Mini Summit IV:

Value Based Care Programs for Patients with Complex Chronic Conditions

March 19, 2019

FRESENIUS MEDICAL CARE

Agenda

Case Study: Fresenius Value Based Care Programs for Patients with End Stage Renal Disease

Improving Care for ESRD Patients through VBC Programs

Panel Discussion: Partnering with Providers and Payors

Case Study: Fresenius Value Based Care Programs for Patients with End Stage Renal Disease

Marty Leinwand

SVP Business Development

Integrated Care Group

Fresenius Medical Care North America

Fresenius Medical Care Mission:

To deliver superior care that improves the quality of life of every patient, every day, setting the standard by which others in the health care industry are judged.

Fresenius Medical Care North America Core Capabilities

Dialysis Services & Products

FRESENIUS KIDNEY CARE
FRESENIUS MEDICAL CARE
RENAL THERAPIES GROUP
NxSTAGE from FRESENIUS MEDICAL CARE

Integrated Care Management

FRESENIUS HEALTH PARTNERS

Vascular Care

azura vascular care

Cardiovascular Catheterization

NATIONAL CARDIOVASCULAR PARTNERS

Renal Laboratory

spectra laboratories

Renal Research

Frenova Renal Research
RENAL RESEARCH INSTITUTE

Renal Pharmaceuticals

FreseniusRx

Technology Solutions

ACUMEN PHYSICIAN SOLUTIONS

Physician Practice Services

FRESENIUS MEDICAL CARE
PHYSICIAN PRACTICE SERVICES

Urgent Care

MedSpring urgent care
ChoiceOne URGENT CARE

Fresenius Medical Care North America

~200K
patients

2,400+
dialysis clinics

67K
employees

70%+
of total FMC revenue

200+
investigators/researchers

250
dialysis research sites

Kidney Disease on the Rise

- More than 30 million Americans have some stage of kidney disease
- 700,000 Americans currently have kidney failure, a group whose ranks are increased by 100,000 Americans every year
- Fueled by increased incidence of diabetes and hypertension, these numbers are projected to increase substantially over the next decade
- Medicare spent more than $113 billion managing kidney diseases in 2016, more than 20% of all Medicare spending
- More than 100,000 ESRD patients are on transplant waiting lists, only about a fifth receive a kidney transplant each year

Market Moving to Value Based Care

"There is no turning back to an unsustainable system that pays for procedures rather than value. In fact, the only option is to charge forward — for HHS to take bolder action, and for providers and payers to join with us."

–HHS Secretary Azar, March 5, 2018

"We have to be open to what I'm hearing coming out of (CMS), that they want to look at different ways for us being paid and how can we really try to create more opportunities for these patients to be better served."

–Rice Powell, Fresenius Medical Care CEO to Analysts, February 20, 2019

https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html

Why FMC is Transitioning to VBC

- Focuses on the overall healthcare experience and outcomes of our patients
- Provides key funding mechanism for additional interventions and programs that improve quality and reduce cost
- Creates better alignment with patients, physicians and payors
- Leverages our patient relationship, clinical data and deep expertise in renal disease
- Incents us to tackle challenges around increasing home dialysis treatments and kidney transplants

Why Value Based Care Makes Sense for our Patients

- **56 year old male patient on dialysis since October, 2016**
- **History on non-adherence to treatment, missing 30% of scheduled dialysis sessions**
- **Low Albumin level**
- **Several ER visits and inpatient admissions over past 12 months**

Desired Outcomes

- Improve treatment adherence
- Get Albumin level into normal range
- Reduce Avoidable ER Visits and Inpatient admissions

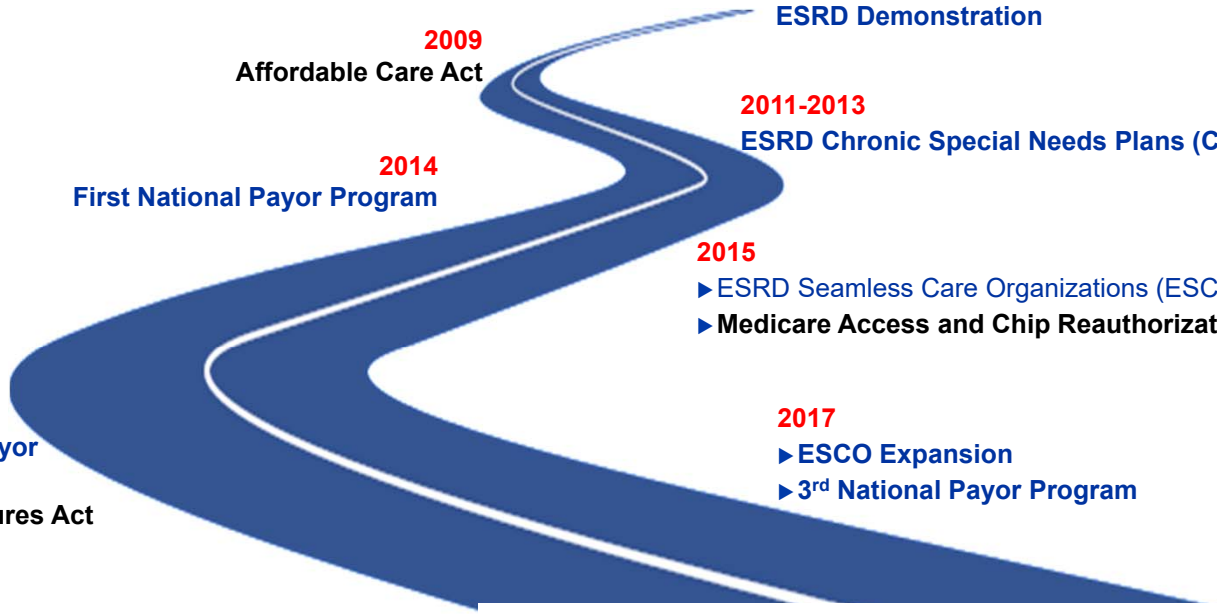
Interventions

- Screening for Depression and other Psychosocial barriers
- Enrollment in intensive 8-week MSW-led program
- Address patient's housing crisis and DME co-pay issues

Outcomes

- ➢ Patient learned strategies to cope with multiple stressors
- ➢ Patient referred to BH services
- ➢ Depressive symptoms reduced (based upon re-screening score)
- ➢ Albumin level brought within normal range
- ➢ Housing and DME payment issues resolved
- ➢ Missed treatments reduced by more than half
- ➢ ER visits and inpatient admissions reduced by more than half

Our Journey to Expanding our VBC Programs



2006-2010
ESRD Demonstration

2009
Affordable Care Act

2011-2013
ESRD Chronic Special Needs Plans (C-SNPs)

2014
First National Payor Program

2015
- ESRD Seamless Care Organizations (ESCOs)
- **Medicare Access and Chip Reauthorization Act (MACRA)**

2016
- **ESRD C-SNP**
- **2nd National Payor Program**
- **21st Century Cures Act**

2017
- **ESCO Expansion**
- **3rd National Payor Program**

2018
- **Further ESCO Expansion**
- **Contract Extensions for all National Payor Programs**

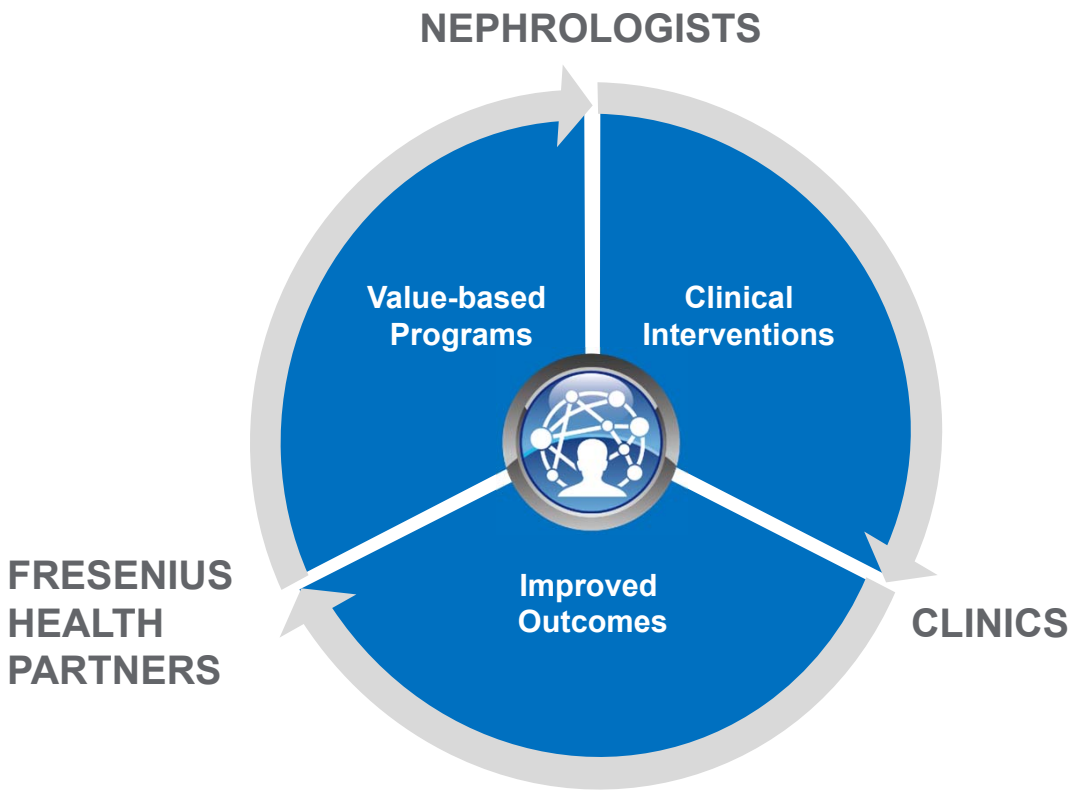
FMC-driven initiaitves

Legislative initiatives

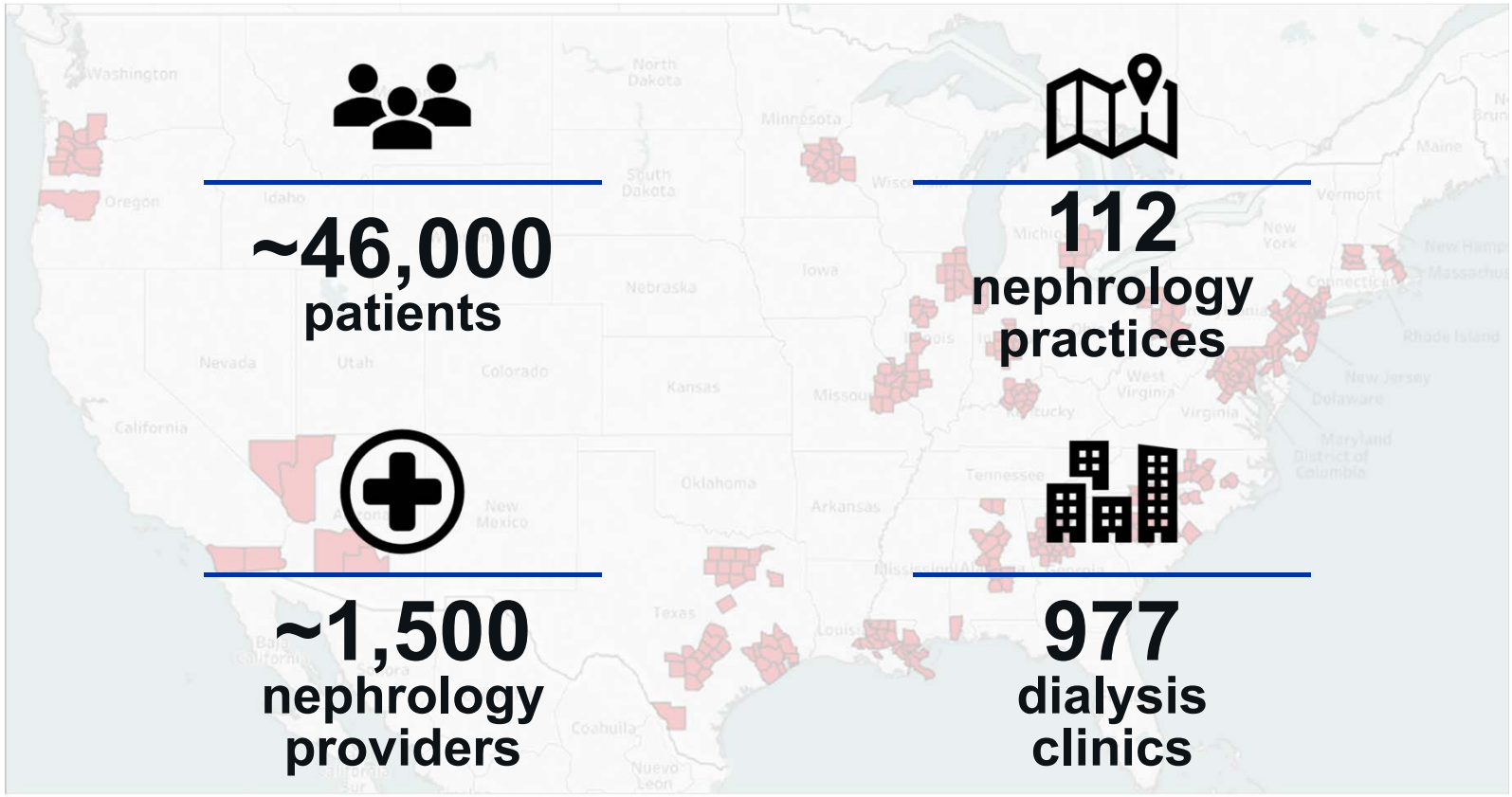
MA Exclusion for ESRD lifted (2021)
Dialysis PATIENTS Act / ESCO 2.0 (proposal only)

Care Coordination Model

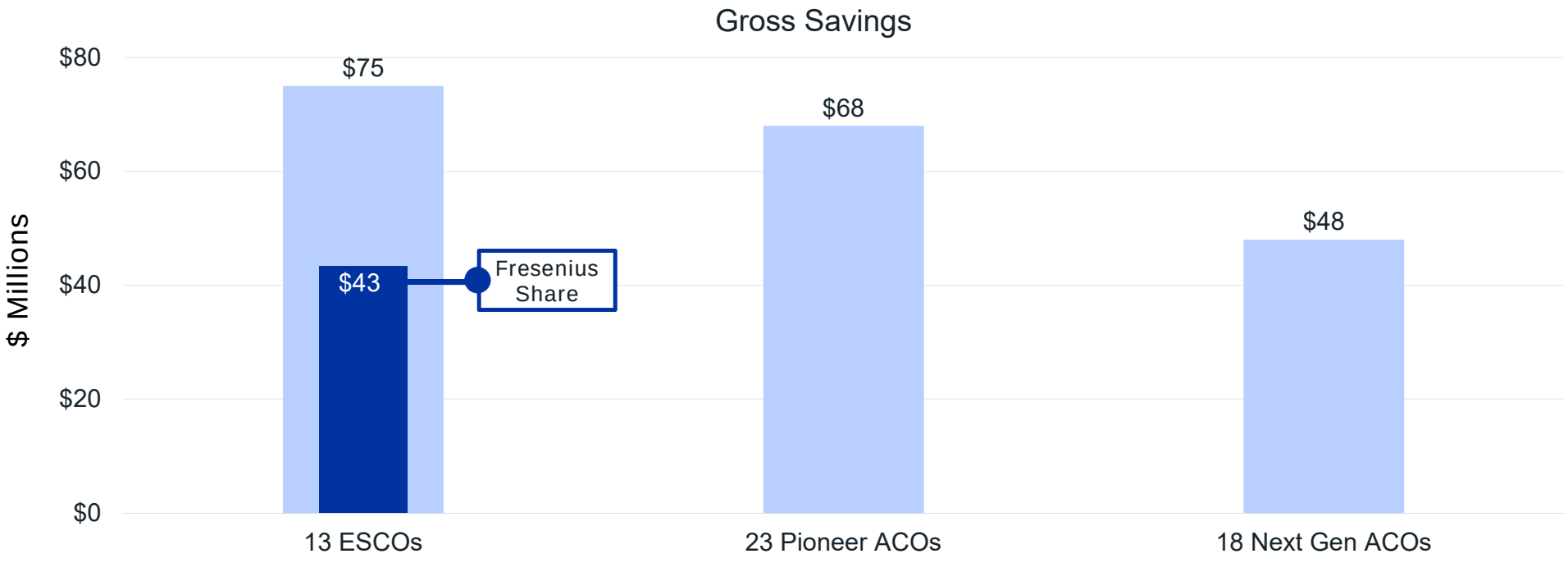
Collaborating to improve patient outcomes



Our 2019 Footprint for ESRD Seamless Care Organizations (ESCOs)



PY1 “All ESCO” Results Compared to Other VBC Programs

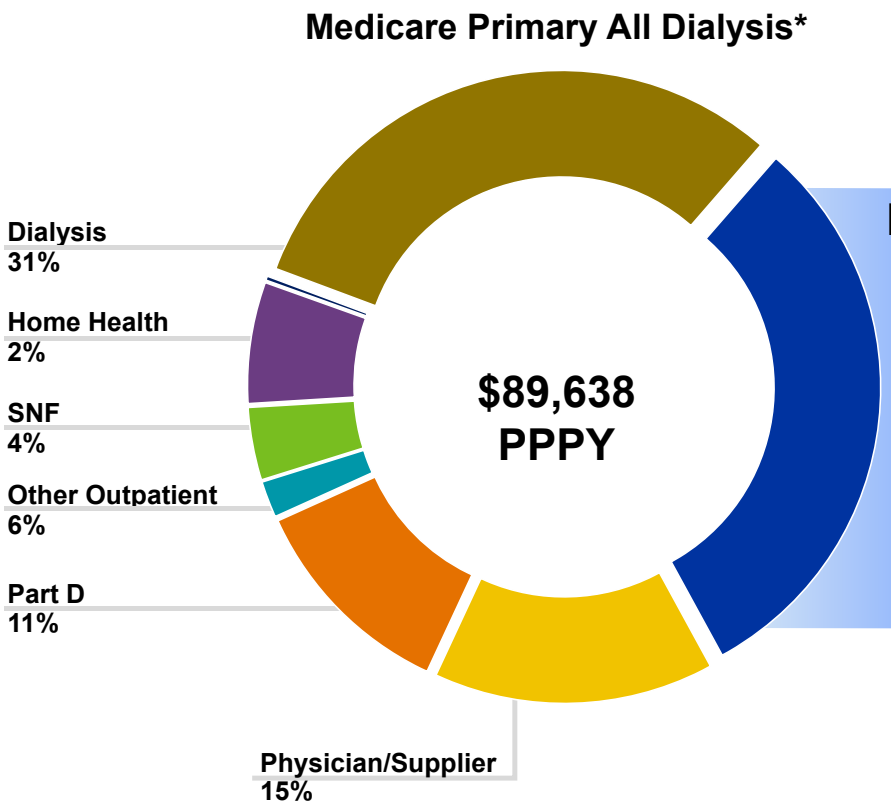


http://www.modernhealthcare.com/article/20171018/NEWS/171019867

Profile of our ESRD “Payor Programs”

- 4 Large National Health Plans and a SoCal IPA
- 7,500 Program Participants
- 85% Medicare Advantage and 15% Commercial
- 85% Two-Sided Risk on Total Cost of Care for ESRD Patients
- 15% Upside Only Gainshare

Opportunity to Impact Costs

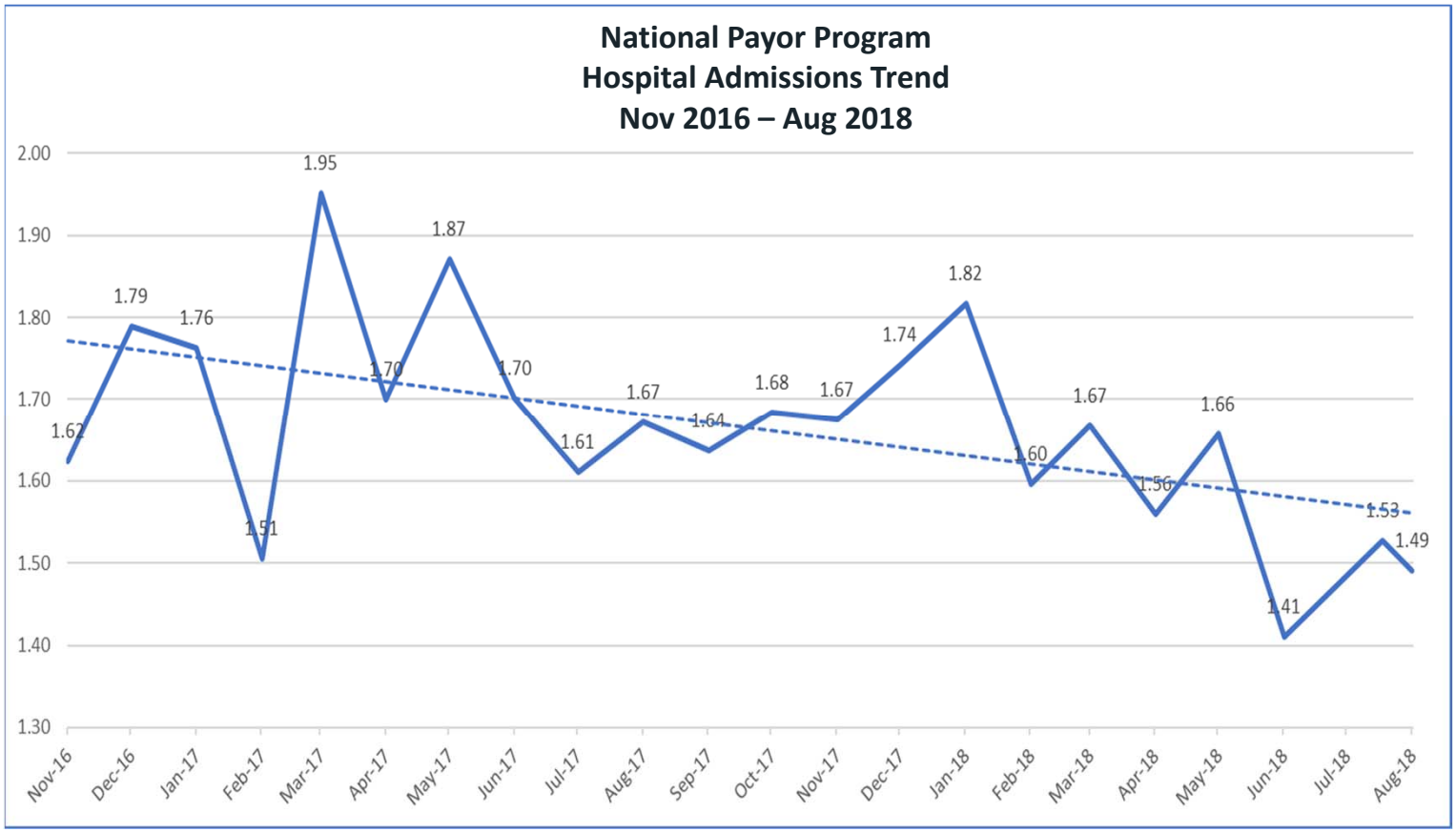


Target Opportunities Primarily in Inpatient Spend

- Decrease unnecessary admissions and readmissions
- Provide access for beneficiaries to get to and from dialysis
- Monitor beneficiary symptoms to identify risks and coordinate care
- Provide additional services to patients in need as identified by patient or care team

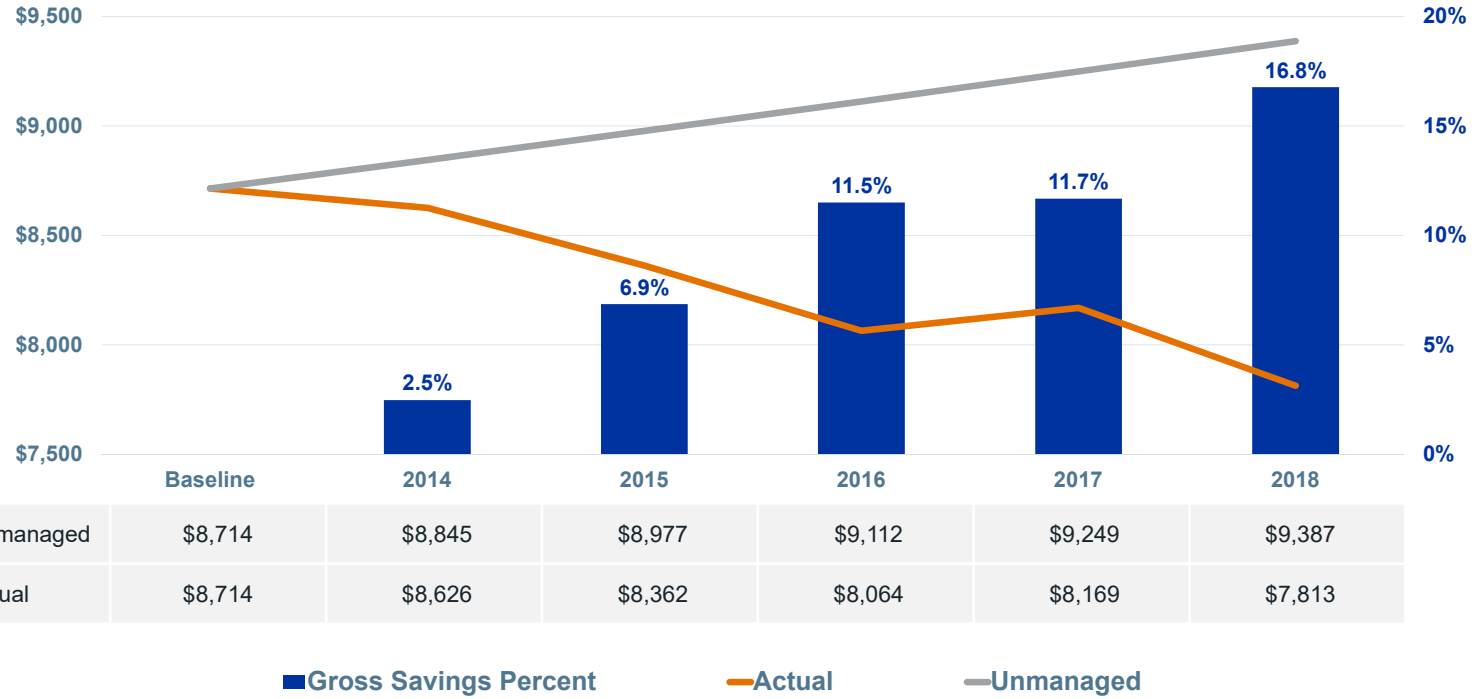
*USRDS 2018 Reference Table K.b: https://www.usrds.org/reference.aspx

MA Payor Program Admissions Trend



MA Payor Program Financial Outcomes

Actual TCOC PMPM > $1500 or 16.8% below "Unmanaged" Trended Baseline PMPM for CY 2018



	Baseline	2014	2015	2016	2017	2018
Unmanaged	$8,714	$8,845	$8,977	$9,112	$9,249	$9,387
Actual	$8,714	$8,626	$8,362	$8,064	$8,169	$7,813

Annual percentage reduction in TCOC: Comparison of Actual Total Cost of Care vs. Unmanaged Total Cost of Care, assuming a 1.5% annual cost trend applied to Baseline Costs.

Impact of Scale on Success of VBC Programs

Why Does Scale Matter:

- Can spread “insurance” risk over larger population
- Greater patient concentration makes larger investments in in-market resources feasible
- More opportunities to innovate with our nephrology and payor partners
- More opportunities to analyze and compare best practices across markets
- Fresenius Clinics have larger number of VBC program patients
  - Impact on clinic processes and culture
- Nephrology practices have larger number of VBC program patients
  - Halo effect on all nephrology patients

Prerequisites for Succeeding with VBC Programs

- Appetite for Risk
- Aptitude for Improving Care
- Innovative Spirit
- Understanding of Regulatory Environment
- High Collaborative IQ
- Focus and Determination

One Size Does Not Fit All

Commercial vs. Medicare Population:

- **Commercial Patient Turnover Rate 2x Medicare Patient Turnover Rate**
  - **Reduces savings opportunity**
- **Commercial Admissions/1000 lower than Medicare Admissions/1000**
  - **Reduces savings opportunity**
- **Commercial Medical Cost Trend > Medicare Medical Cost Trend**
  - **Using prospective cost trend becomes more problematic**
- **Health Plan is "spending" client funds for ASO line of business**
  - **Probably requires shorter reconciliation period**
- **Patient attribution process for Commercial patients can be more difficult**

Key Decisions Regarding VBC Program Structure

- Risk Model:
  - Upside Only Share of Program Savings
    - With or without Base Fee
    - Base Fee at risk?
  - Two-Sided Risk (Savings/Losses)
    - Sub-capitation
    - Upside/Downside Risk with Cap/Floor
  - Percent of Premium
- Covered Medical Expenses
  - Total Cost of Care
  - Exclusions
  - Stop Loss (Individual or Aggregate)

Key Decisions Regarding VBC Program Structure

- Patient Attribution Methodology
  - Exclusions
- Baseline Costs
  - Selecting the right historical baseline period
  - To Re-base or Not to Re-base
- Medical Cost Trend
  - Established prospectively or retroactively
- Quality Metrics and Adjustments
  - Gating Metrics: Potential Loss of All Risk Payments
  - Ladder Metrics: Quality Score determines share of eligible risk payments paid to Provider
- Financial Reconciliation Process

Where do we go next?

…Today I want to lay out what it would look like to pay for kidney health, rather than kidney disease—and pay for Americans with kidney disease to actually get good outcomes…

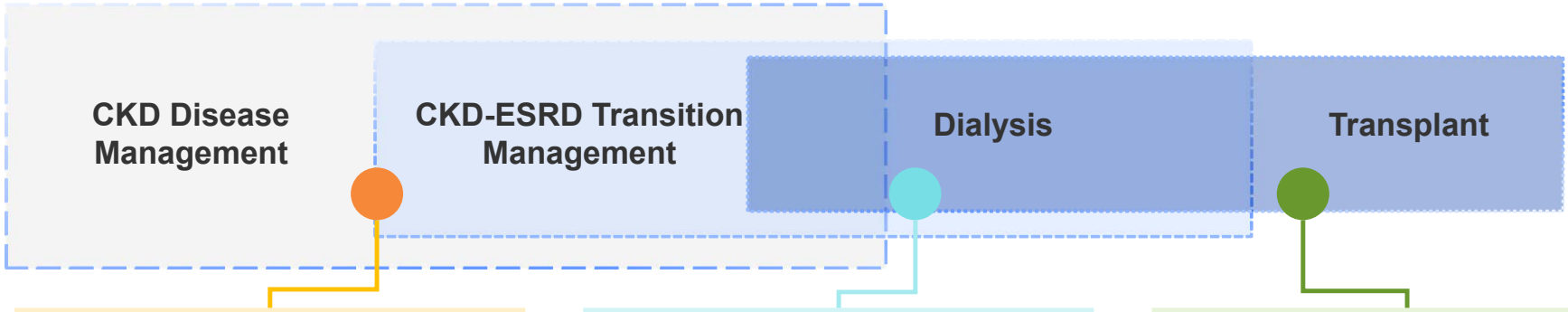
First, we need more efforts to prevent, detect, and slow the progression of kidney disease.

Second, we believe patients with kidney failure deserve more options for treatment, from both today's technologies and those of the future.

Third, we're going to look at how we can deliver more organs for transplants and develop wearable and implantable artificial kidneys, so we can help more Americans escape the burdens of dialysis altogether.

–HHS Secretary Azar, March 4, 2019 (to National Kidney Foundation)

Upstream and Downstream Opportunities



CKD Management

- Slow progression of CKD.
- Educate CKD patients on treatment options, prioritizing transplant and peritoneal dialysis or HHD.
- Prepare CKD patients for ESRD in order to avoid crashing into dialysis, which leads to bad health outcomes and high cost.

Dialysis Management

- Continue education and management of transplant opportunities.
- Educate patients on home treatment modalities as preferred treatment option.
- Deploy innovative and proven care coordination practices resulting in improved health outcomes and lower cost of care for ESRD patients receiving dialysis.

Transplant Management

- Ensure successful transplants through education and recipient follow up.
- Transplant recipients, still technically with ESRD, are susceptible to ongoing health complications and benefit from continued care management.

Improving Outcomes

Terry Ketchersid, MD, MBA

SVP and Chief Medical Officer

Integrated Care Group

Fresenius Medical Care North America

Agenda

- Selecting Quality Measures
- Gating Metrics vs. Quality Adjustors to Savings Payments
- Tracking and Reporting
- Importance of Innovation

Value = $\frac{\text{Quality}}{\text{Cost}}$

Measure Selection Framework

Scientifically Sound

Clear Specifications

Feasible and Usable

Relevant

Achievable

MA Star Measures

- Improving Bladder Control
- Statin Therapy for Patients with Cardiovascular Disease
- Statin Use in Persons with Diabetes

ESCO Quality Measures

- Diabetic Eye Exam: Prevailing Rate in ESRD ~ 10%. Benchmark (90th percentile) = 68%

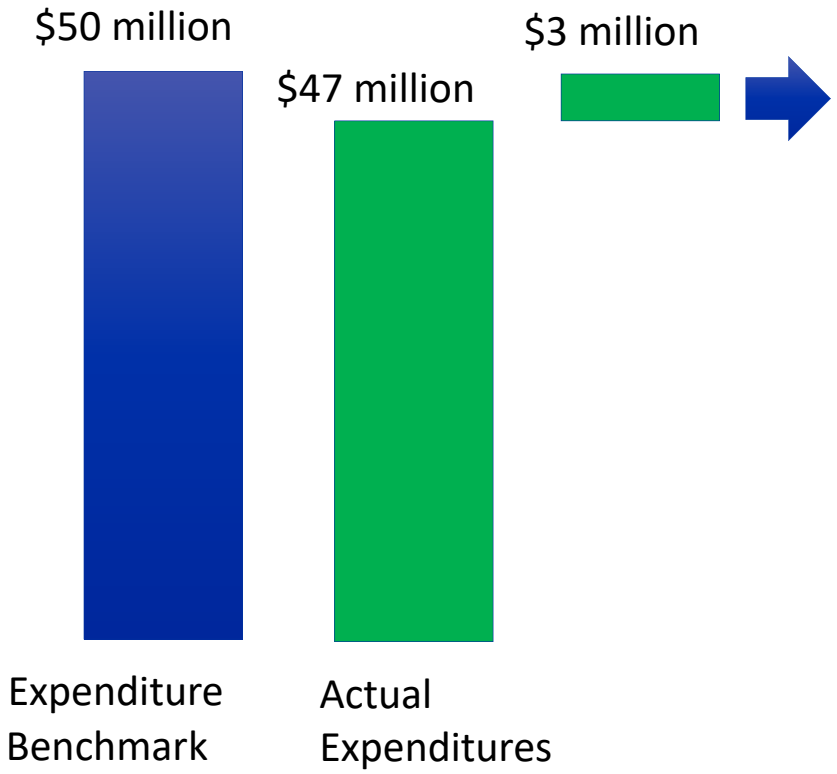
ESRD Quality Incentive Program

- Bone Mineral Metabolism Measure: Phosphorus, PTH, or Calcium?
- Percentage of patients with calcium > 10.2

↑ Value = ↓ Quality / ↓↓ Cost

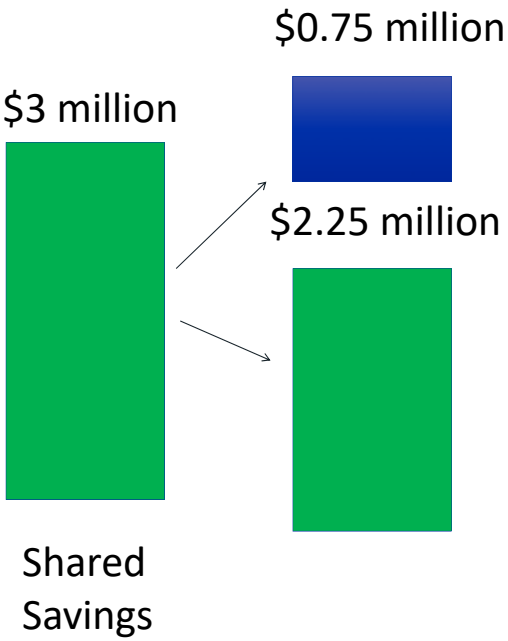
Gating Measures

ESCO Example: Hypothetical Shared Savings



Did the ESCO satisfy the minimum quality requirement?

Shared Savings



CMS keeps at least 25%

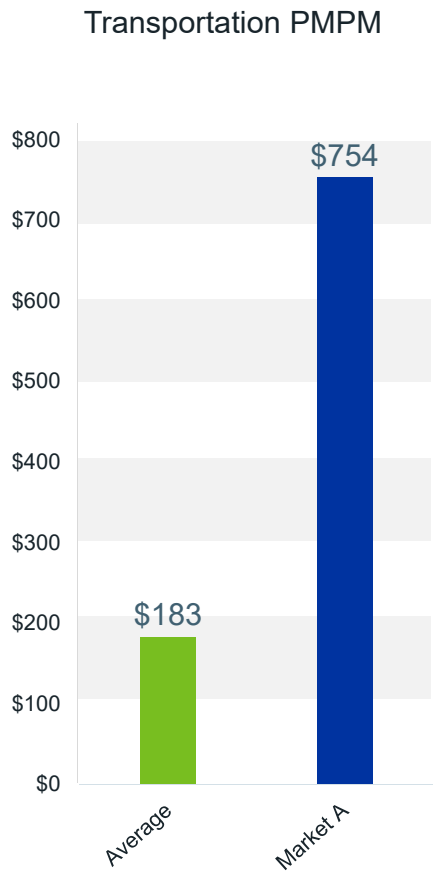
If the ESCO clears the minimum threshold, the ESCO keeps a percentage of the remaining 75%

That percentage is based on the ESCOs Quality Score.

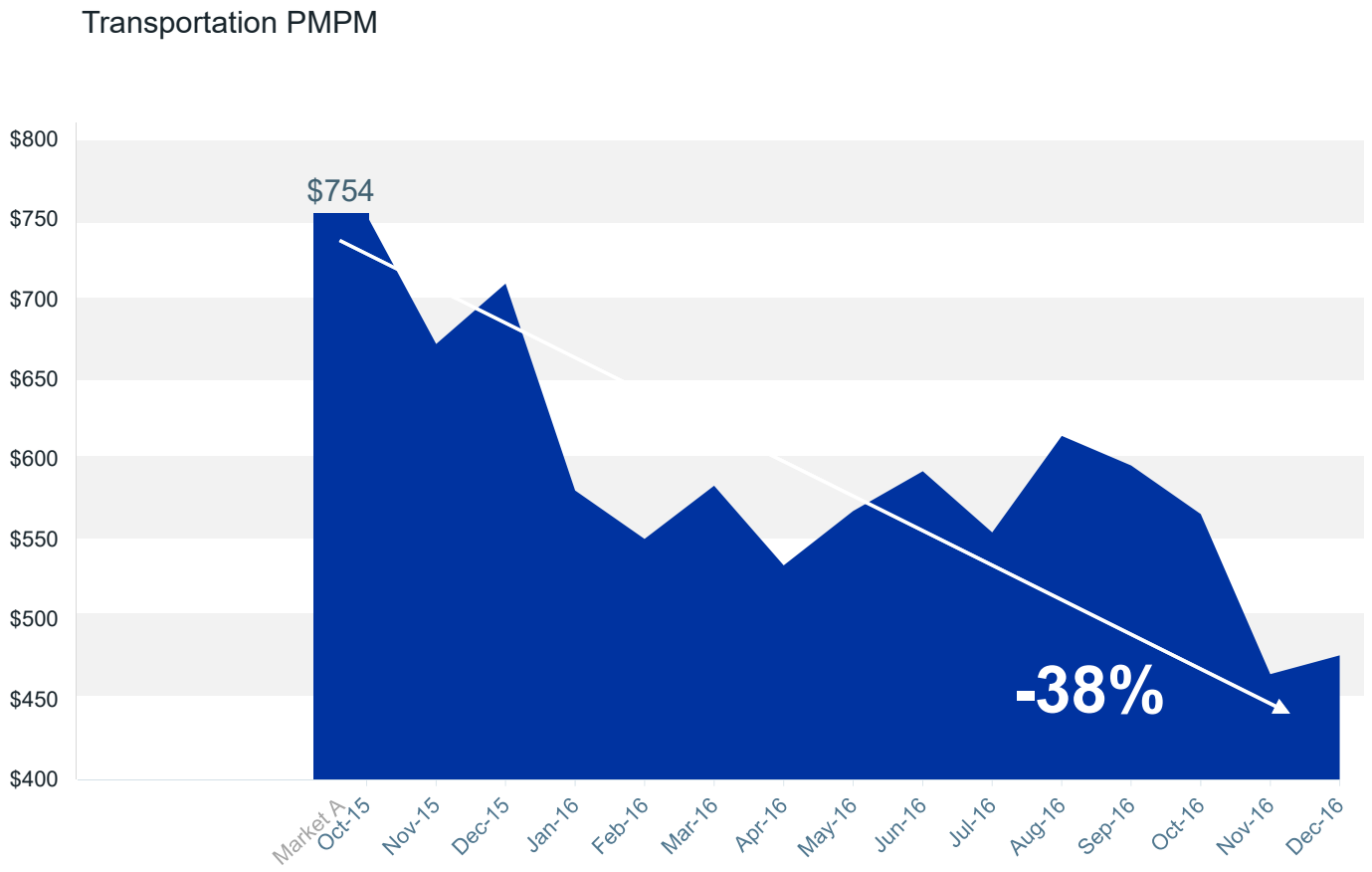
Tracking and Reporting

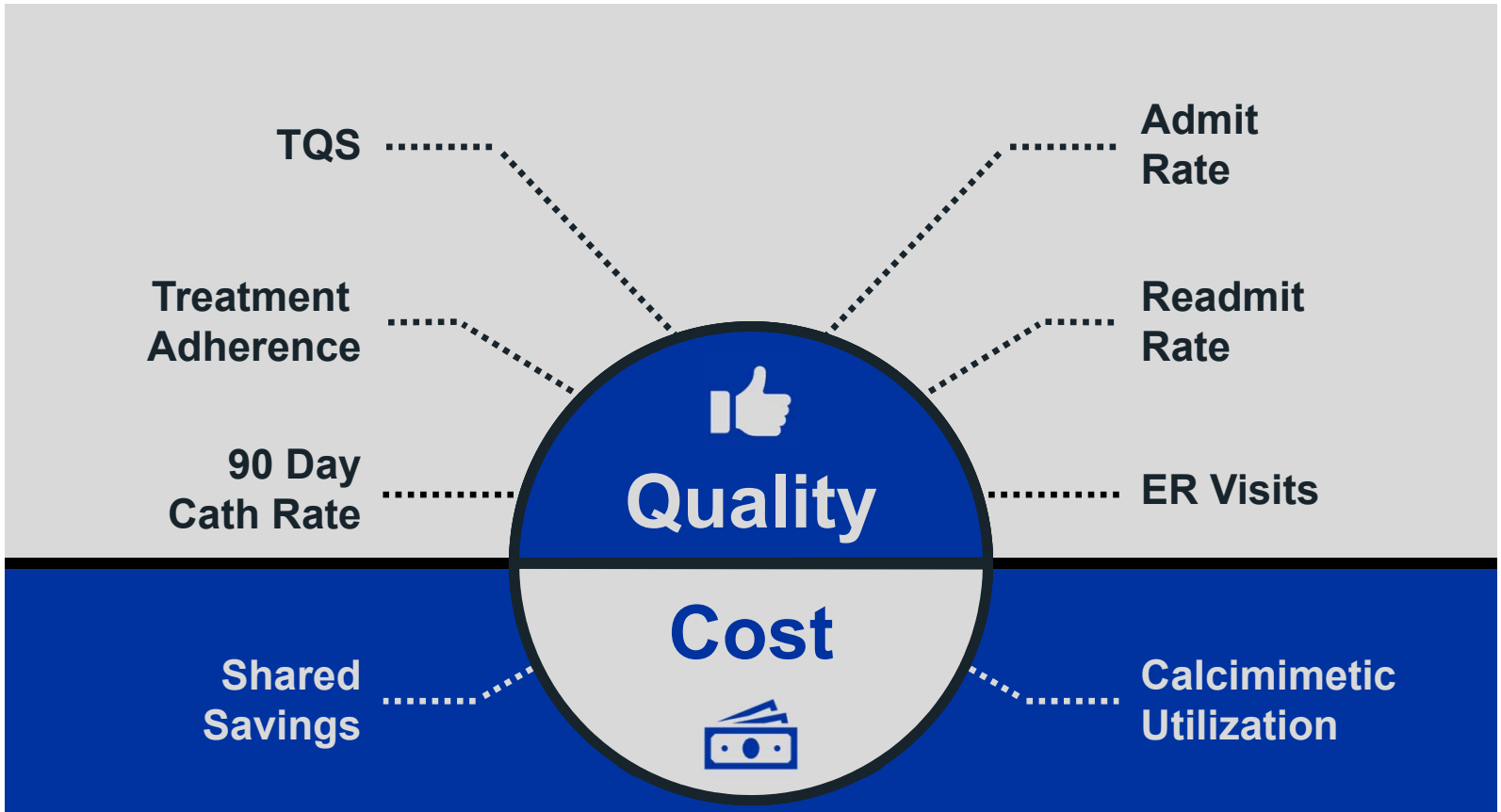
- Accurate Attribution
- Timely Access to Data
- Meaningful Feedback Loop

Transportation Example

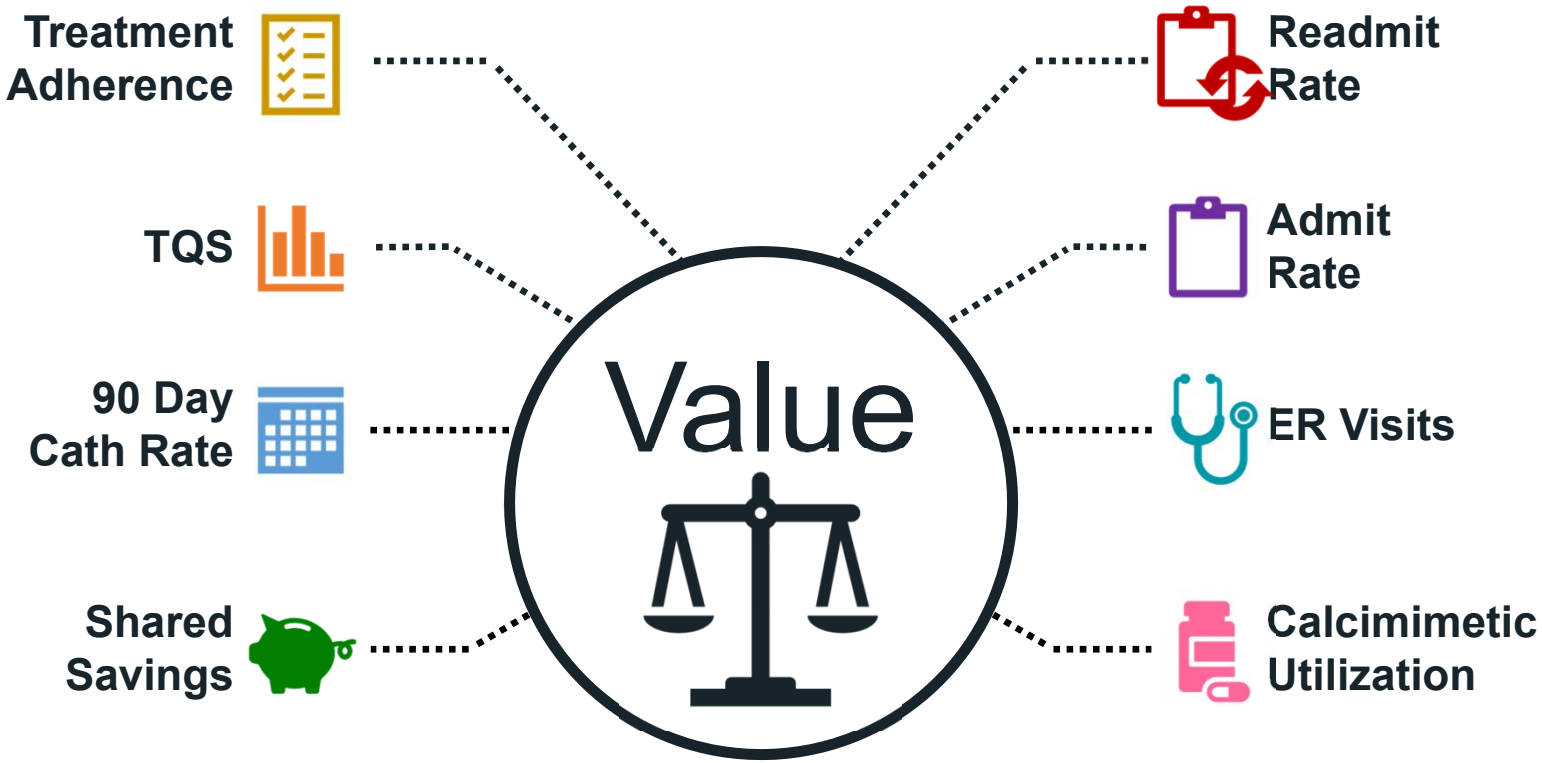


Surfacing Data





Fresenius Transparency Report

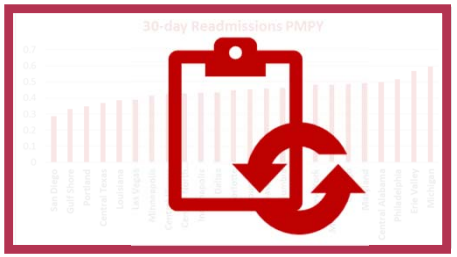


Fresenius Transparency Report

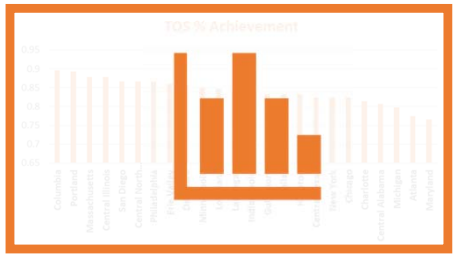
ESCO Market-1	Trend	HD Members with a Catheter for > 90 days	In-Center HD Treatment Adherence	Hospital Admissions PMPY	30-day Readmissions PMPY	ER Visit/ 1,000	Total Quality Score (TQS) % Achievement	Calcimetic Utilization	Projected Shared Savings (Ranking)
San Diego	0	5.8%	98.3%	1.11	.29	141.5	86.6%	21.6%	2
Gulf Shore	0	5.7%	97.0%	1.29	.33	164.5	83.3%	30.9%	13
Portland	0	9.5%	96.9%	1.32	.35	198.1	89.3%	26.4%	16
Massachusetts	1	8.1%	97.7%	1.61	.48	158.9	87.8%	29.1%	17
Central Texas	3	9.3%	96.3%	1.4	.37	179.2	82.4%	20.9%	24
Central Illinois	4	11.0%	95.8%	1.47	.42	169.4	87.8%	21.4%	20
Minneapolis	-3	10.8%	96.1%	1.52	.41	149.7	85.1%	26.3%	3
Central North Carolina	-2	12.4%	96.2%	1.41	.43	175.5	86.6	28.8%	15
Delaware	-2	9.3%	95.5%	1.48	.46	158.9	85.7%	32.5%	8
Louisiana	-1	7.7%	94.3%	1.39	.39	239.4	84.8%	27.9%	21

Treatment Adherence

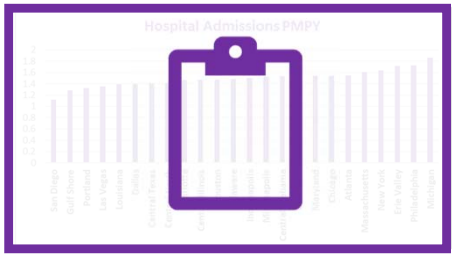
Readmit Rate



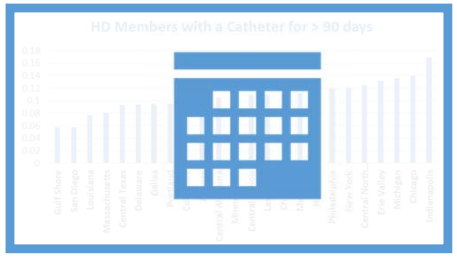
TQS



Admit Rate



90 Day Cath Rate

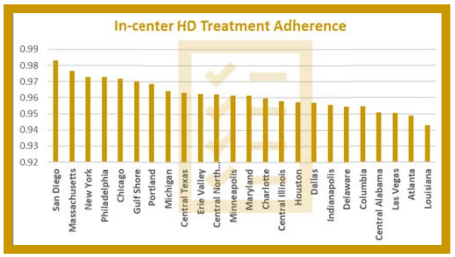


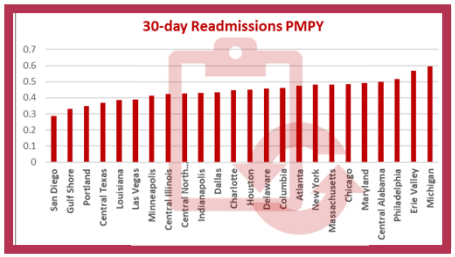
ER Visits

Shared Savings

Calcimimetic Utilization

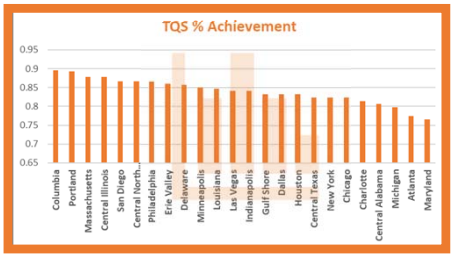
Treatment Adherence

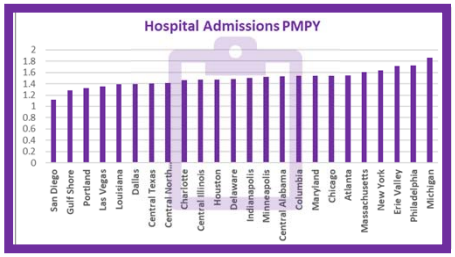




Readmit Rate

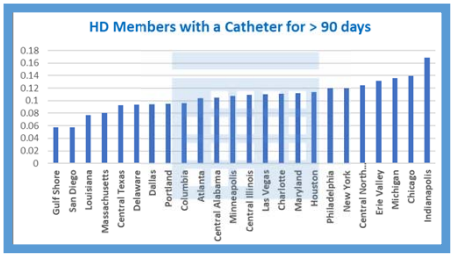
TQS





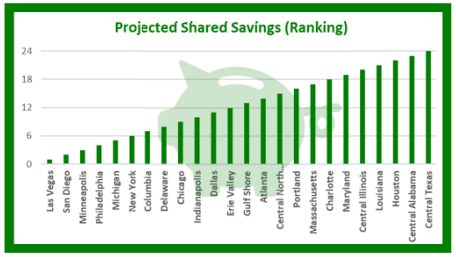
Admit Rate

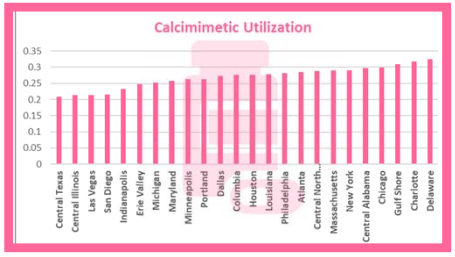
90 Day Cath Rate



ER Visits

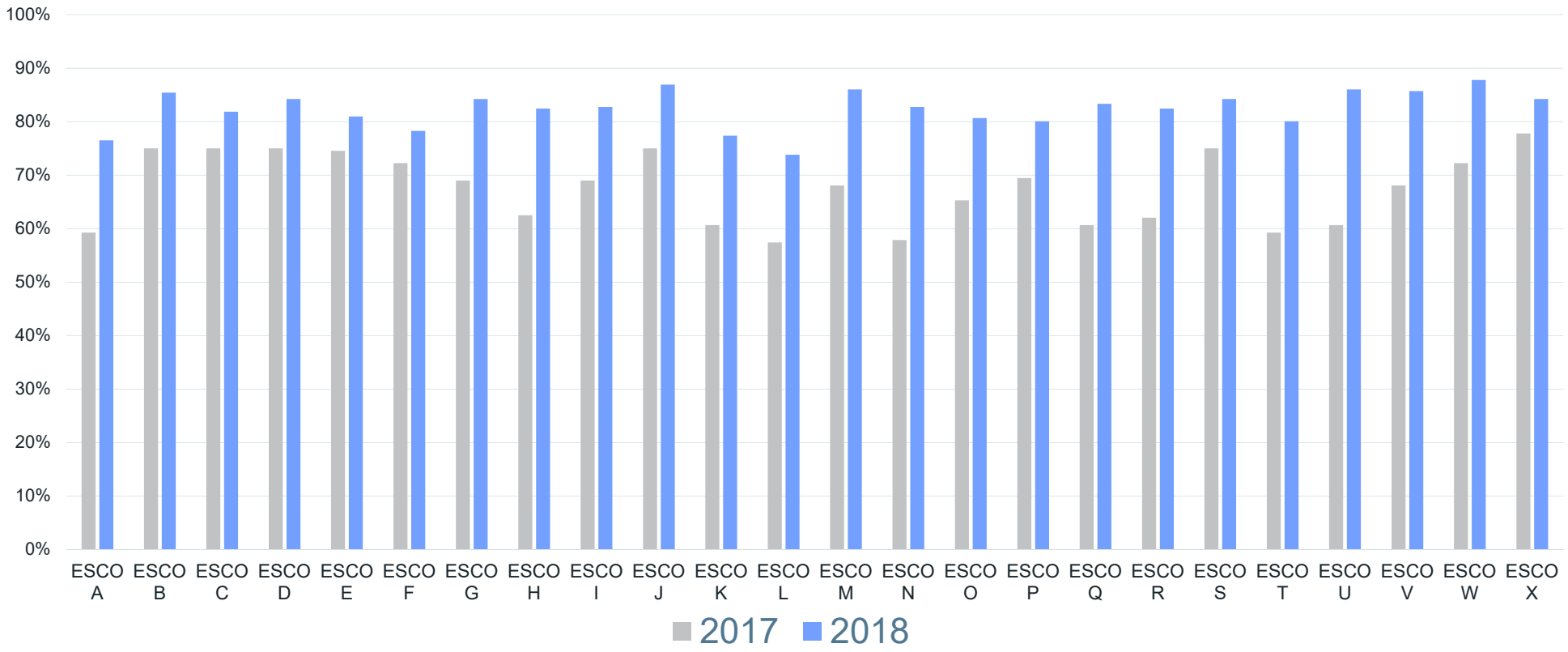
Shared Savings





Calcimimetic Utilization

Total Quality Score From 2017 to 2018



The Clinical Interventions Lab

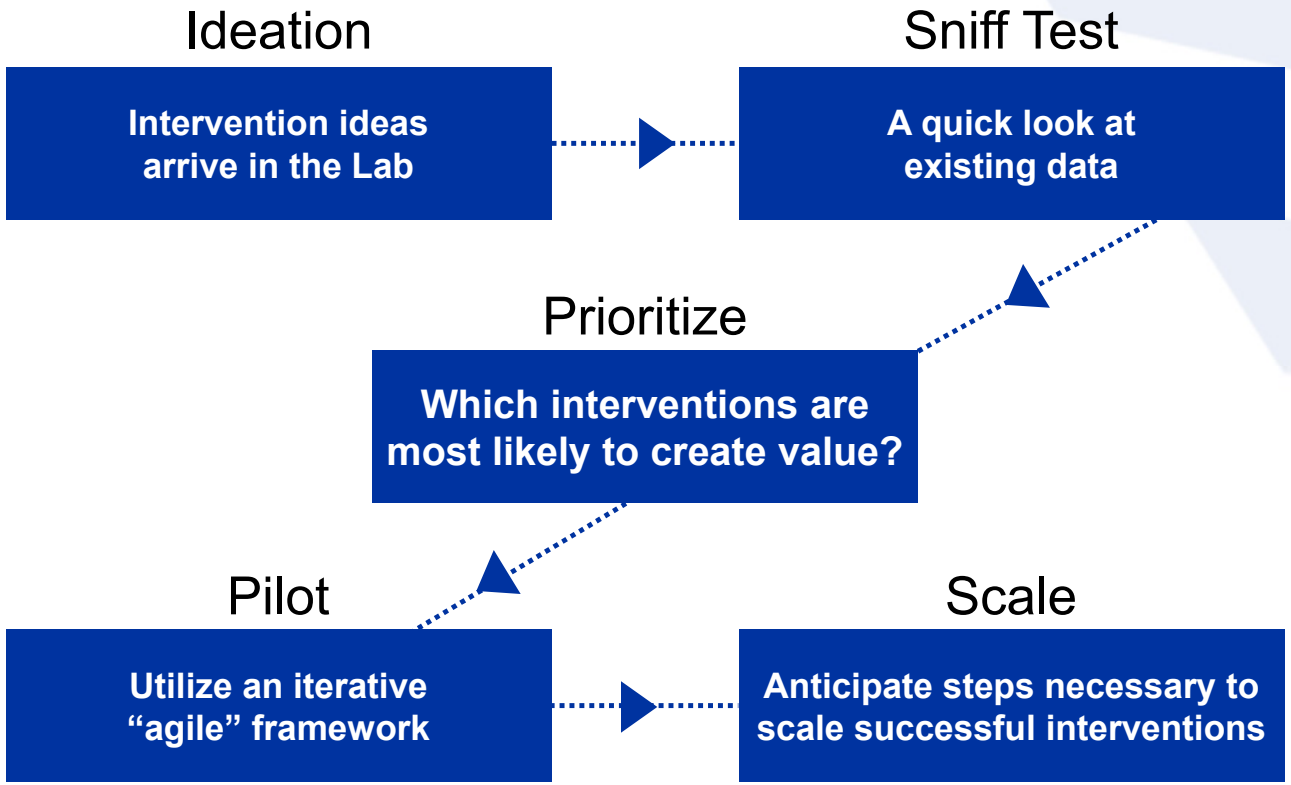
Established 2016

LAB PILOTS

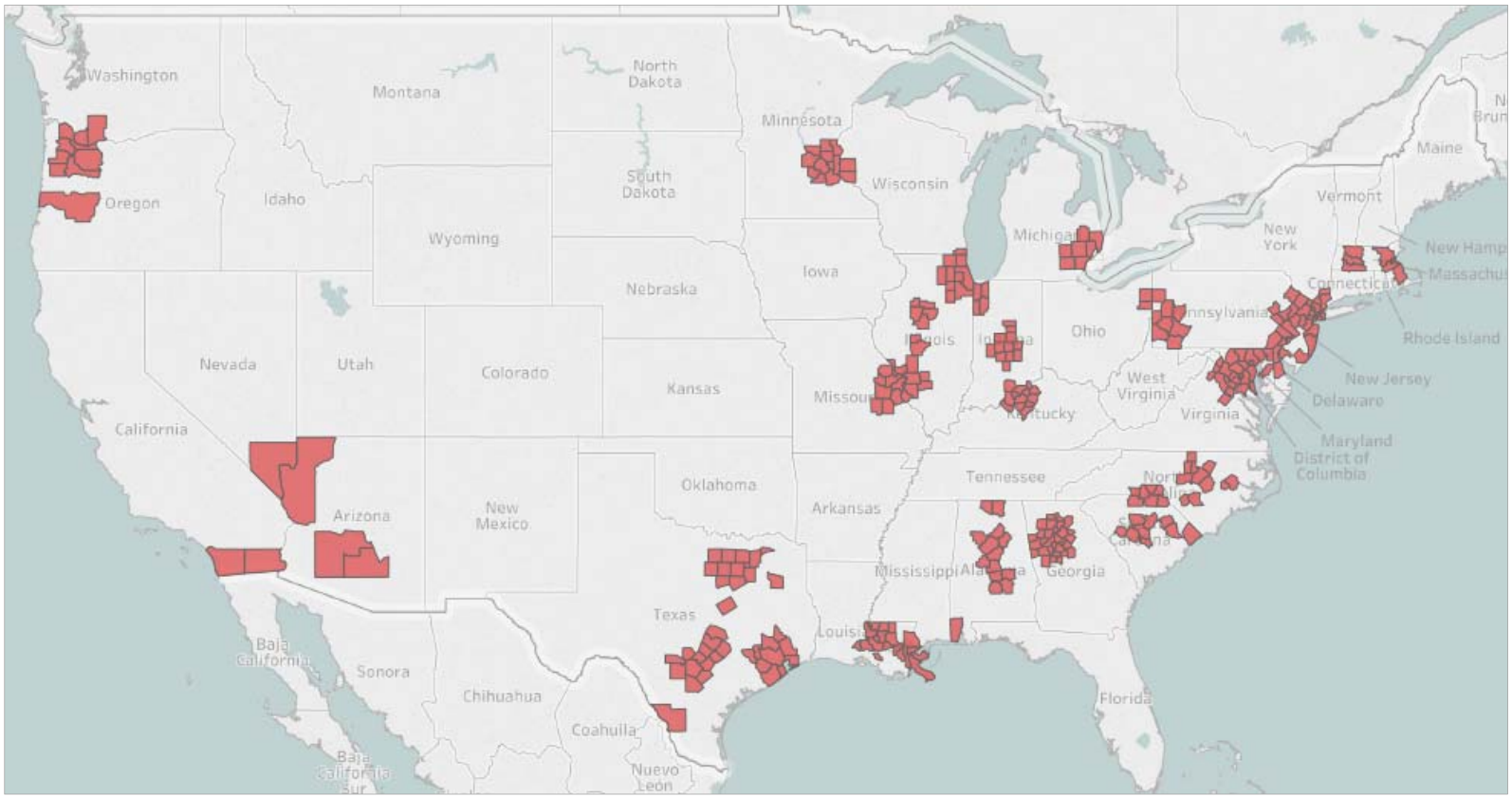
DATA → INSIGHT → ACTION

CLINICAL INNOVATIONS

Lab Pilots


Ideation
Intervention ideas arrive in the Lab
Sniff Test
A quick look at existing data
Prioritize
Which interventions are most likely to create value?
Pilot
Utilize an iterative "agile" framework
Scale
Anticipate steps necessary to scale successful interventions

FMCNA 2019 ESCO Footprint

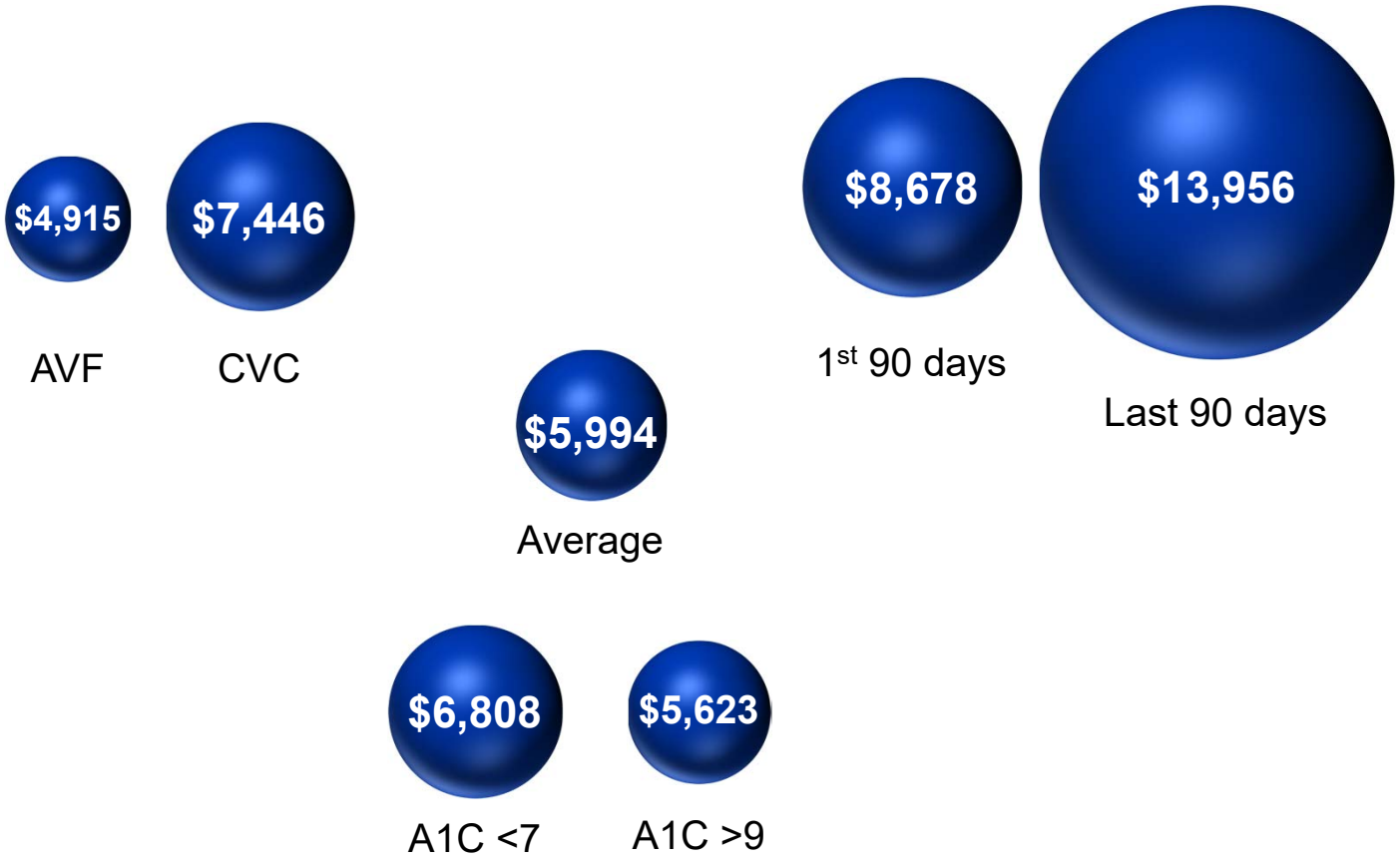


Domains & Attributes Project

Domains and Attributes were developed to categorize Fresenius patients in value-based care programs
The variables allow the Lab to create cohorts that are comparable

Patient	Clinic	Market	Nephrologist
Age	Chair Utilization	Cohort	JV Clinic
Environmental Factors	Clinic Size	ESCO Financial baseline	Practice Size
ESCO eligibility categories	Urban vs Rural	HCC Score	Home Mix
Ethnicity	5 Star	Mitigation	ICH CAHPS
Race	Catheter Rate	Nephrologist	EDW
Vintage	CM Vacancy	PCP	Access Site of Service
BMM Outcomes	Employee Turnover	Admission rate	Engagement
Treatment Adherence	Growth Rate	ER visit rate	
Vaccinations	ICH CAHPS	Readmission rate	
Lifestyles/Buxton Data	QIP	IP Contracts	
Access Mix- AVG/AVF/CVC	Quality Outcomes	Azura Utilization	
Transplant	BSI	ER Avoidance Rate	
	Crit-Line		
	Clear Guard		

Data Insights



Clinical Innovations

In conjunction with FMC Ventures

An imaging tool that evaluates tissue oxygenation	Can we predict the formation of foot ulcers?
An interactive digital health tool to discover and monitor behavioral health disease	Meeting an unmet need in the ESRD space?
A mobile app that connects patients with registered dieticians	Could adherence to the restrictive renal diet improve?

Data

Data → Insight → Action

Value = 

$$\frac{\text{Quality}}{\text{Cost}}$$

Questions?

Mini Summit

Value-Based Care Programs for Patients with Complex Chronic Conditions

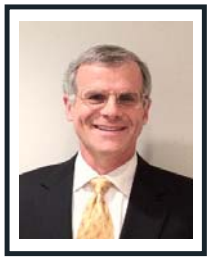
Panel Discussion: Partnering with Payors and other Providers

Mini Summit: Value-Based Care Programs for Patients with Complex Chronic Conditions

Rajesh Davda, MD
Medical Senior Director
Network Performance Evaluation and Improvement
Cigna Healthcare

Michael J. Casey, MD
North Carolina Nephrology Associates

Cosette Jamieson, MD
Metro Renal Associates, Washington D.C.
Consultant to Fresenius Kidney Care, Joint Venture Board Member



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