Who is the National Rural ACO?
The National Rural ACO was formed in 2013 to pool knowledge, patients, and resources so that independent community health systems could participate in new population health-based reimbursement models. Nine rural health system CEO’s came together to develop simple, turn-key programs to transform their delivery systems from a reactive fee-for-service model to a proactive population health model. Today, they follow evidence-based processes to improve the health of their communities and position their health systems for financial success using the framework, waivers and data supplied by the Medicare Shared Savings Program. They provide additional support for the chronically ill and use prevention and wellness-promotion programs to improve outcomes, reduce unnecessary ED and inpatient utilization and build market share. Today, thirty community health systems in nine states are participating in six Accountable Care Organizations that have no downside risk as part of the National Rural ACO, and many more are preparing to join in 2016.

Who Should Join the National Rural ACO?
The National Rural ACO is designed for community health systems – doctors and hospitals working together – who are preparing for future population health-based reimbursement models. Members of the National Rural ACO are a mix of non-profit hospitals and taxpayer-supported county and local government health systems. We make long-term investments in the physical and mental health of our patients and the financial health and well-being of our providers.

Our ideal member profile is a hospital with one or more primary care clinics, frequently with home health, hospice, and skilled nursing facilities operating under the same umbrella entity. The hospital is typically at least 10 miles from the nearest alternative and serves as one of the main social and economic drivers of its community. Physician-only groups, RHCs and FQHCs can join the National Rural ACO alone if no hospital wishes to participate in their community.

What Are the Advantages of Joining the National Rural ACO?
The National Rural ACO was founded because many community health systems do not have enough patients to qualify for Medicare and commercial shared savings programs, nor the managed care and IT infrastructure they need to be successful. The National Rural ACO aggregates smaller health systems to enable them to participate. Each community acts as its own ACO, with its own benchmark and its own goals, but utilizes shared governance and resources in a regional Rural ACO. This network enables small health systems to qualify for shared savings programs, allows aggregation of lives to support other value-based payment models, and fosters a peer learning network.

According to the National Association of Accountable Care Organizations, the average actual first year cost of starting and operating an ACO is $2 million. More than 20% of that cost is for the IT systems to request, access, and analyze the Medicare claims data, with an average satisfaction rate of 6.1 on a 10-point scale. Legal fees will run into the hundreds of thousands of dollars to fully contract and comply with the program. Hiring experienced leadership, if you can find it, will also run up your costs. Joining the
National Rural ACO will allow you to confidently achieve your goals at a fraction of the cost of going it alone, and learn from others who have gone before you. Grant funding can completely offset your costs.

**What is Required to Participate in the National Rural ACO?**

Participants in the National Rural ACO are required to form a steering committee with senior administrative, clinical and IT leadership to oversee the program. This steering committee meets monthly to oversee and review the progress of the health system on delivery system transformation initiatives. Each community must hire a nurse to function as the Community Care Coordinator, who manages high-risk patients and bills Medicare for these services incident to the general supervision of a billing provider. Using claims data and ACO quality measures, the National Rural ACO introduces a new initiative every 90 days, with an education phase, and implementation phase and a measurement phase. Communities can take longer to implement these programs if desired or needed. The National Rural ACO initiatives are as follows:

- 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 Services Are Provided to Members of the National Rural ACO?**

The following services are provided to members of the National Rural ACO for the all-inclusive fees listed below:

**CMS-Required ACO Personnel**
- ACO Executive Director
- Medical Director
- Quality Improvement Officer
- Compliance Officer

**Additional Support Personnel**
- ACO Project Manager
- Care Coordination Coach

**IT Infrastructure**
- Claims Data Requests and Management
- Clinical Quality Data Aggregation and Reporting
- Data Warehouse
- Cost and Quality Data Dashboards
- Target Patient Registries
- Market Analytics

**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
High-Value Referral Network Development

Care Coordination
24-Hour Advice Nurse Line
Evidence-Based Care Plans
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

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

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

How Does Governance Work?
Participants own and control 75% of the ACO. Each community health system owns an equal share of the ACO, has a board seat and has an equal vote. The National Rural ACO also owns 25% of the ACO. Each ACO board also includes a Medical Director and a Medicare beneficiary.

What Does it Cost to Participate in the National Rural ACO and the Medicare Shared Savings Program?
In order to make the transition to population health-based reimbursement affordable, the National Rural ACO charges fees at or near cost for supporting your participation in the Medicare Shared Savings program. Our profits are contingent on your success – the National Rural ACO receives 10% of the Shared Savings Payments received by our members. The cost of applying for the program is only $25,000, and the cost of participating can be as low as $120,000 per year – less than 10% of the cost of doing it on your own, and without the risk of making expensive, time-consuming mistakes. Beginning in the 2016 Program year, the Center for Medicare and Medicaid Innovation is offering to pre-pay shared
savings for hundreds of safety net providers under the ACO Investment Model (AIM) Program. **If your ACO is approved for the AIM program, your fees will be covered 100% by the AIM funding for the three year period of the Program, and your application fee will be refunded.**

If you achieve shared savings, CMS will deduct the pre-payment from your shared savings bonuses. If you do not achieve shared savings, CMS will forgive the pre-payments as long as you remain in the program for 3 years and you comply with the rules of the program. For more information about the AIM program, please go to [http://innovation.cms.gov/initiatives/ACO-Investment-Model/](http://innovation.cms.gov/initiatives/ACO-Investment-Model/).

**2016 ACO FEES**

- **$1,000 Non-Refundable Preliminary Assessment Fee** Due by April 30th, 2015.
- **$24,000 Refundable Application Fee** Due by July 1st, 2015 with complete application.
- **$10,000 Monthly Fees Beginning January 1, 2016** plus $1 Per Member Per Month for more than 2,000 attributed lives per community covered by the AIM Grant if approved.

**What Additional Costs and Resources Are Needed?**

Each National Rural ACO member is required to hire a full-time Care Coordinator to manage the chronically ill Medicare population. Over time, the cost of this person can be completely offset by new Medicare Care Coordination Fees which the National Rural ACO will assist you in obtaining.

Health system leadership (CEO, CFO, CNO, CIO, CMO/Physician Leader, Clinic Management and an ACO Champion/Project Manager) must attend monthly Steering Committee meetings, supported by our staff to discuss project implementation, data, results, and areas for improvement, in order to create accountability and formulate strategies for ACO success. The ACO Champion will dedicate between 10-25% of their time. IT staff will need to work with the National Rural ACO staff on extracting clinic data elements from their ambulatory EHR for quality reporting. The cost of interfacing or generating monthly reports to the data warehouse is covered by the fees. The EHR vendor may charge the community additional fees.

Staff time will be needed annually to complete mandatory quality reporting in January and February. Every effort is made to extract this data prior to the reporting period to minimize effort and disruption. This activity takes place of PQRS and Meaningful Use Clinical Quality Measure Reporting!

**What Can You Expect In Terms Of Shared Savings?**

Currently, on average, the Medicare Shared Savings Program pays $100 per beneficiary per year. If an ACO has 7500 lives, it can expect a shared savings payment of $2,225,000 based on the current averages. The same ACO may have received $1,960,000 in AIM funding, which would be deducted from those payments for a balance of $290,000. Of that amount, 10% would go to the National Rural ACO and a minimum of 20% would go to the clinicians. Some participants will do better and some will not see any shared savings. **It is wise to assume that there will be little or no shared savings received by the participants during the initial 3-year period.** At the end of the 3 years, participants will have enough data and experience to determine whether they would like to: 1) leave the program; 2) enter another three-year, no-risk arrangement; or 3) enter another three-year arrangement with CMS and accept down-side risk. For more information about the Medicare Shared Savings Program, please go to [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/SharedSavingsProgram/](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/SharedSavingsProgram/).

**What Happens if I Don’t Qualify for the AIM Program?**

Participants will have to decide in advance whether they will move forward in the program if they do not receive AIM funding support.. If a participant will only move forward if AIM funding is attained, and they
do not get the funding they need, the ACO will not sign the agreement with CMS and the $24,000 application fees will be returned to the participants. If participants choose to move forward either way, they will be grouped with other ACO participants who will pursue the program regardless of funding. We expect most, if not all, of our applicants will receive the AIM funding. Funding is awarded based on rurality, the quality of the spend plan, financial need, and ACO penetration. If the participant is rural, they are likely to be funded. There is sufficient AIM funding to support up to 300 rural communities in 75 ACO’s.

What Are the Goals of Participating in the Program?
Under this program you will begin a transition from a volume-based system to a value-based system. This transition will prepare your health system for future payment models, increase local market share, and increase patient and provider satisfaction.

We expand upon the “Triple Aim” goal, by supporting the economic viability and sustainability of the rural health safety net. Your health system may want to reduce costs at either a faster or slower rate, depending on your goals and the need to adjust staffing and budgets as you transition into a managed, population health-based reimbursement model. As a member of the National Rural ACO, you are in the driver’s seat and control the rate of change. We carefully monitor your cost and utilization data, so that the health system and providers are fully supported during the transition.

Today’s healthcare providers are overwhelmed with rapid and demanding changes in healthcare. Our program supports their high-risk, complex patients, encourages the use of ancillary staff and automation to decrease the burden of quality reporting, and positions them for maximum reimbursement and bonuses under the Physician Quality Reporting System, Meaningful Use, and Value-Based Modifiers. The Primary Care Provider is in charge, as we provide additional tools and support to help them produce the best outcomes at the lowest cost for the community.

Next Steps
If your organization is considering participating in a Medicare Shared Savings Program in 2016, now is the time to start planning; the application deadline to CMS is July 31, 2015. We suggest that you begin discussions with medical staff and organizational leadership, including your Board of Directors, as soon as possible. Letters of Intent to join the National Rural ACO must be received no later than April 30, 2015 to join the Medicare Shared Savings Program in 2016. Other ACO payor contracts have different deadlines.

Please complete the National Rural ACO 2016 Application Letter on our website at www.NationalRuralACO.com to get started. If you receive conditional acceptance, a non-refundable preliminary application fee of $1,000 will be due. Once the preliminary application fee is received, you will get a full Application Packet, including all legal documents and we will assign a member of the National Rural ACO to speak with you, your staff, your doctors and your Board of Directors about the program. If there is mutual agreement to move forward, the completed Application Packet and a refundable $24,000 application fee will be due no later than July 1, 2015. Your application fee will be refunded if you withdraw your application by September 1, 2015, if the AIM funding is not awarded or if, CMS does not approve your application.

For more information, please contact Georgia Green at 916-500-4777 or email GGreen@ruralaco.com.