The Walgreens / S&W Accountable Care Organization

ACO

The Accountable Care Network of Texas, LLC

W. Roy Smythe, M.D.
Senior Vice President, Institute Development
Medical Director of Innovation
Glen and Rita K. Roney Endowed Chair

“it is the pervading law of all things organic, and inorganic, of all things physical and metaphysical, of all things human and all things super-human, of all true manifestations of the head, of the heart, of the soul, that the life is recognizable in its expression, that form ever follows function. This is the law.” - Louis Sullivan
Why participate in new payment arrangements?

SOCIETAL IMPERATIVES

ANTICIPATING FUTURE PAYMENT

MORAL IMPERATIVES

Societal Imperatives?

• Concerns of the gov’t and the general population?
  – Manufacturing competitiveness
  – Future jobs
  – Reserve currency
  – National defense

Privileged & Confidential

5/21/2013
Anticipating Future (Capped) Payment

Cost Of Care

High cost acute care provider

Low cost acute care provider

Efficient population health manager

Time

PAYMENT

A Moral Imperative

Exhibit ES-1. Overall Ranking

<table>
<thead>
<tr>
<th>Country</th>
<th>AUS</th>
<th>CAN</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
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<tbody>
<tr>
<td>OVERALL RANKING (2010)</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>5</td>
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<td>7</td>
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<tr>
<td>Quality Care</td>
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<td>5</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
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<tr>
<td>Effective Care</td>
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<td>6</td>
<td>3</td>
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<td>1</td>
<td>4</td>
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<tr>
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<td>3</td>
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<td>7</td>
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<tr>
<td>Coordinated Care</td>
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<td>3</td>
<td>3</td>
<td>6</td>
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<td>1</td>
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<td>Access</td>
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<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>6.5</td>
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<td>Cost-Related Problem</td>
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<td>2</td>
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<td>1</td>
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<tr>
<td>Timeliness of Care</td>
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<td>1</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Efficiency</td>
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<td>5</td>
<td>3</td>
<td>4</td>
<td>1</td>
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<tr>
<td>Equity</td>
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<td>3</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>7</td>
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<tr>
<td>Long Health, Productive Lives</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
<td>7</td>
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</table>

A Moral Imperative
“We must do well, to do better…” (Skinner)

- We must radically change the health care delivery system and payment structure
  - more access, quality and health promotion
- We need to change behaviors that impede health

- We need better treatments, and more cures
- We will be unable to apply new knowledge without more financial and structural resources

New Payment Models

- Pay for “performance” or “value”
- Methodologies
  - Accountable Care Organizations
    - Shared savings partnerships
  - Bundling
    - Payment for “episodes of care”
  - Capitation (primary, secondary, global)
    - Payment for a population on a pre-defined basis

RISK
- Government
  - Commercial
  - Provider-based

TOOLS
- Incentives
- Rewards / Penalties
- Capped payments
An ACO is an Accountable Care Organization... providers (physicians, hospitals, others) working together to manage the health, cost and outcomes (“medical risk”) of a population of patients.

From the purposes of this MSSP (MSSP = Medicare Shared Savings Program) program, and other “shared savings” programs around the country being developed by private insurers:

An ACO is an Accountable Care Organization... providers (physicians, hospitals, others) working together to manage the health, cost and outcomes (“medical risk”) of a population of patients AND receiving “shared savings” from insurers whenever these are managed in a way that improves quality and lowers cost.

Mapping Medicare ACOs

- 32 Pioneer ACOs
- 27 MSSP ACOs (2012 first round)
- 106 MSSP ACOs (2013 second round)
  - >400 applications

The Accountable Care Network of Texas (more than 30,000 attributed beneficiaries)

78% ACOs in April 1 MSSP cohort are physician group only

The Accountable Care Network of Texas

Expected Beneficiaries
- Pioneer ACOs
- Shared Savings Program ACOs
- 5,000-9,999
- 10,000-19,999
- 20,000+
CMS’ Shared Savings Program (SSP)

Off-and-Running as a Voluntary Demonstration

Medicare Shared Savings Program:
- First ACO contracts to begin April 2012; contracts to last minimum of three years
- Final rule issued October 20, 2011
  - Physician groups and hospital eligible to participate, but primary care physicians must be included in any ACO group
  - Participating ACOs must serve at least 5,000 Medicare beneficiaries
  - Bonus potential to depend on Medicare cost savings, quality metrics
  - Two options available:
    - No downside risk, lower bonus payment
    - Downside risk, higher bonus payment

Pioneer ACO Model:
- Accelerated pathway to ACO formation designed for organizations able to assume utilization risk immediately
- Participating providers must serve at least 10,000 Medicare beneficiaries
- Offers higher risk, higher reward model, providers can obtain rewards ranging from 50-75% of Medicare savings achieved
- Providers can choose retrospective or prospective patient assignment methodology
- Quality measures to match those in final rule for Medicare Shared Savings Program
- Deadline to apply was in August 2011

CMS expected to select Pioneer ACOs by January 2012

The Accountable Care Network of Texas, LLC

- A stand alone LLC
- Staffed by a combination of Walgreens, S&W and full-time ACO employees
  - Vast majority of clinical providers will be S&W, Walgreens will likely add more over time (additional convenient care clinics)
- Provides tools, resources and staffing to manage “population health” in the Medicare FFS patient base
How It Works

- Fee for service Medicare patients only – not Cost or Advantage Plan patients
  - “Attribution” – 3 year look-back, “plurality”, about 31K
- We receive a portion of what we “save” Medicare if we:
  - Meet quality metrics
  - Meet a savings hurdle rate, based on national PMPY cost curve and our own costs
How it Works

- Assume annual spend as $8000/yr for the first ACO year
  - Based on 3 year look back

- In that first ACO year, national Medicare spending increases 6.0%, ($10,000 – $10,600)

- Our “expected” spend would then be $8000 + $600 = $8,600
  - YOU USE THE ABSOLUTE Nat’l NUMBER, NOT THE PERCENTAGE...

- If we spend $7900 over the first year
  - We would make the hurdle rate, as we “saved” more than 2.5% of $8,600
  - We would “save” $700 per attributed member

- If we have 30,000 attributed lives – we would receive (before covering startup and operating costs) $21M/2 = $10.5M
ACO Schema

All System Medicare FFS Patients

HIGH RISK
- End of Life Care
- Dialysis Management
- Shared Decision Making

MEDIUM RISK
- Discharge Transitions
- Medication Compliance
- Depression Management

AVERAGE RISK “TODAY”

Predictive Modeling

Data Warehouse and Analysis

Four Aims – “The Triple Aim Plus One”

ACO Quality Metrics
1. Report 33 metrics Y1 (25 are PQRS)
2. Find and fill gaps
3. Held to metrics Y2 and Y3

ACO Clinical Strategies
1. End-Of-Life Care
2. Transitions
3. Ambulatory Sensitive Conditions
4. Chronic Kidney Disease
5. Somatization
6. Physician Sensitive Treatments
7. “Care Gaps” - Screening, Adherence, etc.

Unlike many other ACOs, we have inpatients and inpatient providers.
Care Transition Strategies

Expansion of existing Walgreens Programs:

- **WellTransitions**: multifaceted intervention including patient counseling and refill reminder calls.
- **MedGap Analysis**: medication reconciliation and Polyglot™ instructions for patients with low health literacy.
- **DailyMed™**: Pre-sorted medication packets.

<table>
<thead>
<tr>
<th>Population health</th>
<th>Administrative burden</th>
<th>Per capita cost</th>
<th>Patient experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>These strategies are specifically designed to prevent readmissions.</td>
<td>Dedicated programs to support patients in the transition from hospital to home and between other care settings.</td>
<td>Re-admissions within 30 days cost an estimated $25 billion per annum. Several studies have shown statistically significant reductions in re-admission rates.</td>
<td>Patients report high satisfaction with Walgreens transitions programs including Well-Transitions, the bedside delivery program, and an embedded pharmacist.</td>
</tr>
</tbody>
</table>

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Scott & White “adds in” whatever transitions competencies and programs we already have in place to develop final strategies that the ACC will employ.

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**Walgreens**

- ~ 8000 pharmacies
- $72B revenue
- 42 million / week foot traffic
- 75% of population within 10 minutes
- 800 Take Care Clinics, and growing
Why partner with Walgreens?

- We are a low cost, high quality acute care provider, due to integration, but we are not expert at population health management
- Shareholders are not all bad (CLOCKSPEED and TIME PRESSURE for change)
- We need pressure to change

“The Great Convergence”

Population Health Management

Humana

Target

Walgreens

CVS

DaVita

“Acute/Complex Care”
Hospital Beds
Education
Research
Supply Chain
Administration etc., etc....
Why partner with Walgreens?

Financials

COST OF CARE (processes, change) >> SHARED SAVINGS REVENUE
Challenges

• Tell your CEO you want to start a program that will cost more than you generate in revenue, for the short term
• Designing care processes, and having the data and analytics to effectively TARGET are hard
• Finding physician time and bandwidth (absolutely necessary) is hard
• If you contemplate entering into multiple new payment arrangements with multiple payers – there is no unified platform to assist you with the complexities of identification, predicting costs, analytics, billing, etc…
• Partnering, where both are new at the endeavor and each are structurally and culturally different, is hard

Summary

• We have entered into a MSSP ACO relationship with Walgreens for FFS Medicare patients
• We view this as a practice change and quality improvement project, rather than revenue generating
• We have a number of societal, financial and moral imperatives to change our health care delivery and manage population health more effectively, and efficiently
• The ACO era is a stop along the way to full risk management and full capitation – which we welcome
• So far, so good