

# ACO BUSINESS NEWS

Timely News and Business Strategies on Accountable Care Organizations

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## Pioneer ACO Applicants Offer Proposals For Innovative Payment Methodologies

And they're off! The applicants for the Pioneer ACO program (*ABN 7/11, p. 7*) that grew out of the health reform law have made their pitches to CMS, and regulators already have begun requesting additional information from some of them, *ABN* has learned. The feds aren't saying how many organizations applied for the Pioneer program by the Aug. 19 deadline — "We hope to announce the site selection in late fall" is all they're giving out — so it's difficult to gauge industry enthusiasm overall. But the organizations that applied say they're stoked about the opportunities the program presents.

"We want to give better care to our traditional Medicare patients, and we felt the Pioneer ACO program would allow us to do that," says Karen Van Wagner, Ph.D., CEO at North Texas Specialty Physicians (NTSP) in Fort Worth. "Our core business is risk, and we can provide options now that we couldn't on those traditional Medicare patients. We really felt if we could somehow get a different financial structure, we could move some of that over to traditional Medicare, and we're very excited about doing that."

Especially exciting, she tells *ABN*, is the prospective attribution of patients to providers that's allowed under the Pioneer program. "The tipping point for us was it seemed that even though there were a lot of unknowns, it was better than doing nothing and simply waiting," she says. "You could tell they wanted this to be successful. The more we learned about it — particularly the attribution process — the more we thought we could make it work."

She adds that the lack of a prospective-attribution option in the first set of proposed regs (for the Medicare Shared Savings Program) was "a deal-buster. We don't know how to manage people who are ghosts to us." Allowing prospective attribution, on the

*continued on p. 11*

## NCQA Plans to Issue One Set of Standards That Fits All Categories of ACO Applicants

The National Committee for Quality Assurance (NCQA) will release a single set of ACO accreditation standards designed to fit all types of applicants and all five types of ACO structures envisioned and enabled by the Medicare Shared Savings Program. The one-size-fits-all approach — which will include both process and outcomes measures — focuses on capabilities, not structure. Now, in fact, NCQA sources tell *ABN*, the standards are being vetted to make sure they can be operationalized by as many kinds of ACOs as possible.

That apparently explains the delay in releasing the standards (*ABN 6/11, p. 5*). Once promised for July, NCQA representatives now will commit only to a "fall" release, with no specificity at all around a date. "The standards are finalized, and they've been reviewed by a task force," says Raena Grant Akin-Deko, the organization's assistant vice president, product development. "Now we're working through how to operationalize them and put them into practice. We're carefully considering who's eligible for the program, and we want to make the standards as flexible as possible so we don't

inadvertently limit the types of organizations that can come through for accreditation through our rules.”

Indeed, she adds, NCQA is trying to expand the standards’ appeal beyond the scope of the health reform law that created Medicare ACOs in the first place. “We understand that an applicant may be hospital-based or built on a large medical group, and we did not want to devise different sets of standards for different structural ACO types,” Akin-Deko tells *ABN*. “At the end of the day, they’re going to be accountable for improving quality and lowering costs for patients, and there’s a set of capabilities that organizations should have regardless of structure.”

Pricing for the ACO accreditation reviews has not yet been set, according to an NCQA spokesperson. That decision should be made in September, the spokesperson says.

The NCQA standards are designed so that all organizations have to demonstrate the same set of capabilities — but the way they do so might look different in each case. “We want to see that you have a strong leadership structure to bring together providers and set goals, for example,” Akin-Deko explains, “but the way you align goals and bring providers together can differ based on how your ACO is structured.”

That variability will be especially evident in ACO applicants’ information technology, she emphasizes. While the organization says there’s likely not a single standard

that all applicants will have trouble with, IT infrastructure is always an issue for health care provider organizations.

“In most instances, the degree to which an ACO is already doing something will determine if it finds the related standards easy,” Akin-Deko comments. “And of course there are very data-rich organizations, and then there are those that just have their own data. One interesting thing that’s happened in the market over the last six to eight months is the realization of the importance of data and how the applicant organizations that are provider-based are going to make sure they have enough information on their patients to manage them appropriately.”

Providers know about the care they’re providing, but might not know about the care the patient is receiving somewhere else. “Are you using predictive modeling?” Akin-Deko asks. “Do you need help coordinating care? If an organization doesn’t have enough data, it’s not going to be able to do those things efficiently on the number of patients needed to make a discernible impact. So there’s a growing realization that the provider-based organizations might need to partner with other organizations that have those data.”

### **NCQA Says Data Standards Shouldn’t Be Burden**

Two of the seven areas emphasized in the overall standards, Clinical Management and Clinical Technology, focus almost exclusively on data management. But the data-related standards shouldn’t be so burdensome that they act as a barrier to accreditation, according to NCQA. “We see accreditation almost as a pathway to building ACO capabilities,” Akin-Deko says. “We think there will be many places where applicants are building the capabilities they need, so there are places in the standards where we are not very explicit about how applicants actually get it done — and data is one of the issues in general where a lot of organizations see challenges in building capabilities. We structured our standards in a way that I don’t know that they’ll add to that problem.”

Those standards, she continues, will contain a combination of process and outcomes measures, including “part of the traditional HEDIS measure set that’s being adapted for a provider-based setting.” The approach, Akin-Deko says, is this: “Do you have the correct processes set up? And have you carried them out?” In care coordination, for example, the standards seek to determine both that an ACO has the appropriate processes in place and that it’s tracking to see if the right information is going to providers — and that it’s taking action if not.

None of this should be a surprise when the final standards are released, Akin-Deko emphasizes. “We’ve talked about it a lot and have been very transparent,” she says. “And we’ve been talking about the same concepts consistently. We’ve also had conversations with the folks who

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piloted the standards, and I don't think there were any surprises there. The pilot sites said the types of things we were evaluating were in line with their expectations."

One open question is whether the standards will meet Medicare's expectations for conferring "deemed" status on ACOs accredited by NCQA. As Medicare has lumbered through the rules promulgation process, some industry watchers have noticed a distinct lack of references to NCQA accreditation. Does that mean the feds won't turn to NCQA for accreditation assistance this time around?

Of course, nobody expects CMS to publish a rule saying NCQA accreditation would suffice without seeing the final standards. "CMS really could not have mentioned us because we didn't have a finished product for them to review and refer to," the organization says. "Of course, we would like CMS to deem NCQA accreditation as satisfying some of its requirements for ACOs. Its doing so would simplify the process for organizations that are accredited and want to participate in Medicare."

In the past, NCQA points out, this authority usually came from statutory language granting flexibility to deem, but the organization acknowledges it doesn't know whether that's imminent with ACOs. "Our short-term goal is to align our standards with CMS's where it makes sense so that the marketplace has a common understanding of what an ACO is expected to be across private, Medicare and other initiatives," the organization says, "so all of them will know that an NCQA-accredited ACO is capable of doing what ACOs are supposed to do."

Contact Akin-Deko via Andy Reynolds at (202) 955-3518 or reynolds@ncqa.org. ✧

## Employers Say Calif. Managed Care Experience Drives ACO Activity

If it seems there's more employer ACO development activity in California than elsewhere, it's probably because there's more ACO development activity in general there than in other parts of the country. And that's no doubt because the Golden State is famously enthusiastic about clinical care coordination and provider incentive alignment.

"We believe that payment models like the ACOs are the best way to create the proper incentives for providers to keep people healthy and reduce the cost of care," says Ben Wilson, director, global health care strategy, for Santa Clara-based Intel Corp. "As a large employer, we would like to see the health care system deliver better value, and bundled or global payments will be a step in the right direction."

He adds: "California is the birthplace of accountable care and has embraced managed care more than any

other state. That foundation makes it easier — although not easy — to deliver accountable care." Intel, Wilson tells *ABN*, has distributed requests for proposals (RFPs) to some regional health care systems to help it select the best providers to "undergo health care delivery redesign that we believe will be in the best interest of our employees in terms of health status, cost and patient satisfaction. Although we know the metrics that need improvement, including health status, health care costs and employee satisfaction, we have not yet set goals for our accountable care projects."

## CalPERS Uses 'Virtual' Model of Care

The California Public Employees Retirement System sure has (*ABN* 4/11, p. 11). Since January 2010, CalPERS has been involved in an ACO pilot with Blue Shield of California that uses a "virtual integrated model" of care, notes CalPERS spokesperson Bill Madison. CalPERS jumped into the ACO arena because it's "continually looking for ways to improve the quality and service of the health care we provide our members, and we have constant discussions and brainstorming sessions with our health provider partners about ways to do that," he adds. During discussions with California Blue Shield — one of the purchaser's HMO health plan providers — the Blues plan "put forth the idea of developing a pilot for integrated health care," he says.

The city and county of San Francisco were similarly looking for ways to rein in costs and boost quality, reports Catherine Dodd, director of the health service system for both jurisdictions. "The patient-centered medical home movement and ACOs as a method of implementing systems with patients at the center of care piqued my interest beyond 'managed care 101,'" she tells *ABN*. "The model engages patients, providers, payers and purchasers as partners. Accountability and transparency are key components that have been absent in benefit and rate negotiations. And finally, connecting with providers as employers concerned about employee health and well-being appealed to us."

The San Francisco Health Service System (HSS) included in its RFP for a non-staff-model HMO a question regarding willingness to organize as an ACO within the HMO, she adds, and California Blue Shield was "the only HMO that responded willingly." The plan established two parallel ACOs that compete for HSS's business (*ABN* 4/11, p. 1). The city and county hope to improve care for their 59,000 members and 107,000 covered lives by "improving communication between providers and between patients and providers, using evidence-based interventions across all providers and improving health outcomes," Dodd says.

In California, "there's been provider-based at-risk contracting going back 20 years," notes Lance Lang, M.D.,

clinical director, California Quality Collaborative, with the San Francisco-based Pacific Business Group on Health (PBGH). "There's a lot of experience and maturity about managing risk, and that includes sophistication in care management at the provider level." Indeed, he points out, some of the roles that health plans play in other states are played by provider organizations in California, especially physician organizations and hospitals.

"There's a lot of experimentation now, much of it in partnership between provider organizations and health plans, to regain some of the energy of the 1990s," Lang adds. He points in particular to the two competing ACOs servicing San Francisco. "In a given geography, that's very exciting to the purchasers," he says. PBGH members, he adds, are interested in contracting with groups directly and figuring out a way to do more of what the Blues plan has done in San Francisco. "Rather than choosing among health plans, we'd rather choose among provider organizations," he explains. "If one does a better job on quality and cost, it will grow. It's not a big deal until it's not just for a single purchaser. We really need for that to be 'the marketplace.'"

That's as likely to happen in California as anywhere. "California has 285 physician organizations with many of the characteristics described in the national debate, and its experiences with those organizations over the past 30 years, both positive and negative, offer insight into the challenges that federal policymakers will face with ACO implementation," notes the Oakland-based Integrated Healthcare Association (IHA) in its late 2010 white paper "Accountable Care Organizations in California: Lessons for the National Debate on Delivery System Reform."

#### ACO HMO Enrollment as a Percentage of Total Insured Californians, 2008

Insurance Type	All Types (Total Enrollees)	Commercial	Medi-Cal/Healthy Families	Medicare
ACO HMO Enrollment	15,943,850	11,285,950 (71%)	3,164,000 (20%)	1,493,900 (9%)
Entire Insured Population	29,691,000	20,110,800 (68%)	6,036,300 (20%)	3,308,800 (11%)
ACO HMO Enrollment as a Percentage of Total Enrollment	54%	56%	52%	45%

Note: The total insured population is larger than the sum of the total commercial, Medi-Cal and Medicare enrollees due to the presence of other types of insurance (e.g., TRICARE).

SOURCES: Integrated Healthcare Association, 2010, based on Cattaneo and Stroud, "#7: Active California Medical Groups by County by Line of Business, for Years 2004 through 2010, Sorted Alphabetically," May 1, 2010. Provided by W. Barcellona, July 27, 2010; and Kaiser Family Foundation, "California: Health Insurance Coverage of the Total Population, states (2007-2008), U.S. (2008)." Statehealthfacts.org, 2009. <http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=6&ind=125&sub=39>. Accessed on July 15, 2010.

Indeed, the organization says, the rest of the nation can learn important lessons from California's long experience with accountable care.

"Many states and cities have one or a few organizations that may be considered an ACO," the paper says, "but health care in California can be conceptualized as an 'ACO ecosystem.'" The state's provider organizations "vary in their conformity with the parameters discussed in the national debate, but many go beyond the minimum set of ACO activities to include preventive care, chronic care management and complex case management, often supported by clinical information technology and financed through partial or global capitation payment," it adds.

A salient characteristic of ACOs in California is that they have been largely unsuccessful in attracting PPO patients, the IHA report says. Indeed, "some consider PPOs to be their competitors and HMOs to be their partners and marketing agents."

But that's not how Aetna Inc. sees it. "Employers in California are looking for PPO-type products priced below the current market that are built on better management of patient outcomes versus network discounts alone," says Chris Day, head of business development for accountable care solutions at the insurer. "When they want PPO products, they're not necessarily developing an ACO strategy. They're calling insurance carriers such as Aetna to find out what we're doing in the market around ACOs, and they're asking us about collaborations we have with providers."

Providers and insurers are leading the development of ACOs, he adds. "California has a large saturation of capitated business, so providers are already taking on risk and managing it for that patient population," he says. "However, providers don't have the same infrastructure in place to support patients in PPO-type plans. Providers are trying to transfer their experience from a capitated environment to a PPO environment to improve results where medical costs are running higher. The challenge is that they often don't have patient data and systems they need nor a care infrastructure to support the PPO population."

Here are additional details from the IHA report:

◆ *54% of people with health insurance in the state receive their care from an ACO* (see table, this page).

◆ *Golden State ACOs care for 15.7 million prepaid enrollees covered by commercial HMOs, Medicare Advantage (MA), Healthy Families and Medicaid managed care, plus numerous Medicare fee-for-service and commercial PPO enrollees.*

◆ *The majority of ACOs in California follow the independent practice association model; there are 152 IPAs in California, serving 4.8 million HMO enrollees.*

- ◆ **78% of California ACOs serve fewer than 50,000 pre-paid patients.**
- ◆ **The California experience shows the difficulty of efforts to expand ACOs across regions,** or rapidly through mergers and acquisitions.
- ◆ **A key differentiator of the California experience is the prevalence of capitation as a payment method;** other states use mostly fee-for-service, even for large multispecialty medical groups.
- ◆ **A challenge facing ACOs in California has been the narrowing scope of capitation payments,** which now most frequently cover only physician services, excluding both hospital and pharmacy services.
- ◆ **ACOs in California play a major role as network providers in MA** and, conversely, MA plans have provided a significant fraction of the revenues and enrollment that sustain the ACOs.
- ◆ **There are two distinct conceptualizations of consumer choice, and the ACOs in California focus on one, “managed competition,”** while the majority of health plans and purchasers nationally focus on the other, “consumer-driven health care.”
- ◆ **ACOs in California continue to derive the vast majority of their patients and revenues from HMO products,** despite the eroding reputation and market share of those products nationally.
- ◆ **Many aspects of the policy and regulatory environment in California have helped ACOs,** “compared to the political culture in states that have sought to protect the cottage industry against the incursion of managed care.” The supportive aspects of California’s policy framework “have been due to the historically strong presence of Kaiser Permanente, as well as the embrace of managed care principles by prominent public purchasers such as CalPERS and private purchasers such as the PBGH.”

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## **Oncology Poses Tough Issues for ACOs; Views on Solutions Differ**

When it comes to medical specialties for which the issues involving Medicare ACO participation are particularly difficult, oncology may lead the pack. Among the complications are that many oncologists manage cancer patients but aren’t considered the primary care physicians (PCPs) for them, and that cancer treatment costs are extremely high and figure to keep rising based on the promising new therapies in the pipeline.

However, views differ among oncology-related organizations about whether CMS’s Medicare Shared Savings Program (MSSP) and Pioneer initiatives are simply unworkable for oncologists or whether there are means to structure the definitions to make the programs financially feasible for cancer physicians’ participation. The one seemingly certain thing is that, for the foreseeable future, most of the action in ACOs involving oncology will be in the private sector rather than in Medicare.

In the view of one major player, oncology physician services giant US Oncology, CMS doesn’t even intend to address oncology or other chronic disease states in the MSSP. That view of Matt Brow, vice president, communications, government relations and public policy at US Oncology, is shared by the American Society of Clinical Oncology, he says. It seems, he asserts, that oncology patients would not count toward either the benchmark or performance — i.e., the actual spending — in MSSP (*ABN* 5/11, p. 5), especially since the provisions would require that patient attribution for purposes of shared savings is based on the provider that actually furnishes the majority of the primary care services (i.e., the PCPs).

Another problem is that MSSP has an “outlier rule” under which patients whose care costs more than \$100,000 in a year wouldn’t count toward benchmark or performance measures, he says. Since a patient getting regular chemotherapy often costs more than this figure, he notes, that’s a big issue in oncology.

“Our belief is that the structure for the MSSP is not fixable for oncology to participate,” Brow tells *ABN*. He contends that oncologists won’t want to participate in MSSP directly, particularly in view of the program’s “downside risk” for participants. Moreover, organizations taking the risk in MSSP won’t want oncologists as part of their ACOs given the nature of oncology cost trends, among other factors.

### **Pioneer Is Seen as ‘Even Worse’**

And CMS’s Pioneer Medicare ACO initiative “could be even worse for oncologists,” according to Brow. This is because it takes a “prospective” approach to patient attribution, meaning, in his view, that oncologists are at a disadvantage since they can’t know who will develop cancer. Moreover, the capitation-related payment system in Pioneer is a problem, Brow maintains, because the nature of the cancer field is that oncologists don’t know how much the treatment of a cancer patient eventually will cost.

Since Pioneer essentially requires one entity to provide “the entire spectrum of care rather than just manage it,” he adds, “we have no interest” in this program.

But that is not to say US Oncology doesn’t regard ACOs as feasible in oncology. On the Medicare side, says Brow, the company thinks CMS will take a “more targeted

approach" to oncology, probably through the "innovation center" created in the reform law. There have been discussions "along these lines" between oncology organizations and the center already, he says, and one possible kind of project could "incentivize" providers to take cost-effective approaches, as in the long-running Physician Group Practice demonstration.

In the meantime, US Oncology has several programs in the commercial market that aren't called ACOs but clearly have elements of those arrangements. One such program involving its 370-oncologist Texas Oncology affiliate is with Aetna Inc. and began last June. It uses an "MSSP-like structure laying on top of a Medicare fee-for-service contract," Brow explains. The program, he says, focuses on such areas as adherence to proven clinical pathways and advance care planning.

Under the program for Aetna's fully insured commercial plans in Texas, he says, some of the payments the oncologists receive are "held at risk" based on spending targets agreed to in advance. Brow says first-year results aren't available yet and that while US Oncology has somewhat similar arrangements with some other payers, it can't identify them without the other parties' consent.

The flexibility of those kinds of arrangements seems to be one reason Brow contends that "the earliest successful [oncology ACO] programs are likely to be on the

private side." He also expresses doubts that the Medicare ACO projects will start on time in 2012, especially since the organizations selected still will have to negotiate participation arrangements.

Many of the concerns voiced by oncologists about the Medicare ACO programs relate to "definitional issues" that can be worked out, comments Alan Lotvin, M.D., president of ICORE Healthcare, a Magellan Health Services, Inc. subsidiary that manages specialty pharmaceuticals for payers and runs a well-attended annual oncology summit.

The issues facing oncology, in Lotvin's view, involve the same kind of care-coordination concerns affecting many other specialties. They can be dealt with, he suggests, with a method that is "administratable" and enables oncologists to control costs. This should not be fee-for-service, as US Oncology's comments suggest it favors, but instead might use case-rate-like payment mechanisms in which certain adjustments can be made, he tells *ABN*.

In some ways, according to Lotvin, figuring out the right kinds of payment mechanisms is a "math exercise." He says, for instance, that there could be expected payment rates and then adjustments to pay when a patient gets cancer. And organizations such as US Oncology could create separate arrangements with ACOs formed by other entities, he adds.

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Lotvin does agree that when a person is diagnosed with cancer, he or she often gets almost all of the medical care for that disease from oncologists. He also concurs that if oncologists are at risk on the cost of drugs for such patients, it's a problem since the physicians don't have control over those expenses. But "it always is feasible" to have risk arrangements, even when expensive drugs are involved, if the definitions in the arrangements are the right ones, he asserts. He cites, for example, stages 1 and 2 of cancer which, by contrast with later stages, are relatively inexpensive to treat.

Oncologists, as Lotvin sees it, must decide what role they want, whether it be holding risk and thus getting extra payments for good outcomes, or not holding risk and thus not gaining those rewards. "You can't have it both ways," he says.

ICORE itself, he adds, sees its role in ACOs in the tools it has built "to reduce variability in oncology care on behalf of whoever holds the financial risk." It has discussed and has upcoming talks about such roles with entities interested in ACOs and, since those organizations participate in Medicare, assumes those entities are interested in the Medicare ACO programs, says Lotvin.

"We want to help ACOs, whatever the flavor is, meet their goals," he asserts.

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## Drug, Device Makers Face Gains Along With Risks in ACO Ventures

ACO development is certain to spur significant opportunities — along with some risks — to downstream players in the health care field, including biological, pharmaceutical and medical-device manufacturers, consultants say. Among the concerns: ACOs will have a major challenge in determining their chronically ill patients and the specialty pharmacy spend for those patients, and ACOs may face financial disincentives for offering the latest medical technology, consultants and lobbyists tell *ABN*. Consultants also say manufacturers will face product marketing challenges. But those "life sciences" manufacturers that prepare for impending changes in product contracting methods likely will realize immediate strategic gains, they assert.

Medical Device Manufacturers Association (MDMA) spokesperson Brendan Benner tells *ABN* that his organization is keeping abreast of how the Medicare ACO regulations are unfolding. But broadly speaking, he says, he is unaware of any of its about 300 members already involved in ACO-type initiatives.

MDMA urged CMS to carve out new technologies from expenditures used to evaluate an ACO's performance in its June 6 comments on the proposed rule for the Medicare Shared Savings Program (*ABN* 7/11, p. 3). The trade group says CMS could encourage the appropriate use of such technologies by using "consensus-based quality measures that promote timely referrals to specialists and are updated frequently to reflect improvements in treatment options." The association also wants CMS to require ACOs to include specialists in the groups that are responsible for selecting medical-practice guidelines.

"While MDMA supports the goals of ACOs to improve patient care and delivery and to eliminate waste and inefficiencies, we remain concerned that the proposed regulations could adversely impact access to new and innovative medical technologies," states Mark Leahey, MDMA's president and CEO.

### Specialty Pharmacy Calls ACOs 'Slippery Slope'

William Sullivan, founder and principal consultant at Specialty Pharmacy Solutions in Orlando, Fla., agrees that the broad ACO concept makes sense, but he describes it as "a slippery slope" from the perspective of the specialty pharmacy industry. He tells *ABN* that accurately determining a plan's chronically ill patients and the specialty pharmacy spend for those patients was a key issue driving some independent practice associations (IPAs) in California out of business between 2000 and 2002. They were swamped by the rapid increase in the cost of specialty pharmacy, which accounted for 20% of the \$307 billion spent nationwide on drugs in 2010, even though it accounts for less than 1% of prescriptions.

Subsequently, the state legislature passed a law requiring health plans to reopen their contracts with IPAs and take back liability for specialty pharmacy if the IPA so desired, he says. He notes that some "strong IPAs" actually retained specialty pharmacy, but contends this likely was related to better contract terms negotiated up front. "You need to be on top of the numbers for specialty pharmacy spend," he asserts. "Clearly the smaller the [ACO-like] entity, the more exposed they are."

Sullivan says ACOs likely would seek contracts with specialty pharmacies that already have capabilities related to handling complex drug regimens and the clinical and cognitive services that go along with that. "It goes well beyond the scope of what's currently provided [i.e., calling to ensure that patients are taking their medications], so you'd probably want to partner with or acquire a specialty pharmacy," he says. He adds that he has not yet heard of any such acquisitions.

Indeed, Sullivan says the specialty pharmacy aspect of ACO development comes later. "You need to do heavy

lifting on the basic components of the ACO, the other 99%, before going to specialty pharmacy," according to Sullivan. "I think that's why we haven't seen action on the specialty pharmacy end.... Even the larger specialty pharmacies have not yet been contacted about providing those services [to ACOs]. I think it will happen later... and evolve into a role specialty pharmacies could fill pretty rapidly." Specialty pharmacies already provide services for the federal 340B drug pricing program for designated disproportionate share hospitals, allowing eligible entities to buy federally discounted drugs to treat patients in outpatient settings. And the concept of ACOs is similar, with outside contracts for specialty pharmacy.

Randy Vogenberg, Ph.D., principal of the Institute for Integrated Healthcare, a Boston-based benefits consulting firm, tells *ABN* there is also the issue of marketing for specialty drugs, devices and diagnostics in the evolving ACO market. "From a manufacturer's perspective, it obviously makes it much more difficult for them to promote their products... and get them positioned," he says. He describes ACO ventures as being similar to working with the staff-model HMO, including carrying insurance risk and providing services, "but more corporatized."

"This works to the advantage of manufacturers because all the dollars are on the table and you're looking for the most cost-effective way to diagnose, treat and manage your patients," he says. But to capitalize on this situation, manufacturers must retool their internal organization since "looking at outcomes research and the value proposition for their products will be more important.... You need an economic component now along with a safe and effective product."

### **'Very Chaotic and Confusing Marketplace'**

Vogenberg describes the market dynamics as challenging. "You have independent doctors battling medical groups and hospitals to build ACOs," he says, with health plans starting to look more like delivery systems and vice versa. "So it's a very chaotic and confusing marketplace for manufacturers to market and promote products."

His manufacturing clients, Vogenberg says, are not involved in ACO discussions yet. He says manufacturers must begin taking a longer view of the market — beyond quarter-to-quarter or year-to-year — to look five to 10 years out. There "absolutely" are opportunities for drug and device makers with respect to ACOs, "but they have to be engaged," Vogenberg contends. "They have to change their philosophy and their operations," including making significant changes in marketing.

"For 40 years, they go out and call on physicians. Now, you won't be able to [continue doing so]," he says. "There will be intermediaries determining which products will be made available for prescribing."

In a recent white paper, Alliance Life Sciences Consulting Group assessed opportunities and risks associated with ACO involvement for biological, pharmaceutical and medical device manufacturers. Among the firm's findings:

◆ **Manufacturers seeking traction with new products must demonstrate "superior outcomes" in order to justify cost and pricing increases.** Ed Masterson, Alliance's senior vice president of consulting operations, expects a competitive advantage for companies able to bring products to market within one to three years in the ACO environment. In addition to solid outcomes, firms must show network-wide savings to gain favorable ACO formulary treatment, he says.

◆ **There will be fewer but larger formularies in the evolved market, so manufacturers must try to secure higher formulary tiers in such a way that more volume is administered through fewer contracts.** Consultants say more focused marketing to ACOs — for example, promoting disease prevention and early treatment — may result in better contracts for manufacturers.

◆ **Drug makers must target ACO pharmacy and therapeutics committees with comparative-effectiveness research specific to patient populations.** This will ensure that the Medicare prescribing pattern spillover is appropriate for other programs and populations, consultants say.

◆ **In order to maximize gains from ACO involvement, manufacturers must understand the market size and potential for products based on disease classifications — and target those ACOs specifically aligned to treat such patient populations.**

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## **Pediatric ACO Program in Reform Law Is Delayed by Lack of Funding**

There is a basic problem facing organizations that want to participate in the Medicaid pediatric ACO demonstration program to be developed under provisions of last year's health reform law. The program is authorized for fiscal years 2012 through 2016, but it has not been funded, nor is there any likelihood that it will be in the near future. While some pediatric care organizations are hopeful that the new CMS "innovation center," which is funded, will take over the program, government insiders say that won't happen any time soon given how overloaded the center is.

However, the innovation center and the federal Health Resources and Services Administration (HRSA) have had meetings with stakeholders, including one in

June, on what a program might look like, notes Kelly Kelleher, M.D., vice president, community health for Nationwide Children's Hospital in Ohio. Smaller working-group meetings are planned for this fall, he tells *ABN*, adding that he's hopeful CMS will allow states to come forward with their own models, as has begun to take place in Ohio. He admits, though, that "states are not coming forward with money" given their own financial binds.

The basic program in Section 2706 of the reform law, as outlined by attorney Barbara Eyman, a Washington, D.C.-based partner in Ropes and Gray, permits states to make incentive payments to pediatric medical providers organized as ACOs. Under the program, providers must participate for at least three years. The criteria for participation are supposed to be modeled on the Medicare Shared Savings Program (MSSP) for ACOs, Eyman notes.

### **Medicaid Demo Might Not Be Just Pediatric**

While there has been no specific progress (including issuance of criteria or application due dates) on the pediatric ACO program in light of the funding situation, she tells *ABN*, the innovation center could fund a Medicaid-related ACO initiative but might not limit it to pediatric in that case. Eyman notes that the innovation center has its own request-for-proposals processes for demonstration projects and that a children's hospital could not apply for a pediatric ACO project "without a state on board."

Aside from any federal program, she adds, there's no reason why a state on its own couldn't establish a pediatric ACO program and get matching funds from the federal government. However, this would require a state expenditure, and Eyman says she is not aware of any such state projects that have been proposed along these lines. It is "highly, highly unlikely" that the pediatric ACO project will be funded by any reform-law money that hasn't already been appropriated given the current budget and political environment in Washington, she asserts.

There are other potential obstacles to the federal program even if there were funding available, according to Eyman. They include the pervasive dissatisfaction with the MSSP model on which the pediatric ACO program would be based, and the cash-light nature of many Medicaid providers, which she says would need up-front funding to make ACO participation feasible. On the other hand, observes Eyman, the three-year participation requirement should not be a problem.

Pediatric providers certainly aren't giving up their hopes for the program. While he acknowledges that CMS has pointed out the program is unfunded and the innovation center is overwhelmed, Jim Kaufman, vice president, public policy for the National Assn. of Children's Hospitals, says his group is continuing to try to advance the concept. Sen. John Kerry (D-Mass.), among others, has been pushing for the program, and several hospitals

are working directly with states on pediatric ACOs, he says. Texas has been eyeing the concept for its "special-needs population" in Medicaid, he adds, pointing out that children's hospitals' average payer mix is more than 50% Medicaid. Kaufman notes that some states, including Florida, are waiting to see what the innovation center does before taking action on their own.

Ohio has gone further than that, according to Kelleher. The state in its budget, he says, "greased the skids" for a pediatric ACO project to develop with the aid of moving Medicaid Supplementary Security Income (SSI) beneficiaries into managed care. Nationwide Children's Hospital already has longstanding ACO-type arrangements with three Ohio Medicaid plans (CareSource, Molina Healthcare, Inc. and the Unison unit of UnitedHealth Group) in which it is at full risk for Medicaid kids, he points out, adding that Ohio now is proposing more of a "partnership" model in pursuing a Medicaid ACO project.

For the pediatric ACO project in the federal reform law itself, it is which "attributes" CMS puts in the criteria that will determine if Nationwide would pursue plans to participate, Kelleher maintains. On performance "we think we can stand up to anyone," he says, but the hospital wants to avoid a recurrence of what has been happening in some of its other contracts, in which payers react to the success of its efforts to reduce medical costs by lowering the hospital's capitation rate.

### **Dialogue With Stakeholders, Feds Continues**

He suggests that the outlook for the federal government doing something on the pediatric ACO project is not as bleak as some others indicate. HRSA and the innovation center "have kept a dialogue going" with stakeholders, says Kelleher, and the feds have a vital role in performance measurement and the relationship with the coming insurance exchanges, aside from any financial stake.

States are not coming forward with money for the project, he concedes. And in meetings he's been in with the CMS innovation center, Kelleher says, while there's "clear interest in having diverse models," there has not been a pledge of funding.

He does point out that the reform law provision refers only to a "pediatric ACO," not specifically mentioning Medicaid, so this leaves the possibility for a program not involving Medicaid. Something like the Pioneer ACO program (see story, p. 1) could work for pediatric, he says, as long as there are some clarifications since, for instance, retroactive assignment of patients doesn't work in pediatric. CMS does not yet have a mechanism for state agencies to get involved in the pediatric ACO project, but this could come, he suggests.

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## CMS Bundled-Payment Program Seeks to Remove Cooperation Barriers

The Pioneer ACO program has a new cousin, as CMS continues to slice and dice the evolving accountable care concept into more and more focused iterations. In the latest move, HHS on Aug. 23 unveiled a new demonstration program called the Bundled Payments for Care Improvement initiative. Made possible by the Affordable Care Act, it seeks to align payments for services delivered across an episode of care, such as heart bypass or hip replacement, rather than paying for services separately.

The CMS Center for Medicare and Medicaid Innovation's Request for Applications (RFA) outlines four broad approaches to bundled payments — ranging from fully bundled to various versions of partially bundled. "Providers will have flexibility to determine which episodes of care and which services will be bundled together," an agency statement adds. "By giving providers the flexibility to determine which model of bundled payments works best for them, it will be easier for providers of different sizes and readiness to participate in this initiative."

During an Aug. 23 news teleconference, Richard Gilfillan, M.D., the innovation center's acting director, noted that interested organizations can bid directly on Model 1, the fully bundled version. "We expect applicants to provide a bid for a specific discount," he said. "In models 2, 3 and 4, we will provide information to applicants that gives them the ability to analyze their current cost of care, and we expect them to submit bids with discounts off their prior-experience rates."

CMS, he added, "won't prejudge what those savings opportunities will be." There is some information available about expected minimum discounts in the printed materials that CMS has made available to potential applicants. Letters of intent are due Sept. 22 for Model 1 and Nov. 4 for the other models.

The innovation center is encouraging hospitals, physicians, physician-hospital organizations, post-acute care providers and others to apply. "The program is open to a lot of different individuals and convener organizations," said Valinda Rutledge, director of the innovation center's Patient Care Models Group. "We've tried to make it as open and as flexible as possible."

Said Gilfillan, "Of all the suggestions we've gotten in first nine months of the innovation center's engagement, we have heard more about the opportunities represented by a bundled-payment approach than

any other topic. It's central to what people believe will actually make care better."

And organizations are already doing it, he added. For example, a Medicare heart bypass surgery bundled-payment demonstration saved the program \$42.3 million, or roughly 10% of expected costs, and saved patients \$7.9 million in coinsurance while improving care and lowering hospital mortality, the feds reported.

Of course, when the goal is lower costs, providers get nervous. "The incentive to participate is hospitals and physicians have felt they wanted to work together to redesign care, but they've faced too many barriers," Rutledge said. "This program eliminates those barriers." Added Gilfillan, "Some of the models include services hospitals aren't being reimbursed for today."

The news-conference panelists noted that a key issue in system realignment is getting doctors at the table with hospitals. "The opportunity we're extending is to facilitate that," Gilfillan added. "That redesign can result in significant additional savings for program participants. We're setting up a competition for people to say, 'We think that by coming together we can redesign systems in a way to deliver a bundle of services for less than it costs today.'"

Providers are expected to be pumped. "As a former hospital CEO who's done this before, I can attest to the excitement around the table when you sit down with physicians and talk about redesigning care without barriers," Rutledge said. Added Nancy Nielson, M.D., Ph.D., the innovation center's senior adviser, stakeholder engagement: "Physicians and hospitals have not always had the most equal relationship. The point of this program is no more barriers between the people who need to redesign care."

CMS expects hundreds of organizations to be involved once the program is up and running. Model 1 is slated to ramp up first, in January, with awardees announced late this year. The other models will take longer to start, but CMS expects notifications in late spring or early summer 2012. Officials hope a successful program then will diffuse into the private sector.

Visit the Bundled Payments for Care Improvement initiative website at [www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html](http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html). Interested parties may obtain answers to specific questions by emailing CMS at [BundledPayments@cms.hhs.gov](mailto:BundledPayments@cms.hhs.gov).

## Pioneer Applicants Say, 'We're Ready'

*continued from p. 1*

other hand, is "a breakthrough," Van Wagner comments. "We can edit the list and say, 'We're ready to go. We know who these people are, and we know how we need to take care of them.'"

There is one thing NTSP would change if it could on Pioneer. "We really wanted CMS to go to a capitated payment arrangement very early on," Van Wagner points out. "We're not still convinced that shared savings will maximize the care we give our patients — nor the savings. We'll do it for the first year if required, but it will be a lost year for us as far as maximizing those two things."

If it could go to capitation from day one, she adds, NTSP would have much more flexibility — and could produce more savings and better care for patients because it would have more margin to provide additional benefits. Payments shift to capitation in year two of the Pioneer program, she notes.

But that one complaint doesn't dampen NTSP's enthusiasm for the program. "The CMS staff are quite knowledgeable about what would and would not work for providers," Van Wagner says. "My concern, honestly, about a 'shared savings' program was that the government does neither [i.e., share or save] really well. But I don't think the CMS staff falls into that category. They were knowledgeable, creative and responsive. We're very pleased."

### ISHN Cites Move to 'Fee-for-Value'

Rob Slattery, president at Johnson City, Tenn.-based Integrated Solutions Health Network (ISHN), is pretty pleased as well. "What we're talking about is a transformative effort on the part of CMS as a payer and us as a system, a network of professionals delivering care to a particular population," he says. "We're going from fee-for-service to fee-for-value and having responsibility for the whole continuum of care for that population."

ISHN's Pioneer ACO, which is subject to CMS approval, will be known as AnewCare Collaborative. "As part of our strategic transformation process, we have developed an entity designed to pull together the infrastructure of providers needed to deliver on the promise of accountable care," Slattery tells *ABN*. Participants include hospitals, primary care and specialist providers, post-acute care providers, behavioral health providers, home health agencies, hospice providers, pharmacies and wellness centers.

Another new entity also will smooth ISHN's path to Pioneer ACO status. "As we go down this path, we have one foot in the old reimbursement system and one in the new," Slattery explains. "Recognizing that our current

reimbursement structure is fee-for-service, the challenge is how you go down the new path when the preponderance of your revenue is still associated with the old model."

So ISHN developed CrestPoint Health, a third-party health plan administrator that now manages the health of all Mountain States Health Alliance (MSHA) employees, or about 15,000 covered lives. MSHA is the 13-hospital health system parent company of ISHN and the ACO. CrestPoint will contract with AnewCare as a payer in the ACO. "Not all payers are doing innovative things like CMS," Slattery says. "We recognized that we had to do some of this ourselves, so we created a benefits administrator so we could partner with AnewCare to test new payment models."

The finances of a Pioneer ACO already have generated some follow-up questions from CMS to ISHN, Slattery reports. "We did submit two alternative payment models that we felt better aligned to our current capabilities," he explains. "We had a question about our ability to really be a risk-bearing entity in the states we serve today." The MSHA market spans from the northeast Tennessee corridor into the southwest Virginia corridor. "We responded in the affirmative that we have been, for the last six months, developing the capability to be a risk-bearing entity both as a network and as a benefits administrator under CrestPoint."

### Most ISHN Contracts Would Be Risk-Bearing

As part of its overall transformation strategy, ISHN will be transitioning most of its contracts to not only risk-sharing, Slattery reports, but also risk-bearing. "We began by thoroughly researching key aspects around licensure as a risk-bearing entity in Tennessee and Virginia, to ensure we understood the requirements and associated costs," he says. "Because that can be a time-consuming process, we decided to engage external expertise, including attorneys and consultants, to help us expedite our work, including the development of a shell licensed organization."

So now AnewCare Collaborative will be able to engage in licensed risk-bearing activities much sooner than the traditional application process for a new license. "We have been told that once the shell licensed organization is purchased, it would have to be registered in the state of domicile, and that process has a range of time requirements with a number of variables we won't know until the shell is identified," he adds. "It is our expectation to have our license in place sometime between the first quarter of 2012 and the first quarter of 2013."

From here, Slattery says, ISHN will continue to move aggressively on its ACO development activity. "We anticipate that our physician-led and -directed activities will allow us to offer new ACO-centric products and services to the MSHA team-member population beginning in 2012,"

he reports. "One of our objectives is to build a truly payer-agnostic model, meaning that as we continue to pursue a partnership with CMS, self-funded employers, state governments or commercial insurers, we will have developed an infrastructure that can deliver improved care, greater value and better results."

ISHN sees its prospective Pioneer ACO participation as a piece of a far bigger program to reorganize the way it operates. "Some of the systems we have in place today for measuring quality have to be improved," Slattery says, "and that aligns with some of the patient-safety initiatives we have under way. And in our primary care practices, as

we develop medical homes, we're going down the path of implementing newer technologies that allow us to have a better view of individual patients."

He adds: "We felt that that in itself is a very challenging initiative, but if we do it parallel to our transformation to a payer-agnostic ACO, when we come out on the other end, we'll have crossed the hurdles that allow us to have better outcomes. We felt the Pioneer ACO allowed us more opportunities to be innovative."

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## NEWS BRIEFS

◆ **An ACO-type pilot partnership of Blue Shield of California, hospital system Catholic Healthcare West (CHW) and Hill Physicians Medical Group cut hospital readmissions for the 41,500 California Blue Shield members involved by 13% and lowered the number of elective surgeries by 13% in 2010, its initial year,** the *Los Angeles Times* reported Aug. 1. The three organizations, according to the newspaper, also said the program for plan members served by Hill Physicians providers affiliated with CHW reduced health care costs by \$20 million in 2010, the top of an earlier \$18 million to \$20 million estimate (*ABN 4/11, p. 11*). Of the total savings, the Blues plan got \$15.5 million under the terms of an agreement with the California Public Employees' Retirement System (CalPERS), while the other \$5 million was shared among all three partners.

◆ **Overestimation of abilities to manage risk, use electronic health records, report performance measures and implement standardized care management protocols are four of the major mistakes organizations may make in becoming ACOs,** two health researchers said in a commentary published in the Aug. 17 issue of the *Journal of the American Medical Association*. Authors Sara Singer, Ph.D., and Stephen Shortell, Ph.D., also listed six other potential errors. They include failures to balance the interests of hospitals, primary care and specialist physicians in creating both governance and management processes; "make contractual relationships with the most cost-effective specialists"; and navigate the new regulatory and legal environment. The last two mentioned are failures to integrate beyond the structural level and to "recognize the interdependencies and therefore the potential cumulative 'race to the bottom' of the above mistakes." View the article at <http://jama.ama-assn.org/content>.

◆ **Not all providers may be ready to take on shared risk in developing ACOs, the Commonwealth Fund concluded in a study released July 25.** The study examined eight shared-risk payment arrangements among health care providers and payers in the private sector. Although the shared-risk/shared-savings concept is a part of CMS's proposed Medicare Shared Savings Program, the study found that current shared-savings models may not be quite ready because they "do not currently have the infrastructure required to take on and manage risk successfully, though some payers are providing infrastructure and other support to providers." Experimentation and flexibility will be key, and "it is unlikely there will be a 'one size fits all' model," the study said. View the report at <http://tinyurl.com/3mplg2c>.

◆ **Existing federal laws and regulations could slow or even prevent the formation of ACOs serving the neediest Americans,** according to a new report published by the Health Economic & Family Security Program at Berkeley Law's Warren Institute on Law and Social Policy. The report, "Breaking Down Barriers to Creating Safety-Net Accountable Care Organizations," suggests ways of streamlining implementation to aid what it considers the most vulnerable ACOs — those involving "safety-net" providers such as community health centers and clinics caring for the neediest populations. Among the obstacles the report cites are older laws governing physician compensation that it says might prevent the newer kinds of partnerships that ACOs require. The report recommends implementation of incentives and rewards for specialists who cooperate with safety-net providers; the creation of special "fair competition" safety zones for ACOs in rural areas; and guidance on the tax status of safety-net ACOs. Contact Susan Gluss at [sgluss@law.berkeley.edu](mailto:sgluss@law.berkeley.edu).

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