

# VALUE-BASED CARE NEWS

Accountable Care • Medical Homes • Bundled Payments • Shared Savings • Global Payments

## Contents

- 3** Success in MSSP Involves Laser Focus, Patience — and Luck
- 4** Table: Top 25 MSSP ACOs by Savings, Performance Year 2
- 6** N.C. OKs Medicaid Reforms With ACOs, Insurers
- 7** Mass. Health Care Law Prompts Increase in Alternative Models
- 8** Selected Recent Health Plan ACO Arrangements, Collaborative Agreements
- 9** Study: ACOs May Need To Adopt Stronger Physician Incentives
- 10** Health Insurance Exchanges May Be Good Fit for Plans With ACO
- 12** News Briefs

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## Medicare Advantage Plans Can Offer Value-Based Insurance Designs for 2017

Medicare Advantage plans in seven states will have the flexibility to offer targeted extra benefits or reduced cost-sharing to enrollees with specific chronic conditions under a new value-based care model unveiled by CMS Sept. 1. One Medicare program expert tells VBC that although Medicare Advantage plans participating in the program won't get extra pay from CMS, there are other benefits such as possible cost savings and potentially higher quality ratings.

The Value-Based Insurance Design (VBID) Model will test whether providing these benefits to chronically ill Medicare Advantage members can lead to higher-quality and more cost-efficient care, according to CMS, which hopes it will improve beneficiary health, reduce utilization and reduce costs.

"The VBID model marks the first time CMS will test a [value-based] model in the Part C space," Sheila Hanley, director of the policy and programs group at the Center for Medicare and Medicaid Innovation, told attendees Sept. 24 at an informational webinar on the new model. "A successful test has the potential to improve care and outcomes for 18 million Medicare Advantage enrollees."

The program will begin on Jan. 1, 2017, and run for five years in seven states chosen for their regional diversity and different Medicare Advantage penetration rates: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee.

CMS expects to release the request for proposals for the program this month, and Medicare Advantage plans that wish to participate will need to apply by December. There's no limit to the number of plans that can participate — CMS is seeking a broad

*continued on p. 11*

## Horizon, NJ Providers Form Alliance to Offer Lower-Cost Health Care Coverage

A new alliance in New Jersey is aiming to step outside the fee-for-service box by bringing together a handful of stakeholders united in their goal to keep members healthy while lowering the total cost of care. The OMNIA Health Alliance, which includes Horizon Blue Cross Blue Shield of New Jersey, six health systems and one medical group, is a "unique, first-of-its-kind statewide alliance...committed to radically altering how health care is financed and delivered in New Jersey," says the health plan. And while some providers have raised questions about the effort, including potential member costs and access to care, Horizon maintains that those concerns are unwarranted.

OMNIA basically "came about because Horizon is listening to our customers," says Minalkumar Patel, M.D., senior vice president and chief strategy officer for the health plan. Both businesses and individuals had been complaining about health care costs and what they perceived as a lack of value, he says. On the Horizon website [www.whathealthcarecostsnj.com](http://www.whathealthcarecostsnj.com), the health plan cites a January 2015 *Issue Brief* from The Commonwealth Fund that reveals "46 states pay less for health care than New Jersey."

*continued*

The insurer points to various reasons why this is the case: In addition to the common problems of waste, errors, “unreasonable costs,” “complex and inefficient systems” and harmful habits that lead to poor lifestyles, there were some New Jersey-specific ones. For example, residents use more medical care than residents in other states. Readmissions are high. Insurers “provide more coverage than other states.” Out-of-network regulations “are abused by a handful of doctors and hospitals.”

OMNIA is “a new way of thinking about how to work with our delivery system partners,” says Patel. The plan will offer a “series of products consistent with the triple aim: better quality, costs and member experience.”

Horizon put together an evaluation process that assessed potential partners based on characteristics such as “quality, scale, the ability to provide comprehensive services and an overall commitment to value.” Patel clarifies that the “initial process was run entirely internally by us.” The plan wanted to create “a value-based network to get at the triple aim in health care,” he explains. Once it had a list of organizations, Horizon engaged them in a “series of conversations.” It wasn’t until “late in the process that invitees knew who other invitees were.”

In addition to Horizon, OMNIA consists of the multispecialty physician group Summit Medical Group and

the following health systems, which represent 22 hospitals, and their aligned physicians:

- ◆ *Atlantic Health System,*
- ◆ *Barnabas Health,*
- ◆ *Hackensack University Health Network,*
- ◆ *Hunterdon Healthcare,*
- ◆ *Inspira Health Network,* and
- ◆ *Robert Wood Johnson Health System.*

“These are high-quality institutions with great reputations,” says Patel.

Horizon says it will introduce new health plans this month that will provide access to all of its current hospitals and physicians “at essentially the same level of benefits [members] have today.” However, members in the new plans will have lower premiums, giving them “the ability...to save significant out-of-pocket costs by using select Tier 1 hospitals and doctors.” Members will still be able to see Tier 2 hospitals and doctors, but their out-of-pocket costs will be comparable to Horizon’s standard 2016 plans. “The lower out-of-pocket costs for premiums...will offset” the higher costs that come with using Tier 2 providers. “Since this is a tiered network, we still have the broad network in play” of Tier 2 hospitals, Patel says, adding that Horizon expects “most members to remain in” these products over the next few years. According to a “fiction vs. fact” Web page on OMNIA, Horizon says it expects 256,000 OMNIA enrollees in 2016, with 40,000 of those previously uninsured. The plan has 3.8 million members.

“We’re a single-state Blue plan,” notes Patel, so “our mission is to serve the entire space.” With this in mind, when the new products are rolled out, the following health systems also will be included in Tier 1:

- ◆ *AtlantiCare,*
- ◆ *Cape Regional Medical Center,*
- ◆ *Cooper University Health System,*
- ◆ *Englewood Hospital,*
- ◆ *Meridian Health,*
- ◆ *Shore Medical Center,*
- ◆ *St. Joseph’s,* and
- ◆ *Princeton HealthCare System.*

### Concerns Around Coverage, Costs Exist

Still, some concerns remain.

A spokesperson for the New Jersey Hospital Association tells VBC that “NJHA has not taken a position on the OMNIA network. As a new approach to plan design, we do believe there are certain issues that need to be monitored as it plays out — namely, geographic coverage and access to care; whether it will exacerbate out-of-network

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issues; and education and awareness — so that consumers fully understand their coverage and the potential out-of-pocket impact.”

“We are watching very closely Horizon’s announcement, as well as the immediate responses from policymakers and hospital executives,” says the Medical Society of New Jersey in a statement to *VBC*. “We share the concern of many of the skeptics that this new product may not have meaningful access for patients in each tier, as far as geographic and cost considerations go. We have been saying for years that we have network adequacy problems in this state, and that they are only being exacerbated as narrow and tiered networks are introduced. We hope policymakers begin to demand true access for all New Jerseyans.”

Patel comments that there is the “misconception that this is a narrow network,” but it is actually a tiered network. Horizon has “taken nothing away” and actually will be offering “more choice,” he tells *VBC*. And concerns that it will have a “catastrophic impact” on Tier 2 hospitals are “not founded on any fact or reality,” he maintains.

### Plan Considered ‘Vertical Integration’

Before Horizon decided to form this alliance, it “evaluated different options,” says Patel, one of which was “vertical integration” by “purchasing a health system.” However, “our expertise is as a payer,” so the plan “did not see an opportunity to vertically integrate.”

Patel declines to offer specifics on reimbursement but says that “similar to our other value-based relationships, we have a series of objectives we want our partners to deliver on” that get at the triple aim. Horizon has “developed incentive models based along specific metrics,” and “over time we may develop” models involving both upside and downside risk. For now, though, the insurer “will be tracking the total cost of care” across various quality measures; it will also survey members on their experience and satisfaction. While Patel will not disclose specific expectations for Horizon’s return on investment, he says that the “pricing differential between the broader” offering versus premiums for Tier 1 use will be a good indication of what ROI it’s anticipating.

Horizon certainly is no stranger to value-based care models. “Historically over the last half decade, Horizon has been involved in patient-centered medical homes, accountable care organizations and other patient-centered models,” points out Patel. “We think of OMNIA as a next-generation” program; “we’re taking it to the next level.” The offering is a “more comprehensive” approach that’s “across our entire continuum of care.”

With OMNIA, Horizon has contracted with the other participants “as alliance partners,” says Patel. “We’re not

constructing joint ventures.” For that reason, it’s “hard for us to know” what kinds of investments in OMNIA, including people, resources and systems, the other groups have made.

And although OMNIA is fairly new, Horizon has gotten “lots of inquiries” around the model. Still, “we’re very much learning as we go,” says Patel. “We’re very excited” and have put “a lot of thought and energy” into the approach. That said, “We have a lot to learn before we start giving advice.”

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## Success in MSSP Involves Laser Focus, Patience — and Luck

How can an accountable care organization succeed — in other words, earn a shared-savings bonus — in the Medicare Shared Savings Program (MSSP)?

That’s the question many ACOs are asking themselves following the late August release of the MSSP second performance year results (see table, p. 4), in which only slightly more than one-quarter of MSSP ACOs earned shared-savings payments (*VBC 9/15, p. 1*), a similar percentage to “successful” ACOs in the first performance year of the program.

Out of the 333 total ACOs participating in 2014, 92 earned performance payments of more than \$341 million, for an average shared-savings payment of \$3.7 million. Another 89 ACOs saved money, but not enough to beat their benchmarks and earn shared savings.

Some ACO leaders blamed flaws in the program — particularly, benchmarks that don’t necessarily reflect the reality of Medicare spending in a region or prior performance of the ACO.

But interviews with ACO analysts and executives indicate it’s not that simple. The CMS-set benchmarks account for some of the difficulty associated with earning shared savings, but are far from the full picture.

“There are a lot of ACOs out there doing all the right things, and they’re not making any money out of it,” says Erik Johnson, vice president for network and population health consulting at Optum, Inc. These “right things” include working to lower hospital readmission rates, to improve care coordination and to steer patients away from the emergency department.

Strong performance on the MSSP quality measures also doesn’t seem to make any difference in the chances of earning shared savings, he adds.

But Scott Hines, M.D., who serves as co-chief clinical transformation officer for Crystal Run Healthcare in Middletown, N.Y., says that just because ACOs are doing

the right things doesn't mean they're doing those things well.

"It sounds easy to reduce avoidable admissions, reduce readmissions, reduce ER utilization and reduce subacute rehab. But I can tell you that this is really, really hard, even when you know who the high-risk patients are," Hines tells VBC. "I think that the ACOs that are

succeeding are doing this well, and those that are not succeeding are not." Hines' ACO did not earn a shared-savings bonus in either performance period.

Hines says many organizations that earned shared savings have been involved in risk-based contracting for some time "and already have the infrastructure in place to succeed. When you are just starting out with this new

### Top 25 MSSP ACOs by Savings Generated, Performance Year 2

Medicare Shared Savings Program (MSSP) Accountable Care Organizations	States Where Beneficiaries Reside	Agreement Start Date	Track	Participate in Advance Payment Model?	Generated Savings in Performance Year 2	Earned Shared Savings in Performance Year 2	Generated Savings in Performance Year 1	Earned Shared Savings in Performance Year 1
Memorial Hermann Accountable Care Organization	TX	7/1/2012	Track 1	No	\$52.93M	\$22.72M	\$57.83M	\$28.34M
Palm Beach Accountable Care Organization, LLC	FL	7/1/2012	Track 1	No	\$32.17M	\$14.46M	\$39.17M	\$19.34M
Physician Organization of Michigan ACO	MI	1/1/2013	Track 1	No	\$27.07M	\$12.06M	n/a	n/a
Oakwood Accountable Care Organization, LLC	MI	7/1/2012	Track 1	No	\$19.07M	\$81.48M	\$17.49M	\$8.57M
Millennium Accountable Care Organization	FL	1/1/2013	Track 1	No	\$17.49M	\$7.98M	n/a	n/a
ProHEALTH Accountable Care Medical Group, PLLC	NY	7/1/2012	Track 1	No	\$17.15M	\$8.01M	\$21.91M	\$10.74M
Allcare Options, LLC	FL	7/1/2012	Track 1	No	\$16.99M	\$6.06M	TBD	\$0*
Qualuable Medical Professionals, LLC	VA, TN	1/1/2013	Track 1	No	\$16.62M	\$7.41M	\$13.69M	\$6.71M
Accountable Care Coalition of Texas, Inc.	TX	4/1/2012	Track 1	No	\$16.04M	\$6.33M	\$19.10M	\$9.36M
Mercy Health Select, LLC	OH, KY, MI	7/1/2012	Track 1	No	\$15.44M	\$6.52M	\$0	\$0
West Florida ACO LLC	FL	4/1/2012	Track 1	No	\$14.15M	\$6.33M	\$8.10M	\$3.97M
Collaborative Health ACO	MA	1/1/2013	Track 1	No	\$13.90M	\$6.29M	n/a	n/a
RGV ACO Health Providers, LLC	TX	4/1/2012	Track 2	Yes	\$13.77M	\$7.53M	\$20.24M	\$11.90M
Quality Independent Physicians, LLC	KY, IN	7/1/2012	Track 1	Yes	\$13.61M	\$6.06M	\$0	\$0
Delaware Valley ACO	PA, NJ	1/1/2014	Track 1	No	\$13.40M	\$6.57M	n/a	n/a
Physicians ACO, LLC	TX	7/1/2012	Track 1	Yes	\$13.22M	\$4.85M	\$12.01M	\$0*
Methodist Patient Centered ACO	TX	7/1/2012	Track 1	No	\$12.61M	\$5.26M	\$12.72M	\$6.23M
Reliance ACO LLC	MI	1/1/2014	Track 1	No	\$12.17M	\$5.96M	n/a	n/a
Maryland Collaborative Care, LLC	DC, MD	1/1/2013	Track 1	No	\$11.87M	\$4.51M	n/a	n/a
Premier Patient Healthcare, LLC	OK, TX	1/1/2014	Track 1	No	\$11.85M	\$5.81M	n/a	n/a
Lahey Clinical Performance Accountable Care Organization, LLC	MA, NH	1/1/2013	Track 1	No	\$11.72M	\$5.17M	n/a	n/a
Accountable Care Coalition of Southeast Wisconsin, LLC	WI	4/1/2012	Track 1	No	\$11.71M	\$4.42M	\$17.70M	\$8.67M
Integral Healthcare LLC	FL	1/1/2013	Track 1	No	\$11.30M	\$4.63M	n/a	n/a
Genesis Accountable Physician Network, LLC	TX	1/1/2014	Track 1	No	\$10.92M	\$5.35M	n/a	n/a
Seton Accountable Care Organization, Inc.	TX	1/1/2014	Track 1	No	\$10.57M	\$5.18M	n/a	n/a

\*Failed to successfully report quality.

M = million.

NOTE: ACOs that started after 2012 did not generate results for Performance Year 1.

SOURCE: Compiled by Atlantic Information Services, Inc., based on data supplied by CMS.

model of health care delivery, the investment in personnel and infrastructure is immense, and it takes time to build the processes needed to coordinate and lower the cost of care."

For successful ACOs, Hines believes about half their success is due to their skill in managing patient care, and the other half is due to the benchmark and to the number of patients actually attributed to the ACO.

Leavitt Partners LLC Director of Research David Muhlestein agrees with Hines that program design is important. "The secret sauce is not in what you're doing, it's in how you're doing it." Successful ACOs' benchmarks play into that, but are not the key to success, he says. "Memorial Hermann [the top performer in both performance years so far] might not have saved so much money with a different benchmark, but they still would have saved," he says.

### **Some Reasons Are Within ACOs' Control**

Stephen Nuckolls, CEO of Coastal Carolina Health Care, an MSSP ACO in New Bern, N.C., that also has not earned shared savings so far, tells *VBC* he sees numerous reasons why more ACOs weren't successful in earning a check from CMS, including several that are within the control of the ACO.

For example, Nuckolls points to the time it takes to accomplish organizational change and the time it takes to see results from the initiatives implemented. In addition, he says, "some ACOs have entered the program to gain experience and may not be fully committed and engaged to make the difficult investments and changes necessary."

### **Other Reasons Are Not**

However, other reasons Nuckolls cites are not in control of the organization, such as the cost of care in a particular area of the country. "Low-cost areas may be low because of access issues. The costs in these areas may be appropriately growing at rates faster than the national average as their 'standards of care' get closer to other areas," he says.

Also, "the ACO benchmarking and rebasing calculations are weighted in CMS's favor," he says. "What this means is that if you keep your patients healthy and they do not develop further complications such as renal and heart failure, CMS rewards you by lowering your benchmark. If this were not the case, I believe CMS would be showing greater savings than they are currently."

Characteristics shared by MSSP groups that earned shared savings include committed leaders who are focused on change, and a sufficient budget for care coordination and the necessary analytical support, says Nuckolls.

But local conditions out of an ACO's control also play into the equation, such as "historical costs in certain areas — like very high home health or skilled nursing home historical costs — that lend themselves to specific and more easily implemented cost containment strategies," he says.

It's certainly not all due to skill, Nuckolls says. "There are obviously some ACOs that achieved savings due to little effort on behalf of the ACO. I know one ACO that did not report quality metrics and had effectively dropped out of the program and still showed savings. Other ACOs such as Cornerstone [Health Care] in High Point, N.C., started with a very low benchmark and through committed leadership and a number of specific and targeted strategies was able to achieve shared savings," he notes.

Hines cites another factor out of ACOs' control: retrospective attribution and the turnover rate of patients attributed to the ACO. "This leads to devoting time and resources to patients that may not wind up being attributed to the ACO at the end of the measurement year." Prospective attribution will be offered in MSSP Track 3, but is not available to ACOs accepting only upside risk in the program.

### **Benchmark Is 'Big Issue'**

And of course, there's the benchmark. "That's the big issue: How do you deal with that benchmark?" says Johnson.

Organizations that historically have spent more than average can do very well in MSSP, provided they can get their spending under control, Johnson says. But organizations that already are managing care well and as a result have historically lower costs are going to struggle, because they'll be faced with a lower benchmark, he says.

"I've told clients, 'You've been really good at this. You may not do all that well in MSSP,'" because the benchmark set by CMS will reflect those good historical results, making it much harder for the client to beat the benchmark and achieve savings, he says.

In addition, under CMS's rules governing the benchmarks set for every MSSP ACO, risk adjustments for established patients can only go down, not up, even if a patient gets sicker. Meanwhile, new patients entering the ACO tend to be younger and less complex, so their scores are lower (*VBC 1/15, p. 1*).

The net result is that the risk adjustment score for the ACO falls each year, which makes it much more difficult to earn shared savings.

Nuckolls adds that some ACOs were very successful in increasing their preventive care and other quality metrics while lowering avoidable emergency department visits and hospitalizations, but did not earn shared sav-

ings. "I think most industry observers, including CMS, would consider this ACO successful, but if the cost of the additional preventive health was greater than the savings on the emergency department visits and hospitalizations, then the ACO might even have to pay money back to CMS under the current rules, assuming they have a two-sided contract."

It may still make sense for organizations to get into MSSP, even without the expectation of a return on their investment in the form of shared savings, Johnson says. CMS had made it clear that it's moving as many providers as possible to a value-based system (*VBC 2/15, p. 1*), and organizations need to be prepared.

In fact, the best ACOs are using MSSP as a springboard to contract with commercial payers and figure out how to approach large employers, he says. "There are learning opportunities on the table to integrate all payers" into value-based payments.

### History Is Against ACOs

So how do ACOs succeed? Patience, and lots of it, plus a narrow focus on one or two clinical areas where they can make a significant difference.

"It's going to take time," Johnson says. "If anyone thought that 75% or 80% of these ACOs were going to save money in the second year [of the MSSP program], then they're not well-steeped in the history of American health care."

Hines advises ACOs to identify their biggest opportunities for saving — which could be inpatient utilization, emergency room utilization, rehabilitation services or imaging — and then address one or two of those comprehensively.

"Don't chase every shiny new penny!" he says.

Muhlestein agrees, saying that ACOs should "look for early victories. When you're an ACO director and you've got 1,000 things you want to improve, if you focus on all of them at once, you're going to fail at all of them. Choose an area that potentially has a very high rate of return. People aren't as hesitant to change if they think change is going to make them better off."

According to Nuckolls, "Groups need to continue to study their cost and quality data and look for areas of improvement and then design strategies to improve in these areas, with the knowledge that sometimes increased spending and investments in care will be necessary."

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## N.C. OKs Medicaid Reforms With Combination of ACOs, Insurers

After several years of debate on whether to include accountable care in the state's Medicaid program, North Carolina lawmakers have approved a compromise Medicaid reform plan in which provider-led entities (PLEs) will co-exist with commercial insurers in a fully capitated system.

Under the reforms, which still need approval from CMS, North Carolina's Primary Care Case Management system will be phased out, and care management for most of the state's 1.9 million Medicaid beneficiaries will be turned over to three statewide managed care organizations (MCOs) and up to 10 regional PLEs.

The plan, which represents a combination of the two main competing approaches for North Carolina Medicaid reform (*VBC 2/15, p. 7*), did not please providers, who had hoped to have a new system based completely on value-based PLEs.

"We oppose the General Assembly's decision to involve corporate managed care in our Medicaid program," says Robert Seligson, CEO of the North Carolina Medical Society, although he concedes that "including some of the patient protections we requested such as performance standards based on quality, cost and patient experience is an improvement."

The North Carolina Medicaid reform plan was approved 33-15 in the state Senate and 65-40 in the House. House leaders had preferred a plan that turned over all patient management to accountable care organizations (*VBC 4/14, p. 1*). Gov. Pat McCrory (R) is expected to sign the legislation.

According to the reform plan:

- ◆ *The state's Medicaid agency will contract with three commercial health plans to provide care statewide to Medicaid beneficiaries.*
- ◆ *The Medicaid agency also will contract with up to 10 PLEs to provide care in specific regions.* A PLE can bid for more than one regional contract, as long as the regions are contiguous.
- ◆ *Medicaid beneficiaries can opt into, or will be assigned, to both the commercial insurers and to the regional PLEs.*
- ◆ *Contracts with both commercial insurers and PLEs will be capitated.* Plans will be required to hold spending at least two percentage points below national Medicaid spending growth.
- ◆ *All contracts will include defined measures and goals for risk-adjusted health outcomes, quality of care, patient satisfaction, access and cost.* Contracted organiza-

tions can be penalized for poor performance under these measures.

◆ *In 2016, North Carolina will cut per-member, per-month payments to North Carolina Community Care Networks, Inc., which provides Medicaid primary care case management, by 15%.* This pay cut, plus new performance measures, presage the transition of care management to the pre-paid health plans.

Beneficiaries who are dually eligible for Medicare and Medicaid are not included in the reforms. Under the legislation, the state will create a Dual Eligibles Advisory Committee to develop a long-term strategy to cover dual eligibles through the capitated pre-paid health plan contracts. A report is due by Jan. 31, 2017.

The reforms won't kick in for several years. The legislation calls for the state's Department of Health and Human Services to submit its waiver proposal to CMS by June 1, 2016. Once North Carolina receives the go-ahead from CMS, the department then has another 18 months before it opens enrollment in the pre-paid health plans.

### Many States Look to MCOs

Despite disappointment from the North Carolina Medical Society over the decision to involve commercial players in the state's Medicaid program, Laura Summers, director of state intelligence at Leavitt Partners LLC, says North Carolina isn't alone in its approach.

"When people think of ACOs, they think of provider-led entities. But that's not always true in Medicaid — a lot of states have MCOs involved," Summers tells *VBC*.

In Utah, for example, the state modified its Medicaid MCO contracts to include ACO features related to quality and distribution of payments. In New Jersey, ACOs operating within the Medicaid program must contract with the state's MCOs for per-member, per-month payments (*VBC 9/15, p. 3*). And Illinois' accountable care Medicaid program involves "a series of traditional managed care plans," Summers notes.

Summers says the focus on accountable care "is here to stay" within state Medicaid programs, but many states feel more comfortable contracting with more traditional managed care organizations than with newer, provider-led organizations.

"States are really looking for cost containment and administrative ease," she says. "It's easier to push that responsibility onto an MCO with experience managing a Medicaid population."

In a white paper on Medicaid managed care published in September, Summers and colleague Douglas Hervey, a director at Leavitt Partners, analyzed 14 states with active Medicaid ACOs or ACO-type elements in their Medicaid programs. The programs themselves

range from fee-for-service with per-member, per-month care management fees to full capitation.

Based on this analysis, there are four major challenges involved with integrating value-based care into state Medicaid programs, Hervey says. These include:

- ◆ *Determining how to deploy analytics,*
- ◆ *Including behavioral health in care management,*
- ◆ *Integrating long-term services and supports into value-based care, and*
- ◆ *Managing the dual-eligible population,* which accounts for 15% of the overall Medicaid population but much more in spending.

Although states do want to improve Medicaid population health, they're most interested in saving money, especially since Medicaid accounts for about one-quarter of state budgets, Hervey tells *VBC*. "ACOs by their inherent nature and structure are cost-cutting efforts. Not all states are shifting risk to providers, but we are seeing more and more models experimented with."

View the North Carolina legislation at [www.ncleg.net/Applications/BillLookup/LoadBillDocument.aspx?SessionCode=2015&DocNum=6316&SeqNum=0](http://www.ncleg.net/Applications/BillLookup/LoadBillDocument.aspx?SessionCode=2015&DocNum=6316&SeqNum=0).

Contact Seligson via North Carolina Medical Society spokesperson Elaine Ellis at [eellis@ncmedsoc.org](mailto:eellis@ncmedsoc.org), and Hervey and Summers via Leavitt spokesperson Jordana Choucair at [jordana.choucair@leavittpartners.com](mailto:jordana.choucair@leavittpartners.com). ♦

### Mass. Health Care Law Prompts Increase in Alternative Models

In 2012, Massachusetts approved a multifaceted health care cost containment law that put a large emphasis on shifting from fee-for-service payments to value-based payment approaches. And while the most recent annual report on the program shows that the increase in 2014 total health care expenditures (THCE) exceeded the state's benchmark, it also reveals that the overall use of alternative payment models (APMs) rose 10% from 2013 levels among commercial insurers.

The *2015 Annual Report on the Performance of the Massachusetts Health Care System* is the third of its kind from the Center for Health Information and Analysis (CHIA), a Massachusetts state agency. The figures in the report are based on an initial assessment and will be finalized next year. However, the numbers in the report will be the basis for the Health Policy Commission's annual meeting on Massachusetts health care cost trends and drivers, scheduled for Oct. 5 and 6. That independent state agency was created in 2012.

Among the findings are the following:

◆ *Massachusetts' 2014 THCE was \$54 billion, or \$8,010 per resident, a 4.8% increase from 2013.*

◆ *THCE exceeded the 3.6% Health Policy Commission-set health care cost growth benchmark for 2013-2014 by 1.2 percentage points.*

◆ *THCE growth was spurred by a 19% increase in spending for MassHealth, to \$15.3 billion; the Medicaid program also saw enrollment rise 23%.*

◆ *Commercial insurers' THCE increased to \$18.9 billion, a 2.9% rise.*

◆ *The percentage of commercial insurers' members whose care was covered under APMs increased from 34% in 2013 to 38% last year.* In the previous period, APM membership among commercial plans rose from 32% to 34%.

◆ *MassHealth MCO membership under APMs fell to 22% from 32% in 2013. But the use of APMs in MassHealth Primary Care Clinician (PCC) plan membership rose to 22% in 2014 from 14% the previous year.*

◆ *Member cost sharing rose by 4.9% last year in the commercial market.*

In addition, CHIA notes in the report that there were "some significant differences" between the 2013 preliminary numbers in the previous report and the final numbers that are included in this one. Perhaps the biggest change was in data for Blue Cross Blue Shield of Massachusetts: The last report had a preliminary 3.65% growth rate in 2013 for BCBSMA, but the actual rate of growth was only 0.7%.

BCBSMA did not respond to VBC's requests for comment, but the insurer did issue a statement after the report was released. "Today's Report underscores the challenge we face as a community to make quality health care affordable for the people and employers of Massachusetts. At Blue Cross, we recognize that we have more work to do to make care more affordable but are pleased the CHIA report highlighted that:

◆ "Our total medical spending has been reported as lower than the state's health care benchmark for two consecutive years. Importantly, based on final data, CHIA reported a significantly lower 2013 spending growth rate

of 0.7% (compared to the 3.65% that was preliminarily reported in last year's CHIA report).

◆ "We continue to lead the market with Alternative Payment Models that studies have shown improved the quality of patient care and lowered costs. We are in the process of expanding these payment models to cover most of our commercial members.

◆ "Our premium increases between 2013 and 2014 were among the lowest in the Massachusetts market."

### Pharmacy Spending Drove THCE Increase

David Szabo, a partner in law firm Locke Lord LLP who represents hospitals, integrated delivery systems, physician organizations and other health care service providers, says that one interesting finding is that "if you started with the total health care expenditures of 4.8%, this is a little over a full percent more than the statewide benchmark," which would seem on the surface to be "not very good news," particularly for policymakers. A closer look, though, reveals that the "main driver is a 13% increase in pharmacy spending, which is consistent with national numbers," he points out. But in areas over which payers can exert some control such as hospital, physician and administrative services, "cost increases were much more modest."

Szabo, who is co-chair of the health care practice at Locke Lord, tells VBC he assumes that pharmaceutical costs will get a closer look in the next report.

The Massachusetts law includes incentives for forming APMs, and another noteworthy datapoint in the report is that "alternative payment methods in the private sector increased slightly," says Szabo. In commercial plans, most APM contracting is confined to HMO products, which are in the minority in the overall commercial market. One could "speculate" that the 38% of commercial membership in APMs is "still creating a bit of a cost constraint," he says. Moving forward, it will be interesting to see how plans can increase the use of APMs in "more open-ended health insurance products."

Szabo also points to the finding that the state is "seeing continued increases in cost sharing, whether it's deductibles, copayments or both." Whether there will be pushback on this remains to be seen. But in exchange

## Selected Recent Health Plan ACO Arrangements, Collaborative Agreements

Health Plan Affiliates	Provider Affiliates	Service Area	Launch Date
Aetna, Inc.	MemorialCare Health System	CA	Oct. 1, 2015
Humana, Inc.	Doylestown Health Partners	KY, PA	Announced in September 2015
	King's Daughters' Health	IN, KY	Announced in August 2015
	North Shore-LIJ Health System	NY	Announced in September 2015
	Partners in Primary Care	TX	Announced in September 2015

SOURCE: Compiled by AIS from health plan press releases in August and September 2015.

for less cost sharing, will people be “willing to go into a limited provider network? I think we’ll see people faced with that trade-off more and more over time.”

View the report at [www.chiamass.gov/annual-report](http://www.chiamass.gov/annual-report).

Contact Szabo at [david.szabo@lockelord.com](mailto:david.szabo@lockelord.com). ✦

## Study: ACOs May Need to Adopt Stronger Physician Incentives

Accountable care organizations may not be offering their physician practices enough of a potential payoff to incent those practices to change the way their physicians operate, a study indicates.

The research, from the University of Michigan School of Public Health, found that physicians in both ACO and non-ACO practices who weren’t accepting much risk received only about 4% or less of their compensation from quality, while receiving a much greater percentage based on productivity.

“Physicians who were part of ACOs were paid very similarly to those in private payment systems,” says Andrew Ryan, associate professor in the Department of Health Management and Policy and lead author of the study. “Our take here is that ACOs may not be providing strong enough incentives for practices to go through the upheaval of changing physician compensation schemes and making other painful changes to their practices.”

The study examined 632 primary care practices, using data from the National Survey of Physician Organizations to measure compensation based on salary, productivity, clinical quality and patient experience.

The authors compared primary care compensation among three groups:

- ◆ *Practices that were not participating in a Medicare ACO and didn’t have substantial risk for primary care costs (76.1% of practices);*
- ◆ *Practices that were not participating in an ACO but did have substantial risk for primary care costs (2.8% of practices);* and
- ◆ *Practices that were participating in an ACO (21.1% of practices).*

“Although practices that were not participating in an ACO but had substantial risk for primary care costs made up a small percentage of the sample, this group was important because their financial risk created stronger incentives for cost control,” according to the authors. “This group served as a test case for how physician compensation might be structured if practices faced these incentives.”

The study found that compensation for primary care physicians varied considerably across practices included in the study.

Primary care physicians in ACO practices received, on average, 49% of their compensation from salary, 46.1% from productivity, 3.4% from quality and 1.5% from other factors, the study said. “This pattern of compensation was similar to practices that are not in ACOs and did not have substantial risk for primary care costs,” the study said.

In contrast, primary care physicians that were not in ACO practices but did take substantial risk for primary care costs received 66.6% of their compensation from salary, 32.2% from productivity, 0.8% from quality and 0.4% from other factors, the study found.

“Participating in an ACO was not significantly associated with primary care physicians’ compensation from salary,” the authors wrote. “Substantial risk for primary care costs was associated, however, with a 35.5 percentage point increase in physicians’ compensation from salary. Participating in an ACO was associated with a 2.2 percentage point increase in primary care physicians’ compensation for quality.” This pattern held up in further analysis, the study found.

It’s not clear what these findings mean for ACOs, the authors wrote.

“Current compensation policies for primary care physicians in ACOs may be the right mix of salary, productivity, and quality for both ACOs and for national policy,” they wrote. “ACOs have other mechanisms, apart from physician compensation, to manage costs, such as more effective use of electronic health records, use of nurse care managers for coordinating care for high-risk patients, and production of internal reports — seen by all physicians — on physicians’ performance.”

But it’s also possible that current incentives for ACO physicians aren’t strong enough to encourage practices to change their compensation models, the authors said. “If physicians in ACOs and physicians outside ACOs are paid similarly, will they practice differently?” they asked. “If incentives are not aligned between practices and phy-

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sicians, the ACO programs may have limited effects on costs and quality in the short term."

The study was published in the July/August 2015 issue of *Annals of Family Medicine*. View the study at <http://annfam.org/content/13/4/321.full>. Contact University of Michigan spokesperson Terri Mellow at (734) 764-8094. ✧

## Health Insurance Exchanges May Be Good Fit for Plans With ACO

With consumers and employers looking to trim coverage costs while ensuring high-quality care, public and private insurance exchanges might be an ideal vehicle for insurance plans that include an accountable care organization (ACO). Only a handful of ACO plans, however, are being marketed on either type of exchange.

David Muhlestein, senior director of research and development at Salt Lake City-based consulting firm Leavitt Partners, says the ACO model makes sense for the exchanges. The model, he explains, helps to reduce coverage costs by managing where enrollees receive care.

Aetna offers ACO products on both public and private exchanges. Its public-exchange ACO plans are sold in Arizona through an ACO relationship with Banner Health Network in Phoenix, in Houston through a relationship with Memorial Hermann and in Virginia through a relationship with Carilion Clinic and Riverside Health System. In addition, Innovation Health, the health insurer jointly owned by Aetna and Inova Health System, offers its plans on Virginia's federally run exchange.

### Medica May Expand Exchange ACOs

Medica Health Plans offers three ACO-type products through Minnesota's state-run exchange. Each is paired with a provider system, such as the Mayo Clinic. The insurer might work with providers in other parts of the state to expand its ACO portfolio on the exchange, but no decisions have been made. In 2012, Medica became the first carrier in Minnesota to make an ACO product available to the individual market. Such products have since proliferated in the state's individual market.

"We see ACOs as one of the few remaining ways to control costs under health care reform, and offer a lower premium alternative to more traditional network products," says Medica spokesperson Greg Bury. Partnering with key providers is "the best way to provide an integrated clinical/payer experience where we take the consumer out of the middle of the traditional complex relationship between providers and carriers," he says. "ACOs allow a laser-focus on improving the end-to-end health care consumer experience."

While early results are encouraging, he says the uptake, particularly on broker-sold business, has been somewhat less than expected. The market has grown accustomed to networks with almost every provider included across a state or region, and may be slow to change. However, as premiums increase, there could be more migration into the ACO plans, he adds.

One hurdle has been in convincing brokers and potential customers that the model is not a return to a 1980s-style HMO. While some ACO-based insurance products place severe limits on providers that can be seen outside the ACO, Medica's products offer broad open access for primary and specialty care. The model doesn't use a referral approach and doesn't require enrollees to select a primary care clinic.

### Perception of Short Shelf Life Exists

There is a belief within the ACO community that shared savings has a short shelf life, Muhlestein tells VBC sister publication *Inside Health Insurance Exchanges*. "Shared savings is built on the premise of taking money out of the system, so eventually you are going to take all of the slack out and reach a new baseline," he explains. Provider groups, which are being asked by carriers to take on increased risk, might decide to build their own ACO-based products and sell them on exchanges by either building or buying an insurance subsidiary or partnering with an existing carrier to process claims.

"The question is, once you've maxed out shared savings, what's next?" he asks. The ACO model might not be any more effective at holding down coverage costs than a narrow-network plan. But unlike narrow-network plans, the goal of an ACO is to use payment models to improve the quality of care while reducing costs.

As we increase the number of distribution channels for health insurance, it's going to make sense for ACOs and health plan products to take advantage of the improved distribution bandwidth, adds Dan Schuyler, a senior director at Leavitt Partners.

For coverage that began Jan. 1, Aetna offered ACOs to group retiree and other employer customers on its proprietary private exchange. The company also offers ACO products through other third-party private exchanges, says spokesperson Sherry Sanderford. In November 2014, Aetna acquired bswift, which provides a technology platform that offers a retail shopping experience for health insurance exchanges and employers nationwide. That acquisition is part of the company's private exchange strategy.

Medica also operates its own private exchange where it offers five ACO-based products and a broader network within the ACO group. Employers that choose to offer coverage through the exchange give their work-

ers a choice between the ACOs and the more expensive broader network option. To ensure adequate specialist representation, the broader option includes some specialists who are part of the ACO but not part of the major care system at its core. According to Bury, 93% of members enrolled in ACO networks re-enroll each year during open enrollment, indicating high satisfaction with the program, he says.

Contact Bury at [greg.bury@medica.com](mailto:greg.bury@medica.com), Sanderford at [sanderfords@aetna.com](mailto:sanderfords@aetna.com) and Jordana Choucair for Schuyler and Muhlestein at [jordana.choucair@leavittpartners.com](mailto:jordana.choucair@leavittpartners.com). ✧

*This article was reprinted from the August 2015 issue of Inside Health Insurance Exchanges. For more information, visit [www.AISHealth.com](http://www.AISHealth.com).*

## CMS Rolls Out VBID Program

*continued from p. 1*

test of the model. In addition, plans can apply for a narrow VBID intervention initially and then ask to expand their program in subsequent years.

Medicare Advantage plans will not receive any financial payment or incentive from CMS to participate, but if the interventions are successful, they may see a reduction in overall costs.

Under the model, plans will target members with the following specific chronic conditions:

- ◆ *Diabetes,*
- ◆ *Congestive heart failure,*
- ◆ *Chronic obstructive pulmonary disease (COPD),*
- ◆ *Past stroke,*
- ◆ *Hypertension,*
- ◆ *Coronary artery disease, and*
- ◆ *Mood disorders.*

Interventions can take four different general forms, according to CMS. They are:

**(1) Reduced cost-sharing for high-value services, supplies and Part D drugs.** This could mean \$5 copays for eye exams for diabetics, or zero copays for ACE inhibitors for enrollees who have previously experienced an acute myocardial infarction.

**(2) Reduced cost-sharing for high-value providers.** This could mean zero copays for diabetics who visit primary care physicians with a track record of controlling hemoglobin A1c levels, or zero copays for non-emergency surgeries at cardiac centers of excellence.

**(3) Reduced cost-sharing for disease management participation.** This could mean elimination of primary care copays for diabetes patients who meet regularly with a case manager.

**(4) Coverage of extra supplemental non-covered high-value benefits.** This could mean extra coverage of smoking cessation for COPD patients.

Medicare Advantage plans can choose just one chronic disease or a single intervention to test, or can do multiple diseases and interventions, according to CMS. They also can choose to test interventions specifically in members with multiple chronic conditions — for example, in diabetics with depression, or past stroke patients with hypertension.

Within each approach, plans also will have significant flexibility on how — and to what extent — to implement that approach, CMS says. Plans can vary their proposed interventions from one target population to another, and from one participating plan to another.

Plans must have a minimum of 2,000 enrollees to apply and cannot design interventions that decrease benefits or increase cost-sharing for members; CMS says the model is only a “carrot” and not a “stick” approach. Plans also cannot make the enhanced benefits conditional on achieving any clinical goals — for example, a plan cannot provide reduced cost-sharing only to diabetics who meet goals in weight reduction, although a plan can require a diabetic to participate in disease management in order to receive reduced cost-sharing.

In addition, plans must provide the enhanced benefits to all members who fall into the targeted group, although members themselves can opt out.

### **VBID Could Boost Quality Metrics**

Although Medicare Advantage plans that choose to participate in the VBID initiative won't see increased payments from CMS, they still could see multiple benefits from participation, says Helaine Fingold, an attorney with Epstein Becker Green in Baltimore.

Plans could improve health outcomes for enrollees, perhaps improving their quality metrics at the same time, Fingold tells VBC. In addition, “to the extent that a plan's VBID project does in fact improve financial outcomes, this might allow the plan to use any savings achieved to offer a more attractive benefit package,” she says. “VBID has the potential to help plan sponsors achieve better financial outcomes as well as better health outcomes for enrollees, as it has been shown to do in some employer plans.”

Fingold could think of only two potential disadvantages to participating: “One would be the likely burden on staff resources,” she says. “CMS says it will try to minimize the reporting and monitoring burden on participants, though it has not yet released specifics on these processes. In addition, and from a cynical perspective, participation in any demonstration or research project of this sort will raise the level of CMS scrutiny across all

MA operational areas. That is something for which a plan must be prepared.”

Larger Medicare Advantage plans may get more of a return on investment from participation, compared with smaller plans, Fingold says. Also, plans with a larger percentage of enrollees with the targeted diagnoses might be able to get results that are more statistically significant, although “it would really depend on the nature of each plan’s enrollment and the VBID approach that it uses.”

Medicare Advantage plan sponsors who also offer chronic Special Needs Plans might want to consider targeting conditions other than those covered in their C-SNPs for this initiative, since they may have fewer enroll-

ees in their non-C-SNP plan with the diagnoses that are targeted in their C-SNP plan, Fingold says.

Plans don’t necessarily need to have providers who are accustomed to value-based care in order to be successful in this program, Fingold says. “Provider comfort with value-based care may increase the effectiveness of the VBID interventions — for example, [those] that seek to incentivize enrollees to seek out high-value care or high-value providers. However, a plan might be able to achieve more significant results from implementing VBID with providers that have not previously been involved in a value-based approach.”

Contact Fingold at HFingold@ebglaw.com. Read CMS’s VBID fact sheet at <http://tinyurl.com/ptjy3sw>. ♦

## NEWS BRIEFS

◆ **Two-thirds of oncologists said the lack of reimbursement for providing supportive care services is a key challenge faced by cancer care centers**, according to a survey by the Association of Community Cancer Centers released Sept. 21. The “Trends in Cancer Programs” also found that more than 50% of surveyed cancer programs are adding more patient-centered services such as nurse navigators, survivorship care, palliative care and psychological counseling. Visit <http://tinyurl.com/n9tkcvd>.

◆ **Blue Cross Blue Shield of Michigan unveiled a new program Sept. 14 to team up pharmacists with patient-centered medical homes (PCMHs).** A partnership of the Michigan Blues plan, the University of Michigan Health System, physician organizations and pharmacists, the Michigan Pharmacists Transforming Care and Quality (MPTCQ) program pairs clinical pharmacists with PCMH practices, starting with 10 medical groups across the state. “The pharmacists will review patients’ medication plans, collaborate with physicians to make necessary medication changes, and work with patients to help them understand how to safely and properly use the medications,” the Blues plan explained, starting with a focus on patients with diabetes, high blood pressure and high cholesterol. After the first year, MPTCQ will be expanded to all 46 participating PCMHs. Visit <http://tinyurl.com/nqazq2w>.

◆ **Aetna Inc. is launching an Aetna Whole Health product in Orange County and slices of Los Angeles County as part of its accountable care collaboration with Santa Ana, Calif.-based MemorialCare Health System.** Employers taking part in the program could save up to 15% over comparable broad-

network Aetna products. The insurer said the new offering, Aetna Whole Health-MemorialCare, would provide coordinated care for Aetna members from the health system’s 2,000 doctors, seven hospitals and 40-plus urgent care centers. The plans became available starting Sept. 1 for an effective date of Nov. 1. Coverage is expected to be available for fully insured customers in early 2016. Visit <http://tinyurl.com/ovhprd8>.

◆ **Des Moines, Iowa-based Wellmark Blue Cross and Blue Shield on Sept. 4 said its Accountable Care Organization (ACO) Shared Savings model saved more than \$17 million during 2014.** The insurer’s eight participating ACOs also improved their overall quality scores by 8%. The eight ACOs cover more than 424,000 members. Wellmark said savings were driven by an almost 11% reduction in hospital admissions, an 8% drop in readmissions and a 10% decrease in emergency department visits. Visit <http://tinyurl.com/qab7yo2>.

◆ **PwC’s Health Research Institute examined the health industry’s move from fee-for-service to value-and-risk-based models in a new report, identifying factors causing it to go slower than expected and outlining strategies for a successful transition.** *Healthcare’s Alternative Payment Landscape* found that regional variation plays a major role in determining where value-based care flourishes; the most successful local markets are those where several different value-based payment models co-exist. PwC recommends that providers build on their Medicare Advantage experience in designing programs for commercial markets, among other strategies. Visit <http://tinyurl.com/nnm3vzh> to view the report.

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