DMHC and Regulatory Oversight of the Accountable Care Model

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ACO Payment Methodologies

- PPACA Section 3022. “Medicare Shared Savings Program”
  - **Part A and B fee-for-service payments to providers continue in same manner**
  - If ACO meet quality performance standards, they become eligible to receive payments for shared savings

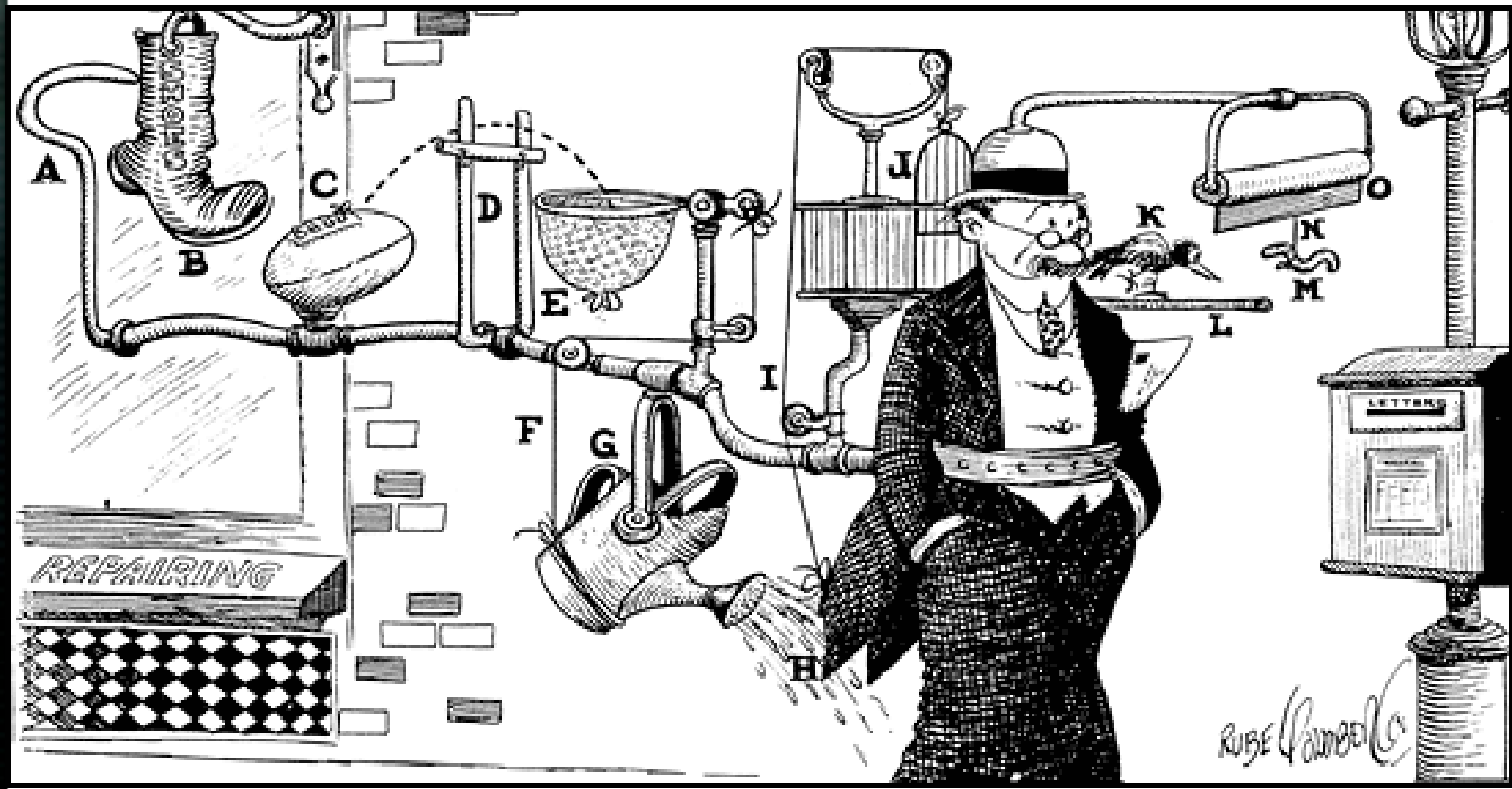
ACO Payment Methodologies

- PPACA Section 10307. "*Improvements* to the Medicare Shared Savings Program"
  - *Partial Capitation* Model
    - *Limited to ACO capable of bearing risk* and highly integrated systems of care
    - Financial risk for some, but not all, of part A and B services
    - Cannot result in increased spending for assigned beneficiaries
  - Other Payment Models
    - "*Any* payment model the Secretary determines will improve the quality and efficiency of services"
    - Cannot result in increased spending for assigned beneficiaries
  - Secretary may give *preference* to ACOs participating in *similar arrangements with other payers*

“The Innovation Center” (CMI)

- PPACA Section 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS
  - Purpose: ***to test innovative payment and delivery models*** to reduce program expenditures while preserving or enhancing the quality of care
  - The Secretary shall select models to be tested, which may include the following:
    - (ii of xx) Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through ***risk-based comprehensive payment*** or salary-based payment

There is No ACO Instruction Manual



Accountable Care Critical Success Factors

Achieving the "Triple Aim"

- Vision and values
  - Why are you doing this?
- Ability to hit quality performance metrics AND reduce costs
  - Engaged physician leadership
  - Appropriate physician incentives
  - Robust investment in IT systems
  - Care coordination expertise
- Collaborative doctor, hospital, and payer relationships
- Strong financial performance and financial reserves
  - Ability to successfully bear risk and generate bonuses
  - Ability to comply with regulatory requirements
- Willingness to be transparent with quality and cost data

The Ca Model Chassis is the Best Hope for Successful ACO Implementation

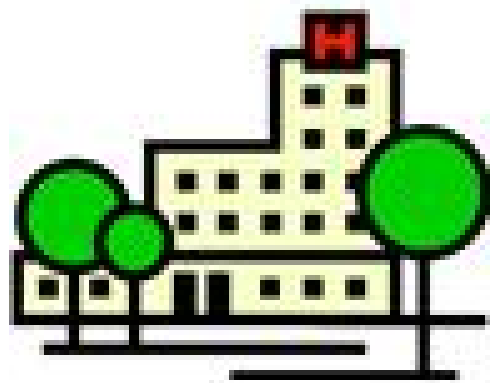
California Coordinated Care Model

- "…*the most efficient and cost-effective way to deliver health care to the greatest number of Californians."* -Governor Schwarzenegger

- 25 year history of physician-led coordinated care
- CAPG: 155 experienced IPAs and Medical Groups
- Areas of demonstrated expertise:
  - Accepting and managing financial risk
  - Organizing physician networks
  - Physician incentive payment methodology
  - Investments in HIT: registries, connectivity, EMR
  - Integrated delivery systems with hospital partners
  - Clinical care management programs
  - Cost effective high quality patient centric care

What About the Rest of the Country?

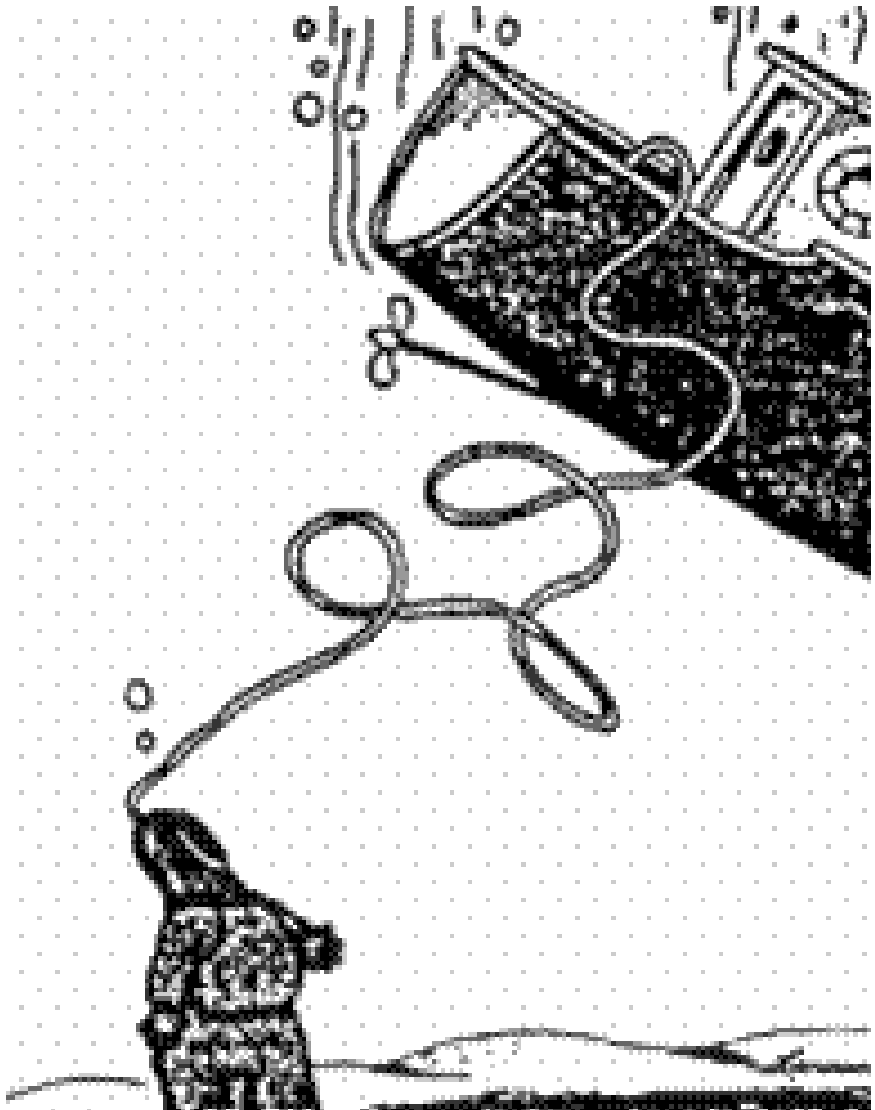
- Generally speaking, physicians are not well organized to deliver integrated, coordinated, accountable care
- As a result, marketplace dynamics are driven by health plans and hospitals, whichever possess the greatest leverage
- Not ideal, if the objective is achievement of the “Triple Aim”



Creating an ACO – a Lot of Hard Work
Monarch/HCP/Anthem Workgroups

- Steering Committee
  - Bi-weekly conference calls
  - Includes Dartmouth-Brookings and DMHC representatives
- Sub-committee Workgroups
  - Member Attribution
  - Contract Framework and Structure
  - Information Technology and Operations
  - Performance Metrics
  - Product Development
  - Communications
  - Medical Operations

Regulatory Protections Will Be Required



Who Will Regulate ACO?

Feds

States

ACO Model: Risks Defined

- Failure to launch
- Failure to achieve Triple Aim objectives
- Insolvency of ACO
- The greatest risk of all (in my view):

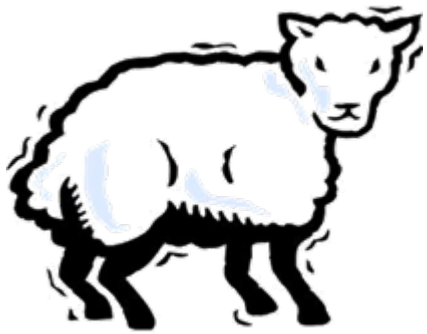
  ACO momentum high-jacked by “ACO imposters” attempting to maintain the status quo

“CMS will support ACO learning networks. Authenticity matters, those who seek to protect the status quo won't be tolerated.”

Don Berwick, MD
CMS Administrator
October 5, 2010

DMHC's Role: Protect Against Risks

"Imposter ACO"

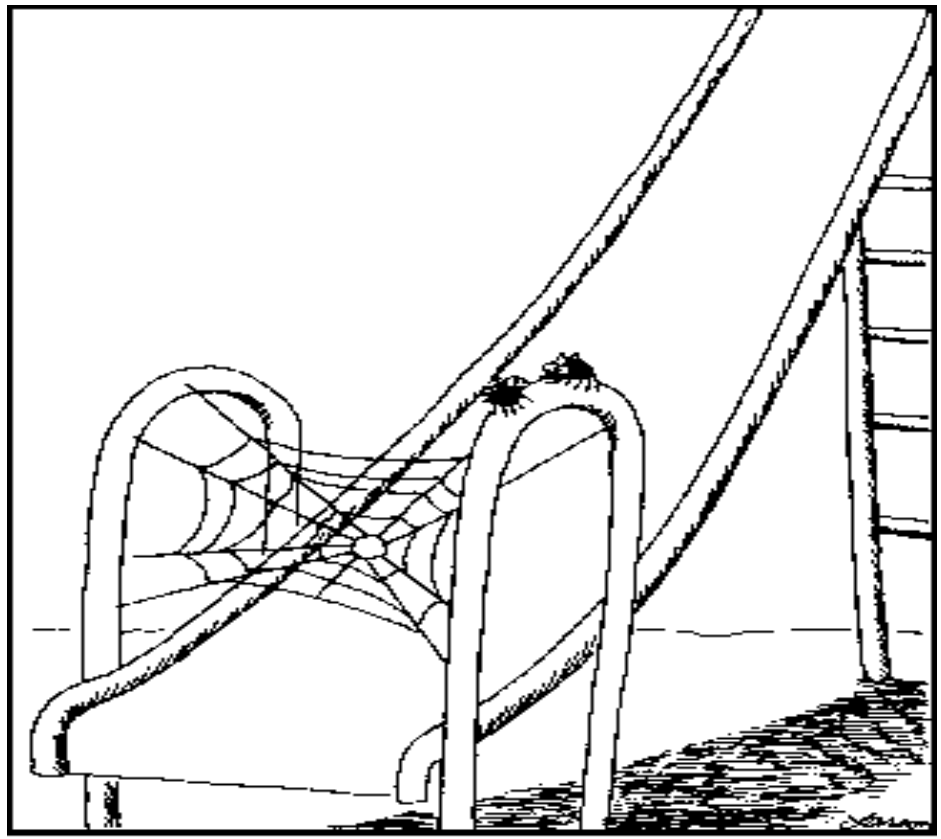


Consumer

Waiver Requirement Recommendations:

- Capital reserve and transparency requirements – Consistent with KKA Licensure
- Demonstrated ability to successfully bear risk (“delivery system capitation”) for at least three years
- Demonstrated willingness to submit financial data to DMHC (i.e. SB 260 regulations) for at least three years
- Demonstrated ability to successfully achieve and report quality metrics (i.e. CAPG Standards of Excellence and IHA P4P) for at least three years
- Willingness to transparently report total cost of care information, including year over year trend

The Most Important Thing: Why They Doing Are This



"If we pull this off, we'll eat like kings."

Unfortunately, you can’t regulate integrity.

Questions and Discussion