus $960,000 per year for 2 years = $2,530,000

AIM Eligibility
• Must also become a Medicare ACO.
• Less than 10,000 beneficiaries
• No hospital in the ACO, unless it is a CAH or PPS with 100 beds or fewer.
• The ACO is not owned or operated in whole or in part by a health plan.

• If you are approved for AIM funding, you will be able to participate in this program for only $1,000 out-of-pocket cost (with the Consortium).
What Do Providers Need to Do in Our ACO?

- Hire a care coordinator – bills Medicare
- Form steering committee – meets monthly
- Report quality annually
- Engage on initiatives to maximize HEDIS scores
  - Transitions of Care Management/Chronic Care Management
  - Prevention and Wellness Visits
  - Post-Acute Care
  - Diabetes Management
  - Chronic Obstructive Pulmonary Disease Management
  - Congestive Heart Failure Management
  - CAD/Stroke/HTN/IVD Quality Measures
  - Patient Satisfaction

What Do We Provide?

- CMS-Required ACO Personnel
  - ACO Executive Director
  - Medical Director
  - Quality Improvement Officer
  - Compliance Officer
- Additional Support Personnel
  - ACO Project Manager
  - Care Coordination Coach

What Do We Provide?

- IT Infrastructure
  - Claims Data Requests and Management
  - Clinical Quality Data Aggregation and Quality Reporting (ACO, PQRS, and Meaningful Use Clinical Quality Measures)
  - Data Warehouse
  - Cost and Quality Data Dashboards
  - Target Patient Registries
  - Market Share Analytics
  - Ambulatory EMR Interface
What Do We Provide?

• Quality Improvement
  • ACO Quality Measure Reporting and Optimization
  • PQRS Reporting
  • Meaningful Use Clinical Quality Measure Reporting
  • Clinician and Staff Education
  • Clinical Quality and Cost Analysis
  • Performance Improvement Strategies and Support
  • Quality Improvement Initiatives

What Do We Provide?

• Care Coordination
  • Evidence-Based Care Plans with Electronic Access
  • Assistance in Hiring Care Coordinator (who bills Medicare, guidance provided)
  • Care Coordinator Training Program
  • Peer-Learning Network

• Patient Engagement
  • Oversight of Required CG-CAHPS Survey Implementation
  • In-Office Patient Satisfaction Survey and Improvement Strategies
  • Promotion of Wellness Visits and Preventive Care

What Do We Provide?

• Marketing
  • Beneficiary Notification Support
  • Press Kits
  • Submission of Marketing Materials to CMS for Compliance
  • In-Office Beneficiary Notification Process Training
  • Marketing Requirements Training

• Change Management
  • Launch Meetings
  • Staff Training on ACO Requirements and Procedures
  • Medical Staff Training on ACO Quality Measures
  • Support for Monthly Steering Committee Meetings
What Do We Provide?

- Other Activities
- Promotion of Evidence-Based Medicine
- ACO Formation, Filings, Taxes and Insurance (Including Cybersecurity)
- Management of Quarterly ACO Board Meetings
- ACO Compliance Program
- Monthly Financial Consulting Services

Should You Join an Urban ACO?

*It depends:*
  - What is your strategic plan?
  - Do you have a choice of tertiary providers?
  - Will they focus on your needs and your success?
  - How will they help you learn to improve?
  - How will they help you build market share?
  - Who gets to see your data?
  - What data will they provide you?
  - How will savings be distributed?
  - What costs will be deducted from your shared savings?

Should You Join a Rural ACO?

*It depends:*
  - You own and govern your ACO.
  - You create and maintain leverage with payers and your referral network.
  - You control your destiny and rate of change.
  - You get all claims data on your patients.
  - You get waivers that help you succeed.
  - You get recognized as a high value provider.
  - If you apply by July, CMS will fund your transformation.
If I Join, What Happens Next?

• Non-binding Letter Of Intent due May 1st, 2015 with $1,000 fee.
• Full Application is due July 1st, 2015 with refundable $24,000 deposit
• National Rural ACO forms the ACO LLC, finds your partners, applies to CMS for MSSP and AIM Funding.
• When approved, you begin operating as an ACO January 1, 2016.
• $24,000 deposit is returned to you when you hire your care coordinator.
• January – April – Monthly training on the program.
• May, 2016 – Get data, launch your steering committee and go live.
• Thru December, 2018 – meet monthly with our team to transform your delivery system.

What are the risks?

• Transforming your delivery system is a lot of work. What will you stop doing that you do now, so you can spend time learning, redesigning workflows and reaching out to your patients?
• If your ACO closes before the third year, you have to pay back your grant funds – so contract carefully to protect yourself.
• If you are really good at coordinating care, and you don’t build market share at the same time with these programs, you could lose admissions, your payor mix could change and you could lose revenue – you must regulate the pace of change and build market share at the same time.
• If your collaborators have losses, they will wipe out your savings and you will not get paid your bonus – don’t count on shared savings.

Provider Transformation Network (PTN)

• Not ready for an ACO?
  • If you don’t have physicians who will participate
  • If you are going to implement a new ambulatory EMR in the next two years.
  • If your CEO is going to retire in the next two years.
  • If your board won’t support it.
• Then what?
  • Technical assistance to help you get ready will be available this summer.
  • Look for announcements on who is approved.
  • They need rural providers!
**What Are Your Next Steps?**

- Enroll in a population health program that provides cost data and focuses you on achieving high scores on ambulatory quality measures so you don’t get left further behind.
  - Join PQRS
  - Join an urban ACO
  - Form a strategic ACO
  - Join a State Rural ACO
  - Join a Practice Transformation Network

*Whatever you do, do something and do it now!*  

**We Can Help**

- Go to [www.NationalRuralACO.com](http://www.NationalRuralACO.com) and click on “Apply Now” to begin the process.

  or

- Contact Lynn Barr at [lbarr@ruralaco.com](mailto:lbarr@ruralaco.com)