

MEET THE MANAGEMENT

Moderator: Oliver Maier
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Participants Fresenius Medical Care:

Rice Powell	Chairman & CEO
Ron Kuerbitz	CEO, North America
Robert Bessler	CEO & Founder, Sound Physicians
William McKinney	President, Integrated Care Group
Frank Maddux	Chief Medical Officer
Oliver Maier	SVP Investor Relations & Corp. Communications

Rice Powell

Thank you, Oliver. Good morning

So just some big picture overview, you know, our 2020 target, \$28 billion revenue, high single-digit, EAT growth hasn't changed, just reconfirming for you that's kind of how we're anchored here, OK?

The next big overview comment I would make is, as you know, we are really focused on chronically ill patients, and we believe by coordinating the network, organizing how they're cared for beyond just the four walls of the clinic, we think if we do that way and we actively manage their medical costs, we will improve their lives and we can do this in a profitable way.

What you're going to find today as you listen to these guys, walk through what they're doing, we are further along with this than you think. We are probably more comfortable with how we're going to do this than you may think.

Value-based care in the United States is a reality. Today's discussion is going to be very U.S.-focused, OK, because that's where we are the farthest along, and again, this value-based care where we're getting out of fee for service, the more you do,

the better, and now, it's all about the outcome and how you deliver the outcome and how the patient perceives the process as well as the payers.

The environment in the U.S. is really allowing us and helping us to drive forward. The old saying, timing is everything, proves to be true. I think as you lead today, you're going to realize that we got into care coordination, we began to assemble these assets, fully aware that the U.S. government as our largest payer was going to move down this value-based care continuum and we wanted to be there, so we think our timing is good.

I will also tell you though as you look at where we are in the U.S. and as these guys walk you through where we're going, you'll begin to see little itty-bitty pockets of where this is going to make sense in other developed markets.

It's never going to be exactly the way it is in the U.S. but it's probably a very good thing, but there are going to be pockets of this that are going to lend this after care coordination. I'm not going to talk a lot about that today but the future sessions, we will.

And we do think that care coordination is really the only way to manage the high cost of chronic illness, and you're going to get some fairly revealing statistics on this as we go through the day.

Now, some specific comments for today and I'll just kind of rehash something Oliver said, this is meant to be educational. This is not a capital markets days. We're not going to go back over Q3 earnings. They wouldn't get any better if we go back over them today, OK?

We're not going to get in the big margin discussions, not going to talk about capital allocation. We're going to talk to you about care coordination and what we're doing and why it's important to us and how it supports the business that we've always been in, OK?

We're going to provide the access today to some of the key managers. These are not all the managers that are in the care coordination business. We couldn't bring everybody to London because then there would be nobody at home to do the work.

But I really hope today when you walk out of here, when you get them all over the weekend, you'll send us an email and let us know if you found this to be worthwhile or of value to you.

Our goal today is to give you more of the why we're doing this and how we're going to do it. And once you understand that, I think as we go to the future earnings call or the next capital markets day which will come sometime in the spring of '17, it will put you in a better position to follow us to write your articles, run your models, whatever it is you're going to do, but I will tell you again just one more time, we're not going to help you build your model today, OK?

And several of you would say, we don't help you build your models that much anyway, but we try if we can. All right. So our first speaker today is Ron Kuerbitz. I've known Ron for 19 years. I'm the young one, just keep that in mind.

Ron Kuerbitz

Good morning. I'm Ron Kuerbitz and I'm the CEO for North America for Fresenius Medical Care. Rice, thanks for the introduction. And all of you, thanks for your interests in the company.

What I'd like to do this morning is walk you through really where our vision is for – particularly for the U.S., where are we going, and then step back and address four issues. Why do we think the healthcare system is ready for our vision? Why isn't the rest of the delivery system better positioned than we are to deliver on that vision?

Then the flipside of that, why are we so well-positioned? What makes us the solution for patients with high cost chronic conditions and patients who have high acuity inpatient hospital admissions and post-acute, post-discharge care?

And then finally, I'll just touch on very briefly at how do we do this, how do we execute on that vision, how do we deliver care to really high cost chronic patients and high cost hospitalization and post-hospitalization episodes.

The latter part, Dr. Bessler and William McKinney, will talk about in detail on how Sound engages in the business and then how do they deliver care for patients in the hospital and after they leave the hospital. And William will talk about our system for coordinating all of the care for chronic renal patients.

And then finally, Dr. Maddux will address, from the medical office perspective, how do we organize this system, how do we do what Dr. Bessler likes to say, just take

not necessarily only the best practitioners, not only the best physicians and nurses, take people who work in the system today and give them instead a better system, give them the best system to work in.

And when we think about it that way, it reminds me of an interview I once read with Paulo Pininfarina, the head of the Italian design firm that designed Ferrari's Testarossa. And I remember him saying once – you know, somebody asked him, "Aren't you afraid that your firm's key assets walk out the door every evening? They put their coat and they go home. If they don't come back, you don't have a firm.

And his answer was an answer that I think is applicable to our business. He said, "Yes, they could go, but they'll never do better work than they did here. We give them a system that allows them to do the best work they'll ever do."

That's what we think we do today, is what we know we can do even better as we organize our vision for the future. And that vision is creating a subsystem, a very specialized delivery system to focus on the particular needs of particular populations.

So a subsystem that focuses on chronic renal disease and a subsystem that focuses on very high cost complex hospitalizations and post-acute – post acute care, and to take those subsystems that are focused on small, specific populations with specific needs, to figure out how we integrate that with the provider network, the regional health systems and with payers, national payers and regional payers who have such a small exposure in volume to these patients with such a large exposure in dollars to these patients.

So first, why do we think this is the right time, and this is pretty simple, the whole country is focused on how do we move from a fee for service environment into a value-based environment, value defined as quality which we're all very serious about and as some of our docs like to say that's table stakes.

They're in the patient in our system that doesn't expect us to deliver high quality, but quality and customer service, service is a little bit of a new thought in the U.S. healthcare system. U.S. healthcare system historically is oriented toward efficiency for the provider, what we need to do going forward particularly for the populations we serve is focused on efficiency, high quality of service, a good experience of care for the patient, and then, of course, doing it at the most efficient way possible at the lowest cost.

Sylvia Burwell who is the Secretary of Health and Human Services for the Federal government has said that HHS' goal is to have 30 percent of Medicare's payments in a value-based system by 2016 and 50 percent by 2018, so a third of Medicare payments in a value-based system where they pay for quality and service, they're going to measure quality, they're going to measure customer service and then they're going to reward efficiency.

The Federal government is the only place that's focused on transforming the system from fee for service in the value-based care. The Health Care Transformation Task Force is an association of large national payers, regional payers, large health systems, regional health systems, national providers like us, we are a member of the Health Care Transformation Task Force, patients groups and patient advocates and governmental organizations.

And its commitment, every member of that, at least the provider businesses in it are committed that by 2020, 75 percent of our business will be in value-based care. We've made that commitment. That is our objective.

And the system is moving there. So the Federal government, the commercial sector, employers, patients have all expressed a goal, a desire to get to a value-based system in the country that's moving.

In 2010, there were 50 accountable care organizations, regional health systems, organized to coordinate care and participate in the value-based program. This year, there are – there are almost 600, so 12 times that many in a five-year period.

And today, 2/3 of the U.S. population lives within a service area of one of these accountable care organizations. And those accountable care organizations according to the Department of Health and Human Services has saved the Federal government and the Medicare program over \$400 million (at stake), \$400 million, it's not a trivial investment by the Federal government, it's not a trivial investment by the provider community.

In addition, the country has expanded into – from simple population or only population-based management into managing high cost episodes – hospitalization episodes and post-acute care, and that's what the bundled payments program is.

Bundled Payments for Care Improvement or BPCI is a program that allows hospitals and hospital-based physicians to organize care when a patient gets admitted to

take responsibility for both the cost in the hospital but also all of the costs that follow for 90 days.

This is what Sound Physicians does. Sound Physicians is the largest participant in the BPCI program in the country. They account for between – depending on which month you're looking at and whose data you're looking at, between 15 percent and 20 percent of the entire BPCI program.

BPCI has gone from virtually nothing three years ago to 16,000 – 1,600 providers in the United States today. And other parts of the system are organizing as well. The Medicaid program has not got 72 percent of their members, their beneficiaries in managed care programs, something like ACOs, something like BPCI.

And Medicaid, as you know, is the insurance program for indigent patients and run by the states. So this is not just one payer saying we're going to make this move. This is 50 states saying we are – we see value, we see the ability to reduce our health expenditures and improve service levels for our constituents.

One of the interesting things, nice things about the states is they are very focused on their constituents, both taxpayers and on the ability to deliver care for those who really, really need it. The endorsement by the state Medicaid programs is probably the strongest, maybe the least recognized but the strongest endorsement of the value and the power of integrated care in value-based systems.

And then beneficiaries are voting with their feet. Today, more than 30 percent of Medicare beneficiaries are enrolled in a Medicare Advantage plan. They don't have to join that kind of plan. Medicare Advantage is the HMO model where commercial insurers can organize, health maintenance organizations are value-based care insurance program for Medicare beneficiaries.

So Medicare beneficiaries have the choice of participating in the normal fee for service environment where voluntarily enrolling in the plan sponsored by a commercial insurance company, and to-date, 30 percent of Medicare beneficiaries have made that choice.

When you start to look at the data, 30 percent of beneficiaries for Medicare in M.A. plans, 25 percent of beneficiaries are in a value-based arrangement through accountable care organizations. So as of today, more than half of Medicare beneficiaries one way or another are participating in a value-based arrangement.

So from our perspective, we think the ship has sailed. Value-based care is here and it's going to stay no matter what happens in the marketplace. The system we think has reached the tipping point where it is not going to go backward toward fee for service like it did in the 1990s.

Question then is, are we the players who can organize systems, better systems, more efficient systems, higher quality and higher service for high cost chronic patients like our dialysis patient and for high cost inpatient and post-acute episodes?

Why isn't the rest of the healthcare system which already has responsibilities through those 600 ACOs and those 1,600 providers in BPCI, why aren't they better positioned than we are?

And I think that the data here really tells the story. When you look at this spending, this is non-(defense), non-institutionalized spending in the United States organized by spending tier, so the top 1 percent of patients account on average for \$90,000 per patient per year. The bottom 50 percent, 90,000, the bottom 50 percent account for \$200 per patient per year, virtually nothing, so half the population spends virtually nothing on healthcare.

But the system is organized to take care of those people. The health – the regional healthcare systems, those big ACOs, they have responsibility for all of this. They have responsibility for organizing a system that does big population management, long-term preventive care, making sure people are getting screened and educated and cared for so that we can reduce long-term the diabetes rate, reduce the hypertension rate, try to avoid risks of skin cancer and other avoidable long term and other avoidable acute conditions.

But that's not where the spending is today. If we – as a country, if we only focus on big population health, we will see benefits 10, 15 years from now. We will not solve our spending problems today.

To address that, we've got to address chronic care. Chronic care – chronic conditions affect about 20 percent of the U.S. population but it accounts for 86 percent of U.S. healthcare spending. Inpatient and post-acute high cost inpatient post-acute episodes, so these tiers, they account for 50 percent of spending.

This is where we're focused. Our vision is taking that very difficult high cost chronic \$90,000 plus patient and figuring out how do we do a better job of caring for them, how do we take costs out of that bucket?

And the same with the top tier of those high acuity hospitalizations and post-discharge care, how do we focus on those really complex patients, small populations and do a better job and the system is doing that is really oriented toward taking care of people who are basically well today.

One thing for us to look at the data and say, do we really think there is an opportunity here and say, yes, there is, it's another thing then to ask, is the system addressing that, is the system already dealing with it.

And so we did a survey this year of physicians and the general public to understand what their perceptions are of how the system is functioning and what the results are, what their perceptions of what their needs are and their perceptions of what the system is delivering.

Some interesting results, in the upper left-hand, 90 percent of patients who have a chronic condition or know somebody with a chronic condition say that if they were well-informed, they could do a very good job of managing their chronic condition, they could take responsibility for the needs that arise out of their condition.

But down in the lower right, 2/3 of physicians said their patients can't do that, that high cost chronic patients aren't capable of self-care. It's an interesting disconnect. And the explanation is in the other diagonal.

Two thirds of physicians say that they could do a better job of caring for patients if the system were better integrated. And we start peeling back that data, 90 percent of physicians said they know the system needs to be integrated.

And if it were integrated, they do – they provide better care. Half of the physicians said, executing that integration by themselves is too difficult, they cannot make all the connections, they cannot guide their patients through this system the way its organized today.

And the other half of physicians said, "Oh, and by the way, when I try to coordinate with my fellow practitioners, I don't get adequate information." So on the one hand, trying to organize this too hard, on the other hand, receiving that information is too difficult.

So the system clearly doesn't enable physicians to execute care plans the way they really want to and patients see that too. Patients see that if the system were well-coordinated, 86 percent of patients will say, their experience of care and the quality of their care would go up.

So we think that explains why physicians think that 2/3 of their chronic patients aren't capable of managing their care. It's not the patients aren't able to do it. It's that the system doesn't deliver the right information at the right time to the physicians and to the patients to coordinate that care and enable both the physicians and their patients to provide a better job of managing high cost chronic conditions.

And we see that in our own day to day experience in the business. Four years, half the ESRD, the end stage renal disease population, comes to a nephrologist first out of the hospital. They are not well-managed by their primary care physician. In many cases, they don't have a primary care physician.

Their underlying disease goes undetected until they show up in the emergency room saying, "I don't feel so good." They're identified as a patient with end stage renal disease and either referred to a nephrologist, a third of patients come directly to a dialysis clinic out of their discharge from hospital.

That is by definition a non-managed system. It is the reason that our patients are at the extreme end of that 1 percent, the extreme end of \$90,000 per patient per year.

Looking at Medicare spending for our population, \$90,000 is a good benchmark for the mean of cost of dialysis patients per year. Commercial patients can easily exceed a quarter of \$1 million per patient per year.

And it's this kind of fractured system, not organized, not identifying patients early, not managing disease progression and not coordinating their care as they go into high cost settings, that is the problem, but also the great opportunity we face.

And this shows why we think the system functions that way. When we go out and we talk to regional health providers and we talk to insurers, they give you the statistics I just gave you. They say dialysis patients on average cost \$8,000 per patient per month. What they don't see is that's not a homogenous population.

Just like the spending curve that we looked at for total healthcare costs went from \$200 per patient per month to \$90,000 per patient per year to \$90,000.

Our population is segmented. The lowest quintile spends \$2,500 per patient per month. The highest quintile spends \$20,000 per patient per month in Medicare spending, multiples of that for commercial patients.

And so while the population is small and individual providers have such a small census that they can't see this variability, they can look only in an average, and they think of this as a fairly homogeneous population that isn't.

Our success lies in our ability to sub-segment a small, very high cost population. And when Dr. Maddux gets up to talk about our data, one of the things that he will talk about is, our ability to identify when we really look at the data, half our patients are not at risk of going in the hospital in a year, half our patients don't get hospitalized in a year.

So while our regional health system will spend a lot of money trying to tackle this average and applying average rules to all of these patients that to them are an outlier because they see \$8,000 of spending here compared to a \$1,000 per patient per month in their general population.

So they look at all our patients as an outlier. We look at all our patients as segments within a very high cost population. We have the ability to identify the drivers of those very high outliers among the outliers and design delivery protocols to address their needs and to drive down their costs.

This slide comes from Sound's data, and it shows that point that not only our patients is their variability within high cost populations for the patient characteristics there's also a wide variability in treatment protocols.

So as I said, general healthcare delivery systems are focused on these outlier patients as a fairly homogenous mean. And what they haven't done is standardize the protocols to address that mean.

What we do is we tear that mean apart and look at sub populations and then what we're able to do is within those subpopulations identify specific clinical protocols and standardize, help the delivery system, help physicians, nurses, other caregivers standardize their activities to the high efficiency of the protocols, the activities that are likely to give the best results, the best service at the lowest cost.

What this slide shows, the orange line is a variability measure, is the ratio of the 75th percentile of protocols to the 25th percentile of protocols within different admission causes.

And you can see that for many of these causes of admission, that variability is a five-fold difference in costs, 25th percentile and the 75th percentile driving a five-fold variation in cost. By definition, that's an actionable system or lack of system.

If you can reduce variability of protocols, you can reduce variability of outcomes. Reducing variability of outcomes, by definition, will move the curve to a favorable position and will reduce cost overall.

And that's what we see. When we look at our data, William will show you that we've had 10 years of data collection in managing the total cost of care for dialysis patients. This slide is actually taken again from Sound's data.

I'm looking at managing the cost of inpatient and post-acute care. But the concepts on the curve are the same. The orange line is a non-managed curve. It's actually is a managed curve. This curve is managed the way most insurance companies manage these populations. They can do good actuarial analysis.

So a big insurance company like Anthem or United or Aetna or Cigna, they have enough data to actually do the actuarial analysis and figure out what is the probable – probability of a spend on this population.

And as you can see, that probability is not normal. It is not a bell-shaped curve. It has a very high tail, very long tail of expense and sort of like shorting equity. There is an almost infinite amount of money you can lose. There is a finite amount of money you can make.

You can't – at least we haven't figured out how you deliver care for no cost. So there is a relatively short profitable tail and a relatively long lost tail. The trick for insurance companies is to figure out what that curve looks like and get paid enough to cover that risk, in fact, it paid a little bit more than the risk, so that they damp that down across regions and they make a margin.

And if they're good, they can get their costs a couple of percentage points below the mean. And if they're good, they do that with good actuarial work and they do that with really good case management and good provider contracting.

We have a couple of advantages over any system like that. We have the ability now actually to do better actuarial analysis than any of them because we've got data on 38 percent of the U.S. ESRD population and data that they don't have.

We have the ability to look at a more granular level at what's driving those costs and we have a greater volume of data than any other player in the United State system. So we can do more detail, more granular actuarial analysis. We can take risks with more confidence than anybody else can.

We also have access to these patients three times a week in the dialysis system. We are their caregiver. We have the ability not just to do case management and not just the contract with providers. We have the opportunity to engage with the patients themselves every week.

William McKinney will go through in more detail how we do that and how we take advantage of that opportunity. And then finally, as I said, we actually operate a big chunk of the delivery system and it was one of the strategies of expanding the scope of our provider network so that we were in a position to directly coordinate the delivery of care, hands on care to these patients so that we are in a position to feed information back to the providers to help them narrow that distribution of protocols so that we can both narrow the distribution of cost and clinical outcomes and drive the curve to the left so that we can generate a mean that's somewhere in the order of 93 percent, 94 percent of expected costs with a lower variability, shortening that high risk tail.

That's what we are doing. That's the economics of how we are going to make money. We are going to put ourselves in a position where we narrow that curve, drive it to the left and, oh, by the way, an insurance company spends all this money, they pay everybody else to deliver care with the exception of United who started getting into some provider businesses.

We own a big, big chunk of our own delivery system. So not only do we take the margin that we can get out of managing care more efficiently, we take a margin out of every single provider segment that we own.

So as we grow our dialysis business, we get the insurance margin, we get the provider margin as we grow our hospitalist business, we get the insurance margin, we get the provider margin. It's a story that started 20 years ago with for this

company when we vertically integrated and capture the margin on the dialysis products and disposables along with the services.

It's the same concept, it's an extension of that vertical integration notion to I think its ultimate extreme. So that's why we think we can do this better than anybody else. The question now is, do we have the right assets, how are we organized to deliver on that.

And we think there are three key elements that we need and that we've been spending the last couple of years assembling. The first is financial management, and that is largely what insurance companies have.

And as William will explain to you and Dr. Bessler will explain to you, we have assembled the actuarial skills, the case management skills, the claims payment skills, all the things you need to run an insurance company.

In fact, William is here because he has ran insurance companies for Medicare and Medicaid programs. He is, as we like to call him, a recovering insurance executive. He's pretty good at it too.

And we have care navigation skills and care navigation assets are shared both by insurance organizations and by provider organizations. They are the nurses and case managers who help physicians organize the network and help patients navigate through the network.

And as I said before, one of the challenges for most insurance companies is they don't engage with their beneficiaries very frequently, and when they do, they're mostly saying no. William will go into greater detail as to why he is a recovering insurance executive and why he came over to the life side of a provider-based organization because we don't have to say no, we get to say if you do it this way, your outcome will be better. We don't have to say you don't get to do it that way.

And then finally, we have the opportunity to engage in medical management. And this, of course, is what regional health systems do. They can do the care navigation and they can do medical management. Most of them don't have the scale to do really effective financial management.

We've got the ability to do all three. Medical management, as I said, is the thing that allows us to A, generate a margin on delivering the care that an insurance

company doesn't generate. And B, really effectively standardize the protocols, help the system move toward the efficient protocols.

Why are we better at it then, anybody else for our disease populations, because anyone could assemble those assets if they've got enough scale. But we do it with focus, we're focused on two sets of issues, high cost chronic, right now, renal populations, and high cost inpatient and post-acute care.

And that scale and focus allows us to take the data that other people don't have on small, high cost populations and identify those sub segments to identify what's driving those costs and then go in and actually change the delivery of care or help patients navigate better to avoid those high risks.

It doesn't do enough to just know that. You don't have to have an organized system, like Pininfarina said, you've got to have a system that allows people to do their best work, so you take that knowledge that you get out of a big dataset, you feed it into an organized workflow where people know what's expected of them, they've got the systems to do the right thing and they have every incentive to go do the right thing. You take that and you create a very high powered engine for effecting change on unmanaged population.

And then finally, innovation, if you take a company like ours with its roots in technology and you've got a system that takes that basic data, can deploy it into efficient, more efficient care processes and then can look at the outcomes and figure out what's the next thing to do, how do we redesign a care process or how do we bring a new piece of technology in to solve a problem that the system today can't address.

To do that, it obviously requires scale and that's what we've been at for really the last 20 years, 19 years. We, today, have 2,200 dialysis clinics treating just under 40 percent, 38 percent of the U.S. health – U.S. ESRD population, doing 26 million treatments a year.

With Sound Physicians, we treated more than 1 million patients last year or this year. That million patients generated to \$2 billion in care coordination revenue so revenues associated with building a system other than just the dialysis – products and dialysis services business to organized care for these patients, we expect the next year to be between \$2 and \$3 billion worth of total medical cost under management.

And you'll hear Mike and Rice and Oliver talking about medical cost under management going forward. William will get into it in more detail. The reason we think that's the right metric is that is that spending curve.

It is the sum total of costs that are going to be spent on these populations per patient per year. Irrespective of whether that sum total comes into our revenue or whether it's just the total expenses that we are managing, but that's a – it's going to be a \$2 to \$3 billion spend next year that we have the opportunity to drive efficiency from.

And we're a big balance sheet, a big P&L. Greater than \$11 billion of revenue, we have the ability to take risk on this high cost population in a way that most regional health systems can't. Now, although most insurers and every insurer does, most of the insurers reinsure this population. We have a chance to go in and take that risk off of their books and off their reinsurance costs.

What is our network, what are the assets that we've assembled to deploy? It's big. It's varied. We still have our core dialysis products business where we produce machines and disposables.

As I said, we all treat 220,000 patients this year, doing 26 million treatments in our dialysis clinics. We have 2,000 providers in almost 200 hospitals in the Sound system managing that inpatient experience and the post-acute experience.

We'll do 13 million lab tests. We're the largest renal lab in the country. And we have cardiovascular – dedicated cardiovascular centers that serve the renal population, 80 of them doing 140,000 procedures this year.

Pharmacy will serve 100,000 patients and that's growing very rapidly. And our health plan, what William will talk about, we'll next year serve in the order of 9,000 patients if he gets his enrollment done right.

And finally, urgent care centers, we invested in a very small chain of urgent care centers partly for the capability of delivering primary care to a population that chronically does not have access to primary care.

One of the really interesting and disappointing features of the current system is as patients get sicker and sicker and sicker, as they progress from stage 1 chronic kidney disease to stage 5, they see their primary care physician if they have one, they see them less and less frequently every year.

And their visits to the emergency department go up and up and up every year. And some of that is just a bad function of bad payment system. Primary care physicians have to see patients in 20-minute increments if they're going to be able to make their practice viable.

Patients, as they get sicker and sicker with chronic kidney disease can't be seen in 20 minutes. It's hard. And their problems don't occur in a timeframe that allows them to schedule a visit out in a few weeks and go in and get it addressed. And so they end up crashing into the emergency department rather than going and getting good preventive care.

MedSpring gives us an opportunity to address that problem. So that's a microcosm of how we think we can take these assets first of all do very well with each of them as a provider business in and of its own right.

So our dialysis business, our core business is growing very nicely with the market, actually a little bit ahead of the market we're taking share. And all of those new businesses have growth opportunities that are in multiple of the growth opportunity in the dialysis business because we have relatively small market share in the relatively fast growing markets.

We can knit those together using the assets I talked about, the capabilities I talked about before and deliver a better product to deliver better care, more efficient care, higher service quality than previously. In the next few slides, we'll just touch on that and I'll let Dr. Bessler and William and Dr. Maddux address it in more detail.

This slide is an example of the value of the data. As I said, we are able to take more data and more granular data than anybody else has on ESRD beneficiaries and we're able to sub segment them.

So this data, we took that data and Frank's team looked at what are the odds the patient will be in the hospital zero times next year, one to three times, three to five times or six times or more. And he can generate a 93 percent accuracy, 93 percent predictive power after I think it's 45 days in our dialysis clinic.

So we can have a very high degree of confidence that we can identify patients who are high risk versus patients who are relatively speaking within our system low risk. When we do that and then change the delivery of care, we can reduce hospital admissions by 31 percent.

We also, as I said, can actually change the clinical practice, so not only do we identify high risk patients and make sure that their needs are addressed, but we can actually change clinical practice.

If we get the right system and the right information and the right tools to our clinicians, one of the big challenges for dialysis patients is managing bone mineral metabolism, taking – managing calcium levels, managing vitamin D levels, managing phosphorous levels and now, managing parathyroid hormone levels in the patient. It's a very complex set of problems that after 19 years in the business, I still can't explain.

And the problem is, most nephrologists while they understand it intellectually, they don't have the time to be able to dedicate to solving these problems as they change month over month over month.

And what we found is where we put patients into our pharmacy, when they enroll at our pharmacy, our pharmacy have that – pharmacists have that time and that attention to addressing these issues.

And when they're allowed to engage with the physicians and patients and address the issues helping to solve both financial problems, so patients get the right financial benefits so they can afford the drugs that they need and solving clinical problems, making patients are getting the right drugs that they need. We can drive down hospital admissions by 24 percent.

Similarly, I talked about care navigation, simple care navigations, just doing a better job of identifying where there are inefficiencies in patients moving through the system, we can reduce hospital admission rates.

When we look at patients in our system have no case management or the case management provided by a regional health system and a payer versus a case management we provide, we can reduce hospital admissions by 50 percent by providing much more targeted, much more intensive case management.

And finally, we have the ability to bring technology to bear all of these problems. So this is an example of a piece of technology that was in the market for probably eight to 10 years and no one could figure out how to adopt it.

There was a piece of technology that allows physicians to actually measure the refilling rate of fluid coming out of the interstitial tissues into the bloodstream and then from a bloodstream, the dialysis machine will measure how much is coming out during dialysis.

And by watching that – the decline in that refilling rate, physicians and our nurses are able to actually determine when to stop ultra filtration to take – taking off fluid from our dialysis patients because they have achieved the target weight that they should be at.

The interesting thing is, in the old days, physicians had to guess at this. They didn't actually know how much fluid the patient had onboard and we do this repeatedly over time, physicians can calculate how much fluid the patient has and how much fluid they should have at the end of their treatment.

And when we compared those differences, what used to be estimated with what's calculated today, we found out on average physicians were carrying – or patients were carrying 2-1/2 kilos of too much water chronically.

That builds up over time. It causes deterioration of the heart muscle over time. It causes congestive heart failure. Both acute congestive heart failure where you start with too much fluid, you drink a little bit too much, you have a little bit too much salt and you go into congestive heart failure and admit to the hospital and then chronic because you caused long-term deterioration of heart function.

By using this piece of technology which we could deploy because we've got the scale to drive down manufacturing costs and we've got the organization to get physicians and nurses to use it effectively, we were able to reduce fluid-related admissions by 25 percent, (all cause) hospital admissions by 11 percent and interdialytic weight gain, that gain of fluid between dialysis treatments by 6 percent.

Interestingly for us as a provider, we drove down our use of EPO by 5 percent because we were able to effectively concentrate that blood so that the heart move more red blood cells with every stroke than it was doing before.

That's basically why we think we can win. We think the market is there. We don't think the current system adequately addresses these populations. We think we have assembled all the right assets and we know from the pilots that we run that

we can manage these assets in an organized system to deliver a value-based proposition to our payers, to our partners in delivering care and to our patients.

And with that, I'd like to turn it over to Dr. Bessler who can tell you how that works in the inpatient post-acute care. Thanks, Rob.

Robert Bessler

Good morning and thanks for having me. I'd like to tell you a little story about myself since I haven't most of you and a little bit about who Sound is. Our story starts back in 2001. My background is in the U.S., I'm board-certified in Emergency Medicine.

And I was practicing in a community hospital after leading a big academic center in Cleveland, Ohio and moved to the West Coast. And the challenge we found was that patients would show up in the emergency department, I would take care of them.

And then it was challenging to find a doctor to see them when they needed to get admitted to the hospital. So patient is short of breathe, they show up in the E.R. and they need to be admitted with pneumonia. The next question is well, who will take care of them for the next three days.

And what was happening was primary care doctors that were in the office were getting too busy with all the paperwork and all the patients in the crush of what Ron referred to as having to see a patient every 20 minutes.

And so patients would sit in the emergency department for a long time, and so it was very frustrating, and that was the impetus for the beginning of what's described as the hospitalists movement in the United States.

Hospitalist physicians are doctors that only see patients in the hospital, they don't have a clinic and they work generally in a shift mentality so that if somebody comes in in the hospital around the clock but they don't have to be the one there 24 hours a day.

When I started Sound in 2001, there were probably 1,500 doctors in the United States that described themselves as hospitalists. Today's there's 35,000 hospitalists in the United States. That's more than there are cardiologists. That's

more than there are emergency physicians in the U.S. It's the fastest growing medical specialty in the history of medicine in the United States.

The benefits were not only that the patients would get seen more timely but there'd be a doctor there 24 hours a day so that when CAT scan report came back at 4 in the afternoon, you didn't have to wait for the doctor to finish their clinic and come back. If the patient has a deterioration in their clinical status, there's a doctor there right away.

And early on, we grew from hospital to hospital in the area just South of Seattle, Washington, mostly out of demand because the primary care doctors wouldn't or couldn't come in to the hospital.

In about 2004, we – I'd like to say better to be lucky than good, we realized that we had a business model that was untapped which was hospitals were beginning to feel the pressure around what's called pay per performance meaning it wasn't just about heads in beds. They were being paid part of their fees from insurance companies and the Federal government around the clinical outcomes, and that was like the beginning of the movement.

And that was really when Sound began to transform from what I described as a good medical group to a performance management organization. And over the subsequent decade, we invested very heavily in that transformation.

We are a physician run and led organization. I work as CEO. We have seven regions across the country and we've grown today to serve over 187 hospitals in 33 states with about 2,100 full-time physicians. I'll go into that in more detail.

You know, I – we joke – we have a joke at Sound that I'd like to say we get speeding tickets on the way to work, not the way home, and the reason is pretty simple. While the hopefully none of you get end stage renal disease, it's a rare human being that doesn't know what are hospitals like or have a family member in a hospital.

And I'd like to say, you know, we're not making potato chips, you know, it's pretty easy, it's pretty easy to get p excited about trying to improve quality and lower cost, and in our case, it's across the United States.

We have two key focuses that have differentiated us. It's a focus on physician engagements. And what I mean by that is part of our special sauce has been

getting our people excited about what we do and making them really understand how important it is beyond just taking care of patients, how we take care of our hospital partners to be more successful, how we take care of the communities that we serve.

And the program bundled payment that Ron talked about was really perfectly designed for us. It's a funding mechanism I described to do the right thing. Because 50 percent of healthcare spending in the United States happens from the time the patient gets admitted through 90 days after discharge, we realized a long time ago that we needed – that it was (an abyss) in quality when patients left acute care and we could do something about that. It's just – for years, it wasn't a very good funding mechanism to do that.

So I'm going to share with you a little bit more about our story. We grew from the Northwest of the United States to across the country. We'd like to describe ourselves as a hub-and-spoke model where we'll partner with some of the leading health systems in the United States and then grow within those health systems both metropolitan urban markets and suburban markets is kind of – has been our focus.

And we're only in a 187 hospitals. There is about 4,800 in the U.S. today. We have lots of growth organically that's until we did our transaction in November where we acquired Cogent Healthcare, all of our growth had been essentially organic and we still see a very big story going forward around our organic growth.

So we have three core components of our business. And when I'm, say, at the holiday season trying to describe what we do to the family that are not in medicine, I described it as we combine a multisite inpatient physician group with essentially a healthcare consulting business, our focus around performance management to drive better results inside the hospitals.

So we have our own technology platform, our own training, our own analytics functions, and I'll walk you through that here today.

The first part of our business is our hospitalist business. So that is when – as I described, once the patient gets admitted, the patient comes in with pneumonia or your mom breaks their hip and they're on eight medicines as well, well, you want the orthopedic surgeon focusing on putting the pin in the hip, not managing the patient's heart failure, and so we'll manage all their medical problems.

And the real (sell) there is that we're going to improve the outcomes for the patients. We're going to improve their experience while they're in the hospital so that if the CAT scan is done at 10 A.M., we're back talking to the family right after the CAT scan comes back, now when the primary care doctor finishes their work at the end of the day in the clinic.

And we're going to really focus on improving the cost structure inside the hospital. For those that are not aware, about 70 percent of hospitals today get paid a fixed amount of money for the admission. And usually, that's through what's called the DRG or diagnostic related group payment model in the United States.

Commercial payers, most of them have also negotiated with hospitals of fixed payment. So this means if a patient stays in the hospital with pneumonia, the hospital gets a fixed amount of money whether the patient stays for three nights or 10 nights.

So there is a very strong incentive to reduce length of stay. This is the number one way hospitals can reduce cost of care inside the hospital.

The second way, there is a lot – obviously, we can reduce utilization to less tasks in the hospital, but the best way is to treatment the patient the right way right from the beginning. So if we diagnose the patient early, get them on a treatment plan quickly, that's the best way to lower the cost so that you're not playing catch up.

And the final way, as many of you heard, there's a crisis in the United States around readmission rates. If you think about the Medicare population, almost 20 percent of the patients bounce back into the hospital within 30 days. And if you think about it over 90 days, it's north of 30 percent.

And so today, hospitals get a penalty if a patient gets readmitted. In 2017, of interest, Medicare will have or hospitals will have 7 percent of their Medicare revenue at risk for performance around quality, utilization, patient experience and readmissions.

Now, while 7 percent might not sound like a lot of money, if half of every hospital is filled with Medicare patients, OK, and the average not-for-profit hospital in the United States have 3-1/2 percent margin, that means their entire margin is at risk for performance, right, 7 percent, half of that, 3-1/2 percent margin. So big deal, so that's the business we're in, we're in the business of improving quality to lowering costs for our hospital partners.

We also have intensive care unit physician practice called the intensivist group. And in this model, it's very similar to our hospitalist business but it's only inside the intensive care units and we're in about 25 hospitals today with lots of growth opportunity ahead.

These are the most expensive patients. Obviously, it fits very well into our strategy across the portfolio with Fresenius because these are the sickest of the sick and you have to take care – you know, that \$90,000, that can rack up in a few days in an intensive care unit in the United States.

And so we do the same things in this population. There's a little bit less around patient experience because most of the patients are not conscious at the time but it's a lot more around quality and cost.

And then what we've done after patients leave the hospital is there's this tremendous variation in care, and so we employ nurse practitioners that go into the home for our high risk patients. There is a stat well known in the United States where there is a big access problem to primary care.

And, of those patients that bounce back into the hospital for readmit, half of them never saw a primary care provider before they bounce back. And so we built our nurse practitioner model to go into the home to see those high risk patients, make sure their medications are filled, make sure their follow-up was arranged, make sure there's not a loose rug in the hallway. Our average age of our patients is 76. So this is a very gradual population.

The second part of our post-acute strategy is we send nurse practitioners and doctors into the nursing homes in a hub-and-spoke model around our acute care hospital. And this allows us to really drive better outcomes in the skilled nursing facilities, long-term acute care facilities. We have facilities and assisted livings around our hospitals.

We're passionate, hopefully you can hear it in my voice, around making patients better and we're on a real journey to perfection and quality. I'm not going to get on a plane later, hoping today is the day that the plane runs perfectly and that we should have an expectation in our healthcare system when you get hospitalized that it's perfect.

So there is four key quality measures in the United States that every hospital is measured on. We're proud to say that in Q1 of 2015, 41 percent of our hospitals got a perfect score, and this is on 10s and 10s of 1,000s of patients.

You don't get to perfection just because you have good doctors. You get to perfection by having better processes, by embedding technology, by inputting training in place and having a fail-safe system, and that's what we've really done. These are acute myocardial infarction, heart attacks, heart failure and pneumonia and stroke as examples.

From a hospital perspective, the value we bring to them is around both quality and the economics. And the two key economic indicators that we drive for hospitals are the length of stay which we've talked about and a term called the case mix index.

In case mix, every diagnosis from Medicare has what's called a relative weight that leads to revenue. If you sum up all the relative weights and divide it by the number of patients, you get an average which is called the case mix index. And in the U.S. system, hospitals are paid based on the case mix index or severity of illness of the patients in that hospital.

So our job as the clinician is to document very effectively all the resources consumed during that admission so that the hospital can be reimbursed appropriately. I'll give you an example. If I admit a patient and only write that the patient had pneumonia, but in reality, the patient was an alcoholic that fell asleep and had vomited and really was an aspiration pneumonia meaning they (swallow), they vomit and they got a pneumonia, the diagnosis, the relative weight or the severity of illness is much greater for the second patient.

The treatment plan is much more intense, but if I only documented pneumonia, the hospital wouldn't get their appropriate revenue. So just trying to drive home, we have to teach our physicians about that documentation, we have to have processes in place that appropriately reimburse.

So we want everybody in the upper left corner, the Healthcare Cost and Utilization Project database is an 8 million number, HCUP database from Medicare that we compare ourselves to so we can benchmark.

And we want to have a higher case mix index because we document better, meaning above 100 percent. And we want to have a lower length of stay than the average, and most of our patients sit – they were running about nationally about 12

percent to 15 percent lower length of stays than the average in that Medicare database, and about 4 percent or 104 percent of the average illness severity by better documentation and more accuracy.

Another way to look at this is when you – when you look at the time we've been at the hospital. So this is the value we create for our hospital over time. This is all of the programs we started since 2011. There's been 11 quarters this dataset.

As you can see, the longer they're there, the length of stay drops as a percent of that database, so around 85 percent, and the case mix index or the severity of illness goes up over that same period of time.

This has led to about \$340 of improved contribution per admission at each of our hospital partners. We show this to our hospitals every quarter at every one of our sites as a way to drive that return on investment.

The two ways we drive performance are really around – or two ways we differentiate are around how we engage our clinicians and how we drive performance to our hospital partners and our payer partners.

Around engagement, we have a partnership model for our physicians. We have a very lofty vision at Sound as, say, G.E. is known around building global leaders. We have a lofty vision of being known as the organization building the next generation – sorry, the next, yes, generation of physician leaders in this country in the United States, and so that's something we're really proud of.

We have a whole training institute of how do we take a good clinician to be effective in their role in a new world. And then we put meaningful data in front of our clinicians on a daily, weekly, monthly and quarterly basis and that's what we call clinical integration, is putting meaningful data there to our clinicians.

Around performance, we are really effective at driving and reengineering the clinical workflow in our hospitals. This is what I've talked about almost like a healthcare consulting business inside our business.

But unlike a consultant who delivers a nice PowerPoint and walks away, we never leave. We redesigned the process and then run it in perpetuity. We built our own Web-based technology platform called SoundConnect. We started this in 2004. We have our own in-house development team.

This is the spinal cord of our business. From the time a patient shows up in the hospital, it's integrated to the hospital's electronic record, it drives our workflows, it drives our patient list, it drives our revenue cycle process, our payroll, our training is embedded in here, our communications to the community of physicians, our communications to the nursing home environment, it's all linked together through SoundConnect.

We have our army of folks in performance management that do this reengineering of process. And in every one of our hospitals, we embed nurses – registered nurses, RNs, alongside our physicians to drive these processes on a daily and weekly basis.

Moving forward as we – we've built the road to 2018, we'd like to call it, we think about Bundled Payments for Care Improvement as the funding mechanism to do the right thing because if you think about that 90 days of care, from a cost perspective, 35 percent of that care is what's described as the anchor admission.

And you have to think about this through the lens of the payer or the Federal government, Medicare payment program. Medicare pays a fixed amount of money to the hospital. So while we can lower the cost of care to the hospital, it doesn't lower the cost to the Federal government when a patient gets admitted. They're paying that fixed amount.

Sixty five percent of that care, however, happens after the patient leaves the walls of the hospital in that 90-day window. This is what Ron described in that last of the graph, that 25th, the 75th percentile. This is a tremendous variability and this is the area where we have – we see a lot of opportunity going forward.

We entered the program, this is the Center for Medicare & Medicaid Innovation, CMMI. There are four different models, we chose model 2. It's a retrospective model where there's reconciliation after the spending happens.

So we still get paid fee for service for the care we deliver when our nurse practitioner goes into the home and deliver services through what's called transitional care codes. We still get paid in, you know, 14 to 45 days, depending on the timing.

But after 90 days, there is a reconciliation that happens about 270 days later on the total cost. There is 185 diagnosis, DRGs, that map into 48 bundles. Half of those bundles are medical diagnoses, half of them are surgical diagnoses.

And in this program, we guarantee the Federal government 2 percent savings. Everyone of our tax ID numbers in each of our state is in the program in some form or another, but in each tax ID number, we can choose which of the 48 bundles we want to be in based on where can we make clinical interventions that make sense.

All the docs, all of our hospitals, our hospitals still get paid in fee for service, and what's nice about this program as opposed to some of the other programs that have been developed is it does not disrupt the current economics for our hospital partners which is a key part of our – you know, we're partnered with our hospitals, our business is focused on making sure they are successful as well and the episode doesn't start until a patient gets admitted into the hospital.

A little picture tells 1,000 words. If you think about the anchor admission being 35 percent of the cost, there is a ton of variability after a patient leaves. The two – there's a couple of big areas that I'll talk about, the biggest one is skilled nursing facilities.

It's about 25 percent of the cost meaning the nursing home after a patient leaves. Readmission is about 12 percent and those are the two areas we think we can make a big impact and then Part B spending which is all the provider spending is about 13 percent meaning doctor's offices, tests, et cetera.

The nursing home environment has two key components of costs that we see as opportunity. The first is which patients go. Today, before we got into the program, I would argue, there wasn't a lot of science nationwide used on who meets criteria to actually go to the nursing facility versus home.

A lot of it is clinical judgment or experience of the hospital's case manager that makes this decision or discharge planner. And we're bringing science to who goes.

A couple of data points, if you know the organization Kaiser, Kaiser has – and they do a pretty good job nationwide on utilization and they're considered kind of best practice in utilization. They have about 600 senior bed days per 1,000 lives covered in nursing facilities.

The general population of fee for service Medicare has about 2,000 bed days per 1,000 lives in that same senior population in nursing facilities, so a tremendous opportunity. Length of stay in nursing facilities in the – in the U.S. in the fee for

service population unmanaged is almost 30 days. And that's not surprising since that's how the system is paid up to 30 days.

Managed Medicare, which is the Medicare HMOs, has a length of stay in nursing homes of just over 15 days, same outcomes, that therein lies the opportunity for us on removing variability.

The second area, and so the two ways we drive down bed days for nursing homes going forward is number one, making sure we send the right patients there, and number two, once they're there, having our doctors and nurse practitioners see them daily and weekly to ensure that they're on the right care path, they're getting the right care at the right time and they go home when they need not and it's really around managing to the outcome, not the benefit design.

Around readmissions, there is a crisis as I described, and it's mostly around access and compliance. And when we – while we can't solve the whole compliance problem, we're not a primary care group and we believe primary care is best done at the local level, it's hard to scale, we think about our model as something that's very scalable because all hospitals operate on the same economics nationwide, that payment model is very similar, and so it's a much more scalable solution.

We're trying to deal with fail discharges by seeing the nurse practitioners in the home and sending the nurse practitioners into the home, getting patients back into their community provider.

And there is a bigger crisis in readmissions in nursing homes. There is (an abyss) in quality there, and by putting clinicians into the nursing facilities, we can really get rid of lazy medicine, have doctors there, you know, every day and make sure we're making sure that patients get better before they bounce back.

So three key interventions, the first is, as I described, we bring science to the discharge process, we use a tool called the care at the right location tool that allows us to embed some science into where patients go, we have two ways to lower the – to lower the number of bed days per 1,000 in the skilled nursing home population.

First way is, if you think about it, simple math, if I have 10 discharges to nursing homes, if I get one less to the nursing home and do nothing else, I just saved 30 bed days, right? I'm on in 10 patients.

The other way in those 10 patients is lower the length of stay to 27 on 10 patients, same outcome. So we're doing both. In certain markets, there is an opportunity to send less patients to the nursing home. In every market, there is an opportunity to lower the length of stay in the nursing home.

And then the third way is by making our work force mobile with our nurse practitioners and our doctors and going into the, both home and to the nursing facility. It's a very resource-intensive model, people-intensive model and something we're really proud of.

So if our patient starts in the hospital, our hospitalists are involved as the primary decision maker of where patients go. We embed nurses in with our program that drive that reproducible process. When a patient leaves the hospital, they're in the care of our transitional care physician leader. Our doctors and nurse practitioners are going into those facilities and then our NPs are going into the home.

This is anchored on the foundation of our – a new role we built that we – similar to the nurse, hospitalist R.N., that's what HRN stands for, role that we've had for more than a decade in the hospital, we now have this transitional care R.N. that we embed in with our hospitalist teams that's really focused on the discharge process.

And then this is all on a foundation of a technology platform that link – that is connected to SoundConnect that tracks the patient for the 90-day period. And this is just a visual showing what the – if we have the hospital at the center in our community, the nursing homes around that really kind of allows us to deliver on our new model.

So with that, I think we're going to move to a break. I'm happy to answer questions during the Q&A and glad to be with you and hope you get a little bit of understanding of what we're up to, so thanks.

William McKinney

So raise your hand if you thought you've got a pretty good handle on U.S. health insurance. I'm hoping for at least one hand up in the back.

So I'm going to talk about health insurance. I'm going to do my very best not to use health insurance terms. I've been told that you, guys, have like yellow card

you can hold up (and) start using too many health – you know, how many got those?

So – but as I go through this, my goal is to try to help you understand at a very high level the structure that exists that we're trying to play in. And in some cases, I'm going to over generalize, if any (do block) you've got a good handle on U.S. health insurance, you may find a few places that I maybe being a little too general. But I think it will help you get the idea of how all this comes together for us and how we're going to participate.

So Ron did a great job of setting up the fact that the U.S. government has decided to change the way they're thinking about healthcare. And this is somewhat uncomfortable in a lot of cases for providers out there.

When you talk to physicians in the U.S., traditionally, they haven't had to care about costs. And in fact, they can go the other way. You could be highly motivated as a physician in the U.S. to do everything possible for a patient because of the possibility of a legal action against you if you don't do everything possible.

And in the new model, what we're saying is, you have to still deliver quality. You don't get the skimp on that, but you have to also understand what things cost and no matter what great quality you deliver, if you're not also lowering the cost to the system, it doesn't matter, it doesn't count.

And if you think about what Dr. Bessler presented on BPCI, that's a great program because you've got the hospitals very aligned, right? We get the admission and now, let's just make sure we save the money after they leave the hospital.

Well, a lot of these programs, again, very uncomfortable for hospitals because the way you save money is the person never goes to the hospital to begin with. So you've got hospitals that now have to change the way they think and they're not thinking anymore about 10-year capital planning and occupancy in their hospital and filling as many beds as possible. They have to think about patient outcomes. And so it changed the dynamic a lot in the U.S. and the way that providers across the board are thinking about healthcare and cost and you're seeing this change happening extremely quickly.

The benefit of this is that it suddenly creates a funding mechanism to do lots and lots of cool things, much better things for our patients. I had the chance to talk to a lot of Fresenius medical directors in the room a lot like this.

And I asked, who in here was involved in some pilot with Fresenius that you felt like you really improve the patient outcome, you kept patients out of the hospital, something that was a benefit to the system.

And most of the hands go up, right? That's the kind of stuff we do as a company. I said, who here saw those changes get rolled out very broadly, and most of the hands come down. And you start probing and asking why is that, what happened.

Well, the issue is those cost money, those interventions cost money and there was no funding mechanism to roll them out. But suddenly, we think those changes we can make, those clinical protocols, those things we can do, those investments we can make are going to save money, they're going to shift Ron's curve, that gap between those two lines on Ron's two curves, that's now the funding mechanism. Those are the dollars you just created to go improve the healthcare system. And that's what this does for us ultimately and that's what we're pretty excited about it.

We do think that we have the tools to manage across the spectrum here and this to me, as Ron said, a recovering insurance guy, is really important because insurance is a perfect middleman business generally, right? You're just – you're getting revenue in and you're trying to keep your end consumer from using as many services.

And there are things you do, those case management, you know, how to make people healthier, but you've really got 5 percent of the population spending a lot of the money and you're trying to do utilization management on those – that high cost population.

So really the work you're doing, it's financial. I mean a big healthcare company for the most part is a financial firm. The hospital systems, they do a great job with medical management, but I can tell you because I've talked to systems constantly they don't necessarily have the financial wherewithal or the financial skill set to do what the insurance companies do.

So traditionally in our healthcare system, you've seen those things partner up in a lot of ways. And then when you talk about the big integrated health system where they do have the financial acumen, they do have the medical management, the thing they do differently, the thing they do better is they help their patients navigate that system off and close system and they get great results. I think Dr. Bessler mentioned Kaiser, great example.

We think our population, we think the skill set we have and the work we do looks a lot more like an integrated system and the results we can drive that we've seen are lot more like an integrated system because we play in all three of those wedges.

We've done this before. This is not new for us. It's not something we've talked a lot about, but we have been working in alternative payment models for a number of years. As a matter of fact, a lot of these models, and I'm going to talk about a couple of them, we were the ones pushing them because we know if we can make a better outcome, it creates a funding mechanism to continue to improve healthcare, improve the health of our patients.

So the first one goes back to 2006 where we went to CMS and convinced them to do a demonstration project, that's when CMS tries something else before the current CMMI where they do all their demonstrations now.

They did a demonstration, they modeled it after Medicare Advantage. It was not a Medicare Advantage plan, it was a demo. And they said, "OK, we're going to model this program after M.A. where you enroll people with ESRD and let's see how you've been managing with three companies participating in that demo." We did it, DaVita did it and United did it.

And if you look at the results of that program which are available after demonstration period, you'll see that, as you would kind of expect United didn't do that great, it's complex population to manage, they didn't have the access in the data that we do and DaVita do, DaVita did OK and we did pretty well.

We were happy with that model, and in 2010, CMS let those in the model that wanted to, we did and DaVita did convert those to a new type of Medicare Advantage plan a chronic special needs plan for people with ESRD.

As you probably know, ESRD is the one clinical preclusion to enrolment in a Medicare Advantage plan. If you're in a Medicare Advantage plan today and you develop ESRD, they can't kick you out.

But if you come into Medicare because of the entitlement, because you develop ESRD, you cannot enroll in a Medicare Advantage plan, you never had the opportunity, and as long as you have ESRD as a diagnosis till you're transplanted, you will not be able to enroll in Medicare Advantage.

So this is a special type of plan and we can now go after people we can never go after before. We could give them options that they never had before.

What we had to do in that though was it was Medicare Advantage, there had to be an insurance company behind it. And at the time we weren't an insurance company, so we had to work with what I called fronting carriers that was someone who was regulated by the state as an insurance company, it had networks to pay claims, it was an entity that actually had the contract with CMS. We had to work with them through that period.

And what happened in about 2013 was the company we were working with in that program was bought and sold a couple of times and exited everything non-core and non-strategic and they looked at the small margin they were making on this business with us where we were paying them essentially to administer a plan for us, and they said, "Route". So we left that in 2013 because we didn't have a choice, we didn't have control.

At the same time that we were picking up other types of alternative payment models, we began to take risk with other entities maybe through the emergence of the ACOs. There were other Medicare Advantage plans that we were going in and managing their population for them, and if we could save money, sharing in that savings.

We started taking risk with other M.A. plans and we told them, "Give us the population, let us manage them for you, and we will guarantee you that we're going to improve the outcome and the claims costs." So a number of other programs started up during that time.

If you look at the two different shades of colors, that's the business' two main types of programs and that's what I'm going to talk about in just a moment, but I think it's one of the questions we've heard again and again from you, guys, is how – what are these models and what's the difference in the models and how you're recognizing revenue and what earnings look like and how you have to manage them.

So the darker blue is what I'm going to call a capitation model. Capital model is we get paid something maybe as a premium that is going to cover all the medical costs that we're responsible for.

The other one is the shared savings model. That's where you're just paid on the savings that you generate at the end. And we have strategies for both of those models, both of those models are very important because this market is still evolving and we don't know ultimately which model wins out.

So let me talk first about the shared savings model. Accountable care organizations, who has heard, read about accountable care organizations? OK, so a smothering of hands? An accountable care organization or ACO is currently the government's preferred method to bring providers together.

It could be – a lot often it is seated by a hospital group which you're bringing group of providers together and you're saying, "You, guys, all work as a group and improve the outcome and lower the cost. We're going to take patients who were in fee for service, we're going to attribute them to your ACO and you're going to be responsible for them and your job is now to manage that population to a lower cost and a better outcome.

So the reason the government does (it), it's twofold. Someone asked me this a couple of days ago, well, why do the government prefer this ACO model? They prefer it because you're not taking full risk so that providers don't have to be licensed and regulators and insurance company.

And also in most cases, the providers can take what we call upside only risk. If things cost more, you're not on the hook for that. Most of the ACOs out there are only taking upside. They only win – if costs go down, they don't lose if cost goes up.

So – but what happens in these models, and you'll see a couple different bars here, you know what the expected cost is. That's what the government says you're responsible to manage, right, that whole cost, and in a Medicare ACO that's all the Part A and B expenses, all the hospital expenses, and professional expenses.

Now, what you got to do as an ACO is have your actual cost now lower than that. So, your job as an ACO is to keep people out of the hospital, you lower cost treatments, keep people healthier to make that actual cost as low as you can. And what comes out of that now is the savings. And as an ACO, that's what you get to recognize as your revenue.

So – and what happens is you don't know that month-to-month, right, because you've got – any given month, right, cost go up and down.

There's run-out period because it takes a while for claims to come in, so you run through an entire program year, you give the government time to reconcile. They do whatever quality overlays have to exist on top of that, and then the government says, "And here's what you saved." So that comes later.

Now, you've got some cost because you did things over that year to save that money. You've sent – as Rob talked about some hospitals – send nurses to the home post-discharge to make sure people are compliant, doing what they're supposed to do. So that's the interventions. And you may have to share some of that savings with the government or with other entities in the program, but at the end you end up with a net savings.

There are flaws with that program. It's not perfect. But as I mentioned, there are a number of reasons why it was the right program for the government to use to begin the lining providers, getting hospitals and physicians thinking differently about care, thinking about the cost element as well as quality. The CMS recognizes that it's not perfect, and they started making some changes. So, things like the next-generation ACO is a pretty fundamental change.

And one of the programs, we think, has begun down that path of improving the shared savings model are the ESCOs.

So, we, as a company, have two strategies to tackle the shared savings programs that are out there. The ESCO, or ESRD Seamless Care Organization, is a shared savings program that the government has put in place specifically for Dallas providers and nephrologists. It's run out of the comprehensive ESRD Care Office.

So, CMS, quite committed to this program. There is an office built within CMMI dedicated around lowering the cost of ESRD through the ESCO program. So, we are a participant. We are the largest participant by 2X in this ESCO program. It launched October 1st of this year after some delays on the part of the government. So, how is it better than the old shared savings model that we see in the ACOs?

Well, one thing is we're going to get a lot of claims data every month and we're going to know who our beneficiaries are when we start, right? I know today who's in the ESCO. We can begin managing those beneficiaries. I don't have to wait until the end of the program to find out who they assign to me. And believe it or not, that's how most of those old ACOs work.

The government doesn't really want you to know who is assigned to you because they want you to manage your whole population so they wait until the end.

Oh, by the way, here's who we attributed to you. Well, they didn't do that with the ESCOs, right? They are telling us upfront, "Here's who you have." And every month I'm going to get about 40 files across the ESCOs, very large claim files across the ESCO so that I know how effectively I'm managing these patients. And they're going to attribute a very large number of patients to us in geographic concentrated areas, so in the ESCO markets, in the places that we propose and are implementing the ESCOs, we will have high concentrations of these patients in our clinics. So that means our ability to think about changes in clinical protocols, it means our ability to have the nephrology practice engaged with us.

If we decide we need to put extra feet on the street to do things like home visits, we can do those with the ESCO because we have very large populations that we are – we know ahead who they are in a very concentrated geography.

Now, the down side of this program and again someone asked me earlier this week, "Well, what don't you like about it?" There's a natural lag, right? We started October 1st. This first program year will run through the end of 2016 and we're not going to know for sure what the government thinks we earned until the end of 2017.

We're going to be able to estimate it we've got claims data. We know what the big levers are. We're going to have a pretty good idea, but it's not something we can book as revenue. It's not something we can realize because our revenue and our medical spend under management are two different things. We've got a way to the program reconciles in the end, and then we'll get to see that review.

So, the work we're doing starting October 1st this year through all of 2016 no revenue until 2017, probably late in the year.

And when we talk about medical spend under management though, we are managing for all of those ESCO patients all their Part A and B spend today, so it's a big medical spend under management, but no revenue until later. So that's the ESCO program.

The other thing though that we can do around shared savings, which is interesting, is we can go out and in a very consultative way, support all of the hospital systems who are frankly often struggling with this program because they don't have the

financial acumen, they don't necessarily know how to think about risk, they don't have some of the depth of data that we have. And so what we found – and again I spend a lot of time talking to hospital systems is they have a great hunger to speak with people like us who can come in, who have credibility because we're doing these programs ourselves and help them manage one of their very, very high-cost populations.

And what's interesting that I've seen is, as a team, we have a skill set that the hospitals don't. And often those conversations that start as a conversation about CKD and ESRD evolve into just more broadly how can we be a partner helping a hospital system, think about risk.

Capitation model. So this is the one you probably here talk about as full risk. Good example of this, Medicare Advantage.

In Medicare Advantage, the Medicare Advantage company gets paid a premium on a monthly basis for people enrolled in the program, and that premium is designed to cover the medical costs that are expected for that patient. That's estimable. You know what it is. You know who is enrolled in your program. You get to book that premium every month as revenue. And then you're taking that premium and you're using it to pay those claims, so as providers see the patient, they submit a claim. You get that claim, and then – and then you pay the claim out of the premium dollars that you received.

I told you in the past we had a Medicare Advantage program we ran through a fronting carrier that decided they wanted to exit that business. We are going back into that program with another C-SNP, and I'm going to talk about that in a moment.

But at the end of the day, while our medical spend under management is equal to revenue in these programs, you notice that the same idea of now how much improvement can I drive, what did it cost me to drive that improvement, and what's my net savings, it looks about the same. So, that's an important distinction on revenue. And the reason I make that revenue distinction is because mix matters.

If what I'm talking about as a shared savings program, low revenue, about the same earnings as what I see on a capitation program where big revenue dollars, same earnings. So, as these programs evolve, as our population shifts one to the other, CMS comes out with new designs. If and when they change ESCOs to look

more like next-gen so it's more capitation-based. As our mix changes, the margin percentage that we're driving on these programs is going to shift as well.

So, an example of that, if a patient use round numbers is worth about \$100,000 a year, has a medical expense of \$100,000 a year, in a shared savings program, if I can drive a gross savings of \$7,000, my revenue is \$7,000. In a capitated model, and I'm getting the right premium, my revenue is \$100,000. That's a huge difference.

What's our strategy around capitation models? Well, I told you, we're going back into the C-SNP business where we've done that. We are launching January 1st with a chronic special needs plan under Medicare Advantage for people with ESRD.

This time, we're doing it ourselves. We have the insurance licensure. We have the claims payment engine. We have the team in place that knows how to run an insurance product. We have spent the last two years building the infrastructure necessary to be an insurance company and to take our faith in our own hands around managing this population through a capitated model.

For those that track Medicare Advantage and all, you'll know AEP started on October 15th, so we're about a month into the enrollment for people who will be in our plans starting January 1st and so far, I'm very happy with how that program is going.

The disadvantage of this model is we start from zero. Today, I have zero members of my plan, which means I have more employees than members, which is a bad metric from what Ron has told me.

So, January 1st was those people become effective that ratios get much better. So, January 1st, we'll have people enrolling. We've been enrolling during AEP, but we go from zero. You have to build networks. You have to do expansion county-by-county in this plan. So, while I think long-term this is a tremendous opportunity for us to participate in alternative payment model with our patient population. It's one that you have to grow. It's one that you have to convince the consumers they should participate versus the ESCO.

You know what I asked the consumer? CMS just says, "By the way, Fresenius, you now need to manage this patient, so I've got to enroll. So, a little bit of the best of both worlds though is this idea of subcontracted full risk. We've been doing this for a while as well so we built that pretty significant expertise.

It's the idea that find some other entity who's taking risk and not managing our population very well, which means kind of everybody taking risk on ESRD. And let them reinsure that with us. Let us manage that population for them. That could be a Medicare Advantage today.

I can tell you because I've been one, a general Medicare Advantage plan. You've got these patients called ESRD. And the way you think, yes, I've got ESRD patients. And yes, yes, they're pretty expensive. Yes, I've got ESRD patients, then you go manage COPD or CHF or something and get your arms around. It is such a tiny population for a general insurance company. You cannot put programs around it. You don't have good data because your population is simply too small at any given carrier.

So, even the really big carriers, I can go to them and I've got data and an ability to aggregate a population that gives me actuarial credibility that none of them have. I have clinical data and access to the patient that none of them have, so there's a great opportunity here to work with other carriers, to work with state Medicaid agencies, other entities who have risk and take that risk from them for the population.

The nice thing here is this is something that – its attribution. Someone else is already enrolled these patients in a program. So, when I go to a big insurance carrier and convince them to give me that risk, they just attribute the population to me, so it grows very quickly. Downside is it's a very, very long sale cycle because if you been keeping up with media in the U.S. you will know that there's a few things going on in insurance right now.

So, these guys have a lot going on. It makes it a long sales cycle, and you're giving out some amount of margin. You've got a client, and that client wants economic value from the program as well, so that's the downside of that model.

So, they all have pluses and minuses, but the goal across these four strategies is to cover the water front. And if you sit down and think about it, I'm happy to talk about this more over lunch, between these four strategies, I have a way ultimately to use an alternative payment model for every patient in every facility in the U.S. Whether they're in a program today, they're in fee-for-service today, there is a path.

Now, we're not everywhere geographically, and some of these programs are geographically specific, and I haven't signed up every payer to do this, and we need to keep growing the subcontract idea, but we now have strategies to address the full water front.

At the end of the day though, you've got to understand the risk that you're taking. And we have a number of advantages in that, and one I'm going to talk about briefly is the 5 percent sample. So, who's heard of the 5 percent sample? Anybody? OK. This is really important as an insurance company in Medicare Advantage.

Medicare makes available to you claims data for 5 percent of the Medicare population. So when you got a general insurance product, one of the things you do is you go and you pull that 5 percent sample to understand how the population behave market-to-market with the differences are on cost.

For ESRD, it doesn't work. If you go pull the 5 percent sample on the ESRD, you get so few patients, your actuaries can't do anything with it. That's a huge advantage that we have because I have data because of all these programs I've done because of ESCOs, the historical C-SNP, the other shared savings programs where I'm getting claims data from a lot of different places. I now have more claims data and more ability to do the financial aspect of risk management than anybody else out there, tremendous opportunity for us to understand the risks that we're taking, to aggregate and think about a credible population on which we're taking in. But then the other advantage I have and I'm going to talk a lot more about this is the ability to do medical management that a normal insurance company doesn't have.

So I want to talk one more moment about why that's so important, why that data is so important. One is just the statistical variability that you get on a small data set. That's important to the actuaries and they call that concept credibility. So, do you have a big enough population to be credible?

But the other thing is understanding how and when claims come in an ability to forecast because what insurance companies don't like to do and what the actuaries really spend their brain cells working on is predicting today so that we're booking this month what we think happened at this month, and you got to use historical data to do that. And so the idea is what you're seeing here, which is the numbers are important, but it's a – it's an actuarial claims lag.

So, if you take, for example, March of 2013 and you see incurred month goes across the top, what's the month that someone went out and received the service? Well, I received it in March of 2013.

Then the reported month, what month did I actually get something from the provider that said I saw a patient, and I'm submitting a claim for you to pay to me? We get a few in March. Most of them come in April, but then you got a lot of other claims that come over time. And even if I wait and I run this report in December of 2013, I'm not done yet. All the claims haven't come in and that's a concept called "incurred but not reported."

At any given point, I know there's stuff that's happened that hasn't been reported to me through claims yet, and so that's what the actuaries do, and that's why data is so important because you have to understand how your population trends, how your provider base trends when claims are going to come in fact so you can do – have accurate predictions financially about your population. So, we have built the infrastructure to do that.

We're done. The infrastructure we need is what scales operationally as we grow these programs. This is in place. Financially, we have a fantastic actuarial team that is a very, very important component to us. It is not something we've outsourced. We had in-house actuaries that understand our population and our data set.

From a regulatory standpoint, we need insurance licenses, right? You have to be an insurance company. It means you're regulated financially by the states to make sure you have proper reserves to handle the claims payments that have come in. So we've checked that box. We've got insurance license. And I'll tell you, historically, that's been another constraint for us in tackling some of these possible opportunities.

There was a state specifically that we – has wanted us to do something creative with the state and their Medicare program for a number of years. The problem was the state felt like we – you need to be an insurance company to do this with us, right? You need to have the risk infrastructure to do this with us, and we were. We were a provider.

Well, now we're an insurance company. I think over time that's going to open up a lot of opportunities for us to work with states and work in other alternative

payment models without necessarily having to have a middle man that we're paying a margin, too.

Operationally, we've been on the provider side. We're now on the payer side. We've been sending bills, sending claims out, and now we're receiving and paying claims. So, kind of a different side of the same coin, but it is additional infrastructure, operational expertise capability systems that you have to have.

But the other component of that that's really important is network. In a lot of these structures, you don't get to pick and drive the network. You may be able to influence, but it's not your network.

One of the things that we get through our current plan and some of the models we're pursuing is the ability to drive the network. So, for example, if you think about the things Dr. Bessler talked about that he's doing post-acute, you got to believe if I'm putting hospitals in the network, the hospitals I want in the network are Dr. Bessler's hospitals because I know what he's doing to drive down the cost when someone is discharged.

What I'm thinking about how someone's getting vascular care, I want to make sure that whenever possible they're getting or I think they're going to have the best outcome, which is the Fresenius vascular centers, right? Same thing for NCP and other assets that we have that network is an important component of what we can do under this model as well.

And finally, the clinical. As an insurance company have to do utilization management, right? One of the components of what you do when you look at a claim and say, "Was this medically necessary?"

The good thing is one reason this just feel better as an insurance guy to do this kind of work is that is not how you're going to make money on our population. We're not going to make money by telling people no. A matter of fact, our population in general needs to go to the PCP more. They need to go to the specialists more, right?

The way I'm going to make money is I'm going to keep them healthier, I'm going to keep them out of hospital, I'm going to keep them from dying, right? That's how we're going to make money. And now suddenly everybody is really aligned. And the insurance company is the good guy. And I'm going to talk about how we do

that, how do we keep them healthier, how do we keep them out of the hospital. It's a concept we call care navigation.

And at the center it's something that makes us such a unique opportunity, which is the fact, I know we've mentioned this a couple of times, we know where these folks are. We know where they are three times a week for four hours, and we have a tremendous amount of data and a tremendously deep relationship with these patients. And it lets us do so many more things than not just a normal insurance company, but even integrated health systems can't do.

So I'll start at the top, high-risk patients. And Dr. Maddux is going to talk a little bit about some of the modeling we do. The health plan within Fresenius uses a lot of the models produced by the medical office. We were the original customer for a number of those models to say help us identify patients. We can or should do something different or there are things like refer them into our social work intensive program or better manage our incident populations or beginning dialysis.

Post-acute, today we're not doing everything that Dr. Bessler is doing. I think there are some great best practices we can learn and leverage from Sound, but we are doing a number of things and doing them quite well. One is being very, very aggressive both while the patient is in the hospital, and then as they're being discharged, working with the patient or caregiver in the hospital to do proper discharge planning.

And when they are discharged, one of the first things we need to do is get that patient hooked up with a Fresenius pharmacist, a renal pharmacist that is going to be able to do a medication reconciliation and make sure that there was nothing prescribed in the – during the hospital visit that will cause us to change their medication therapy.

Non-dialysis, things as simple as helping people schedule PCP appointment so they get in and get it done. Things like helping them understand don't skip dialysis because that's the only – that's the only time your primary care physician said he was available for an appointment. We'll call your primary care physician. We promise you will find another time.

Helping people get durable medical equipment so that if they need an oxygen concentrator on Friday night, it actually arrives because if it doesn't, they're going to end up back in the hospital on Saturday. So what are the things we can do to

help them understand the community benefits they may have, the healthcare benefits they may have because a lot of people have benefits they don't leverage.

And then finally, and one thing that's really core to- is mistreatments. We know of our patient's mistreatment. It's much greater likelihood they're going to end up in the hospital. So, we have in care navigation, a dashboard if a patient that we're managing is more than 30 minutes late for a dialysis treatment, we get an alert. We know.

And the first thing we do is you pick up the phone, we call the dialysis clinic, "Do you know where Ms. (Jones) is?" "Well, no." "OK, great. Have you tried calling her?" "Yes, we've called two numbers, haven't gotten her." "Do you know what hospital she would have gone to?" "Yes, she would have gone to one of these three hospitals." Then we, in (CareNav) 01:53:12 start calling every number we have for that patient that we've collected over time.

We start calling local hospitals. We find that patient. So what it means is, one, we often have an opportunity to intervene while the patient is in the E.R. We've talked to E.R. physicians and said, "Look, if all these patient needs is a dialysis treatment, discharge them, and I guarantee we will get them in a dialysis chair today." And we have saved admissions because of that. It also lets us know much more accurately than a - than a normal insurance plan when a patient is hospitalized. I know because I've been there.

There is a huge lag within an insurance company. You don't really have an ability to do post-discharge planning; we do, because they're missing a treatment. We know there somewhere, and we find them in a hospital, and that lets us engage and do that post-acute work, so that's really, really key to us as well in the strategies that we have. So I want to walk through one patient example that I think ties a lot of these together. It's one of the very early patients we had in care navigation. I'll use his initials, (R.F.).

(R.F.) was a dialysis patient. He dialyzed with his wife who was also a dialysis patient. He was visually impaired, and he was kind of a big guy. And the dialysis center are the ones that engaged us in (CareNav). They were very frustrated with this patient. He kept coming off of his treatment early. He would come up after 15 minutes and go sit in the waiting room and wait for his wife to finish treatment.

As a result, over the course of nine months, he have been hospitalized eight times, OK. And so you understand. For those of you who don't know the U.S. system, a hospitalization, even a short one when you got dialysis as a secondary diagnosis, that is \$10,000 to \$13,000 visit probably, on average. OK? So, this guy is costing his insurance company a lot of money.

So, we started engaging with the patient with his caregiver. We tried to get a deeper understanding of what was happening with this patient. He has had severe anxiety because of some things that have happened in his home life. The nephrologist had actually attempted to medicate him, but it was probably a sub-therapeutic dose. It was a medication class, the nephrologist wasn't entirely comfortable with. The guy really needed to get a behavioral health consult.

So, we looked at the benefits available to him. We scheduled that behavioral health consult. We made sure he had transportation range to get there. We got in there. We followed up afterwards. We made sure he was medicated properly, and what happened was he started staying on his treatments.

Well, it is hard to say the treatment time shortened again because we're still following this guy, right? He's one of our high-risk guys. We're saying the treatment is shortened again. What's going on? We still have a lot of anxiety.

So the next thing we did is we got an iPod Shuffle. We knew this guy like music a lot. We knew (R.F.) really like music. We actually know what kind of music he liked. We loaded that Shuffle up with the kind of music that he liked. We sent him to the dialysis clinic and whenever he came in for his treatment, he listened to music. He's staying on for full treatments.

We managed (R.F.) for four months. He had zero hospitalizations during that four-month period.

Now, the – my favorite part of the (R.F.) story was he – the plan that was our client through which we had him as a – as a risk patient lost him as a patient. He moved to another plan. I know there's an ESRD can't enroll in M.A. This is a little more complicated from an employer group.

So, he moved to another big Medicare Advantage payer. Well, I was then talking to that particular payer about working with them on subcontracted capitation arrangements. And I was able to tell the (R.F.) story, and at the end of it and say, "And by the way, he's your patient now."

So, this is the actual numbers. That work that we do, I gave some examples. I've talked about some of the tactical components. But the result is we keep people out of the hospital. We lower readmissions. And you can see the numbers on here, about a 20 percent reduction in our hospitalization rate for the patients we're managing in this program, and that's where the dollars come from. They come from both the in-patient component, but then just like Dr. Bressler, all that post-acute worked as well for this patient.

So, the ambulance visit to the hospital, the ambulance visit after the hospitalization, all the professional components, the skilled nursing facilities, when you keep people out of the hospital, you don't just avoid that in-patient admission, you avoid all of those post-acute costs as well. And that's where we save the money.

So, at the end of the day, we are a big believer in these models, alternative payment models. We think they're extremely important to what our – what our largest client, CMS, the government wants things to go where large payers are beginning to want the system to go. And we think, most importantly, it's a funding mechanism to do all those improvements we should be doing because if we are not the ones innovating and improving the care and the outcomes for the renal population, I don't know who it's going to be. And I'll turn the payment models to the way we can do that, so we can improve care.

And what's going to happen as we improve care is we're going to find that we're the network of choice whether it's your public or private payers. They're going to want us involved in managing these patients, which is only going to create more and more opportunity to leverage the existing alternative payment models and look at new models in the future, and influence the direction that those models take.

So, the alternative payment models I've walked through, I think they all have standalone economic value, but they really beyond that help strengthen the overall story for FMC and the care we can provide to our patients.

So with that, I'm going to turn it over to Dr. Maddux. Thank you.

Frank Maddux

Thanks, William. So I want take this last section and try to tie a little bow around this package that we've been putting together for you, and recognize that we want to talk a little bit about the primary goal that we have for our patients. It's improving their quality of life. It's being a leader in the field of how we're managing this high-cost chronic population and, with that, trying to look at how we've begun to architect, focus that scale for that value equation that Ron Kuerbitz showed you, the recognition that it's quality, service, and cost that ultimately leads to an opportunity for us to leverage the vertical integration that we've had across our own entire group.

So, I want to start with some recognition that when you begin looking at all of our patients falling into this top 1 percent category of the high-cost chronic disease patient, there are unique characteristics to this population that we have to be fundamentally aware of. Their characteristics are that we know what their problems are. This is not a diagnostic dilemma. It's actually a fact that since we know there are risks, we know that they are not part of this event-based healthcare delivery system that exists today where you break your arm and you have the healthcare system respond.

But they, in fact, are in a system where we know that if they don't follow the routines that have been prescribed for them, they will have consequences from that, and so the avoidance of known crisis becomes the focus goal. And that's what really distinguishes the reason why actuarial risk alone and utilization management alone doesn't actually cut it with this population. You've got to, in fact, actually do fundamentally more management.

So, what I'm going to talk about today is a little bit about the past, present, and future. What we talked to you about 18 months ago at Capital Markets Day, where we are today with regard to evolving our organized medical care system, and then, at the end, talk a little bit about what I see going into the future that will be some of the drivers that you'll see us talking about in the – you know, over the next couple of years.

So, I showed you this slide back 18 months ago and it is still pretty pertinent that we recognize that we must have business models and plans around each stage in the continuum of care of our patients. We have this cost profile that peaks during the transition from chronic kidney disease, or CKD, through incident end-stage

renal disease. This is a very risky point in time for patients both in morbidity, mortality, quality of life, experience of care, and cost.

And then what's happening with the prevalent end-stage renal disease patient becomes an issue where we are having to fill in the gaps on our portfolio in things that we become more sophisticated. And as the patients get closer and closer to the end of their life and their supportive needs to avoid some of the expensive costs of fetal care and some of the activities that surround the population as they become sicker and sicker over time.

This is a picture of the renal disease patient. I want to point out just a few components of this. It, in general, is an older population. It is a population that has both high morbidity and hospitalization rates, but also high mortality rates compared to the general population.

The use of medications is extreme in this population, 16 different medications on average during a week a patient has to take. And with those medications, some of them are at dosing schedules that are hard for any of us to actually take. Imagine taking for one of the pills 12 to 14 tablets a day. That's very, very hard. It offers us an opportunity to bring in medications, for example, into our technology portfolio that offer only three or four pills a day to do the same effect of 12 to 14 pills per day.

Almost 99 percent to 100 percent of our patients depending on how granularly you actually look at it have cardiovascular disease. It's a huge adjacency to the renal disease that they have. And for those of you that have been watching the news just this week, you'll notice that one of the examples of that was Jonah Lomu who died two days ago, a very well and renowned rugby player from New Zealand who had nephrotic syndrome renal disease, required a transplant, and died of a heart attack at the age of 40. This is typical of our patients. And so our sensitivity to the issues around cardiovascular disease is really one of the key areas.

We've talked about the cost per day. What we haven't talked about though is that with the 34,500 minutes of dialysis annually where people are sitting right in front of us, we see these patients more than anybody else on the healthcare system. But guess what? That's only 5 percent to 6 percent of their actual daily life and time, which means that 94 percent to 95 percent of the time, they're at home making healthcare decisions that actually affect their outcomes rather substantially.

So as we move forward into organizing care, we've got to be more sensitive to the issues of what's happening to patients when they're not sitting right in front of us. And so we'll talk about that a little bit.

And then finally, I would talk about this last number. The 30-day readmission rate of this population, actually two years ago, was in the rate of about 34 percent to 35 percent. We've actually, with some of the things we started doing in the last few years, brought our rate down to 29 percent at this point. But remember, that's against the general population that is sub 20 percent in just the Medicare population. And the general population is only around 11 percent.

So, it strikes me that we have huge opportunity to take an organized system across a vertically integrated platform and change the way that we fundamentally deliver care in the United States for these high-cost chronic disease patients.

This actually recognizes that one of the highest risk points for patients for when they have life transitions, and those life transitions are when they're asked to do something fundamentally different for their care such as go from chronic kidney disease not on dialysis to picking a modality for dialysis or from the things that Rob Bessler is actually taking – you know, taking responsibility for in the BPCI program, and that is recognizing when they transition from an acute care facility to home, from an acute care facility to a sub-acute facility, from a sub-acute care facility to home. These transitions are very risky for patients for morbidity and mortality, hospitalization and bad events to occur.

And so organizing around these becomes extraordinarily important. And so one of the greatest things that – in integrating the activities of the portfolio assets that you've seen us develop over the last few years has been, in fact, to actually gain great knowledge around this transitional care management as one of the gaps that needed to be filled in our understanding on how to actually do a better job for patients and actually reduce the cost of care through more effective management.

So, some of the things I want to talk about within the present and going forward for us are going to be how we leveraged our vertically integrated platform and recognize that when you look at the way we've organized what we've done, we've done it around two primary things – where do patients receive care that we need to create points of clinical leverage on that care, and what are the conditions that patients have beyond just the renal disease requiring renal replacement therapy that we need to have more sophistication in. We'll talk about that in a moment.

Secondly, we have to recognize that the nephrologist can be recognized as a principal provider for care, but they aren't going to provide every component of that care. There will be other disciplines that need to be involved, and yet every decision point usually has a component of difference from the general population because of the renal disease that patients have.

I'll talk a little bit about how our technology platforms offer us opportunity to get other more data in the future about the patients that we care for, and that this decision-making is going to extend beyond the 5 percent of the time that we see patients directly in front of us to that time when they're in their own environment living their lives with their families.

The continuum of care is really an important point to this. We have to know what to do when the patient is at the right stage. We need to be able to develop means by which we can predict what the trajectory is for that patient. Will they be stable over the next six months? Do we expect to decline? What's the risk of death? How much will they need to be integrated into specific algorithms for care because of the time that they are in the course of their particular therapy? And how much attention do we need to apply directly to that patient?

And then finally, I will talk a little bit about our data resources and how we've tried to leverage that from an analytical capacity and a modeling capacity, and how this is actually going to be merged towards what, in the United States, we're seeing, and I think gradually we'll shift in maturity throughout the world in what I call a consumerized healthcare, more retail type of medicine that is focused more on what the patients needs are than the provider or the system needs are as it is today.

So, we've been assembling these assets really for 19 years at this point. And these assets are – fall into three categories. They're either categories that leverage our ability to provide therapeutic technologies, which is devices and pharma; service provision where we create opportunities around our service side or actually in the businesses that become more fully responsible for the patient and leverage the technology that we have around that. And these are just – this is just one depiction of how this portfolio began to be built really from the – from the inception of Fresenius Medical Care, but now has begun to expand rather dramatically as we finally have a payment system that's beginning to align with the development of these theories.

We need to integrate around the conditions that patients have, and they really fall into this category of high-profile associated conditions – cardiovascular disease and that’s both cardiac and peripheral vascular disease; diabetes and metabolic function of the patients; obesity, we have, in the United States, a very, very substantial impact from lifestyle changes that patients have, and obesity gets into both the kinetics of patients, the diet of patients, and the activity of their involvement; hypertension, which is about 75 percent of our population; end of life supportive care; and how we meet the needs of a chronic illness that has fundamentally changed the lives of these patients who, in many cases, were very productive, want to be very productive and very involved with their families, but struggle with that because of the intensity of the illness that they have, and do this across all of the venues whether it’s at home, the hospital, the post-acute care space, the dialysis facility, or the ambulatory space.

As the system of care changes, there are some features that will fundamentally change, and they are features that, I think, were referenced by Ron, William, and Rob in their comments. And it’s primarily that we have a system today that is centered around essentially I’ll call it respect for the providers.

All of you may well have gone to seek healthcare, and that healthcare has not been centered around your time. It’s been centered around your provider’s time.

I think as we move forward in this, we’re going to find many of the components that we’ve seen in MedSpring actually will become components in the standard healthcare system for these high-cost chronic disease patients.

Every patient that goes to a MedSpring facility goes thereby their choice at their time. And the entire service set that MedSpring provides is geared around the experience that patient has when they walk in that facility so that they will come back the next time they have a need that’s perceived. And I think you’ll begin to see many of these criteria as we move towards value-based care, change towards things that are evidence-based standards, taking an organized way of actually managing the patient through their experience with that, measuring that experience, and utilizing the patient and their family to actually have more informed shared decision-making on some of these really complicated problems that exist today. That’s not how the traditional system has been set-up.

So I want to talk just a little bit about how we’ve used some of our clinical and analytical integration to support certain characteristics of becoming more

sophisticated in other venues of care than the dialysis facility, and how we've actually leveraged that to the advantage of our patients with regard to that. So I'm going to use just three fairly quick examples of this, and then talk about where we're - where I think we're headed in the future with this.

As we merge some of the analytic resources that we're in Sound is they developed a very measured process and recognize that they had three key performance indicators - length of stay, case mix index, and mortality. That's some of the things that either drive how they are successful with their hospital customers and how they're also successful with their - with their patients.

We developed a model where we created at a very granular level at the hospital level the ability to predict what an expected adjusted length of stay case mix index and mortality rate was, and looked at how Sound's performance was different from the performance of that granular region, geographic region of the country, type of facility that was very similar to the facility index, and basically an aggregate. We're able to show that whether it's length of stay and Sound's performance better than what the expected of stay was whether it was a higher case mix index, which becomes a financial driver for the success of the hospitals under the traditional model of care or whether it was mortality rates being improved within this organized process that was care.

This is one of the ways in which we've used both our analytic teams and the data that Sound Connect captures with national data that we have access to create a very granular opportunity to look at this.

Fresenius Vascular Care, we looked at what is an organized system of care. So, you all know in the end-stage renal disease population dialyzing by hemodialysis, we've got to gain access to the blood stream, we've got to be able to put blood through the artificial kidney so that we can both clean it from the toxins that have built up, and we can modify the amount of fluid that patients have in their body during this time.

But we said to ourselves, how can we actually show that, in fact, if we organize this system of care versus what generally would happen in what I'll call ad hoc provision of care, do we actually show that there are better outcomes for patients. So, in this case, we took 1,300 patients utilizing our own organized vascular access centers that include both endovascular physicians looking to make sure that these vessels stay open, but also vascular surgeons that actually create these accesses in a timely manner.

And we then did what's called "propensity matching" where we took matching on 40 elements – 40 elements that match patients by vintage, demographics, clinical elements, and lifestyle elements to look at them and say did the organized system perform better than the general system, the standard system? And, in fact, this showed a 22 percent lower mortality rate in the population of patients.

We strongly believe that when we organized the care system we're actually going to be delivering much better care and hitting these four components that are highest outcome performance measures – mortality, hospitalization, quality of life, and experience of care.

Ron referred to the study that we did with FMC Rx. We wanted to look at the exact same kind of things. Clinically, if we actually bring renal pharmacist into the care team and medically manage populations of patients, which generally is not the case. The pharmacists are not part of the care team today in an integral fashion, but we have they need to be. If we bring that to bear, do we see better performance, and we showed that in this one where we did this detailed matching, but instead of 1,300 patients, we did it on almost 38,000 patients.

We had enough patients across the country. We could match every single one of the pharmacy patients to a patient that looked just like them that didn't use the pharmacy. And we showed better performance on the bone and mineral measures. But what I'm here to tell you as well as we showed improvements in hospitalization, and we showed a three-time improvement, a 3X improvement in reduction in their mortality rate. That's unheard of in this industry to be able to make those kinds of changes.

And so we again think that controlling the environment becomes a huge piece, and it's why vertical integration from a technology platform to a service provision, to our analytical and our value-based assets all work together to provide a much better picture.

So, 18 months ago, I told you about a process we were just starting at that time. How are you using all this data we captured about dialysis treatments to develop a series of predictive models? And we had just begun one model on high-risk hospitalization that I think Ron referred to before.

We now have a structured way in place where we've actually had 23 different clinical models requested and there are about four actual business models that

we're doing predictive analytics on right now. We green-light at 16 of these models. We've completed 11 models, some of which are still in their latter phases of testing.

We had one that we actually tried to develop and couldn't develop a model we thought we could be successful at. And we have five models that are in active daily use today that are giving us information about our patients directly related to this day's care for that population. I'll talk a little bit about that.

This process is growing quite rapidly at this point and now has extended beyond just the clinical elements to where we're actually doing models who are predicting certain activities or risks that we might have in our population of clinical leaders, for example, in the company. How do we predict what the likelihood is that we'll have a disruption in our clinical leadership in a dialysis facility that creates disruption in our coordination of care in that facility. So, the analytical capacity has evolved quite a bit in 18 months with regard to this.

What I see happening in the future is something that I think was very well-described some number of years ago by the CEO of Emerson Electric, a company I had grown up knowing, but thought that actually have disappeared but, in fact, is a company very similar in size to Fresenius Medical Care that provides in a variety of manufacturing and other industries sensing devices that allow those industries to understand exactly what is happening to the machinery and the systems of care that are happening there.

We believe that in healthcare there are opportunities to actually leverage that sensing to get more information about our systems of care, the delivery of care through our facilities, and the patients that we see with many of the types of devices that you've began to see and maybe some of you have used with regard to FitBit or Jawbone or some of these types of devices that provide physiologic functional measures.

So, we have begun a number of studies, so where we were with analytics 18 months ago in our process of beginning to look at how we capture physiologic information on patients in a non-invasive way.

We've actually found that we have platforms that we can use for patients, we can embed with them in their homes that provide us information that will give us cardiac function and physiology assessments that will really leverage our ability to be somewhat more sensitive to that. And this is one of the small studies that we've

done where we begun to link data that we've got from a series of measures that we can do with patients when we see them and when they're at home, and that we can capture into the knowledge center that we have and coordinate that with both clinical data, claims data, demographic data, and lifestyle data that we have about the patients.

Secondly, I think when you begin to look at how we've been dealing with efficiencies and care, there are things coming down the pipe that will be fundamentally different for us. And this is an example of one of them.

So, about four years ago out of MIT, this molecule in the upper left corner was actually developed. It's a nanoparticle that has a really interesting characteristic. It fluoresces different colors based on what the glucose level is of the patient. And what they've done in the second picture is they have injected about 100 of these molecules under the skin of a patient. This is a scanning electron micrograph of that.

And actually underneath the tattoo, which is quite large here, you can actually put a reading device just within proximity of this particular area of this fellow's arm and follow in real-time the blood sugar changes that are occurring. So if we begin to think of that in the analogy of what we do, every day we have a patient that comes in for a dialysis treatment, it would be great to know what's their sodium, what's their potassium, what's their bicarbonate, what's their bicarbonate, what's their calcium, what's their magnesium, what's their hemoglobin, what's our opportunity as we move into the future to create extremely personalized treatments on a day by day basis.

Our platforms have evolved where we begun to, on a treatment by treatment basis, be able to look at physiologic fluid volumes in patients utilizing the Crit-Line device and our – and our body composition monitoring devices in Europe. These devices all are going to advance to become smaller, more personalized and give us the ability to understand today's condition of the patient in ways that we haven't seen in the past. This is one of the areas where we're doing that.

We see these pervasive sensing devices being opportunities on our machine platform to develop a way in which the machine becomes something other than what provides the dialysis treatment, but it gives us insight into the patient's physiology that's happening.

And then in our water systems in the United States, we manufacture water, ultra pure water, in 2,200 locations on a daily basis. To be able to do that and actually take the same kind of sensing devices that it work in a jet engine today that's nearly produced, that looks not only at optimizing performance. But what are the maintenance characteristics, what's the likelihood of meantime between failure rates in some of the parts and conditions with that. The opportunities to automate much of this will be some of the efficiencies that develop in the core business over time.

And so I want to finish with one last thing. I began talking to you 18 months ago about how we were beginning to try to actually model behaviors. And we obviously have been involved in anemia management for a long, long time. You all have tracked our performance over time in how we've utilized medications on anemia management.

One of the things we wanted to do to use our analytical resources for were to develop physiologic models that would allow us to, in fact, actually determine how a patient would respond to a dosing change or an alternative regimen and with that, in fact, work well for that patient. And today, we've had the opportunity now to build just about 80 of these, we call them patient avatars, and the patient avatars are basically electronic views of our patients that give us the opportunity to actually model our algorithms for ESA use in advance of actually using them on the real patient and then measure that.

And in both of these patients, you can see one of the – one of the lines is the actual performance of hemoglobin management and medication management on the bars that are under it that are very difficult to see from the back. But the other line is what the model actually predicted, and the prediction of these models is remarkable.

These models are incredibly computationally difficult to do. It takes about the solution of about 10,000 partial differential equations in this model to do this. When we started 18 months ago to do that, to build one patient avatar, took around 500 to 600 CPU hours.

Let me give you a relationship for that to put that in context. Every day, you all know that we have introduced Mircera. This will be my one Mircera comment for the day. We have introduced Mircera into our – into our facilities. We've automated that.

And one of the most interesting features of organizing our ESA use is that 99 percent of our Mircera use is on a single algorithm in which we can actually predict what the responses are the patients will be. And because of that, we have improved those responses.

But, in fact, to run our algorithm that details what the dose of each individual patient receiving the drug is on a daily dose, it takes two-tenth of a second versus building the avatar with 500 CPU hours. And we're hoping with this relationship that we have to actually bring that down to a sub one-day process in our ability to actually develop these kinds of electronic models of actual physiologic states.

So, all of this is to simply say that we think our data resources, our analytical resources, and our vertical integration gives us a huge opportunity to organize this system both across therapies and technologies, service provision, and the ability to move into these alternative payment models that will actually drive the way we take greater responsibility for care beyond simply the – simply the dialysis treatment, but actually for the whole patient, which is good for patients, good for the business, and it gives us an enormous amount of opportunity to develop business models along all three of those potential groups.

Q&A (London, Nov. 20, 2015)

Lisa Clive: Yes, Lisa Clive from Bernstein. A question for Dr. Bessler.

The Sound physician's business model, could you just explain a little bit how the contracts are structured? Is there risk sharing? You know, how much risk are you actually taking? Is it on individual patients or is it baskets of patients or is it a situation where, you know, you sign a three-year contract with hospital X for, you know, a certain financial, you know, finite financial amount per year?

Robert Bessler: It's more like the latter, but we have a performance component that's variable based on our hospital partners' challenges.

Lisa Clive: OK. But in general, you'll sign a contract. Is it – are they usually multiyear contracts? Will it be sort of a \$3 million contract for three years? I mean, I don't know what the numbers are but ...

Robert Bessler: It's definitely multiyear.

Tom Jones: Good morning. It's Tom Jones from Berenberg. One of the things I've covered -- who said at the start, but, you know, your biggest payer is the federal government and one of the rationales for doing all this is just kind of move in the direction the federal government is going.

Within that context, there's two questions for me if I can be a bit cheeky. One, what are you doing to mitigate the risk of the federal government changing direction with all this? And how are you, you know, adapt in a business? We had to cope with that. And then secondly, one of the big problems that investors have with your existing relationship with the federal government is they don't allow you to make too much money.

I understand under these programs the incentive is that you're allowed to make money to help them make money, but the federal government isn't rational. And if you start making money out of this, lots of money, they will come back or the argument is they'll come back and say, "We're not allowed to make that much money. We're trying to make this much money."

You know, how do -- how do you see self-managing that risk going forward? And, you know, could you, in four years' time, will be able sitting here, (planning to) hear about the rebasing of the hospitalist business or whatever it is?

Ron Kuerbitz: I'm happy to take a stab at both of those. I think the answer to your first question is embedded in your second one. How do we make sure that the federal government continues on this? We got to drive down cost.

So, William said it best that, you know, the ESCO program doesn't work without us, and CMS has gone to all the trouble of putting up a program office specifically to address this population.

I don't hear anybody talking about going their preference being let's go back to the fee-for-service system that drove healthcare costs to 18 percent of GDP. So, I don't see that this will go backward.

I think your question about what's the risk that CMS takes that, you know, \$90,000 to \$100,000. As we drive it down to, you know, \$88,000 to \$92,000, how much of that do they take? That's the challenge we're going to face going forward just as we face the challenge with the dialysis treatment, being fixed and having to get drugs bundled in, labs bundled in, and driving efficiencies faster than our

competitors can. That's exactly what we see will have to happen in the coordinated care model.

With the advantage that there are very few other players who can do this, there are a lot of players who will play incremental parts in the – in the process, so we won't own on all the dialysis clinics. We won't own all of the vascular centers. There will always be an umbrella of margin in each of those pieces. We will participate in each of those margins to the extent we are our own network. And CMS can't eliminate all of the margin in the insurance business without driving the insurance providers out of the business.

We see that dynamic replicated in different pockets of the provider segment. And overall, since we're the only player who can be vertically integrated – well, if you could as well. We're the only one of the two players who could be vertically integrated in the real insurance market.

Veronica Dubajova: I think – it's Veronica Dubajova here from Goldman Sachs. Probably best question for you, William. Just – can you help us understand how big is the business that you are managing today, either dollar terms or number of patients? And then if you look at it today, what's the split between capitated and shared savings?

And Oliver is going to hate me for this question, but can you help us understand how much money you are making today ...

William McKinney: No.

Veronica Dubajova: ... or are you still on the investment phase where this business is actually not profitable today but will be once you get your own enrolment up and running?

William McKinney: Yes. My – for the C-SNP, my employee-to-member ratio, like I said, is definitely off until January 1st. So I think Ron headed up on his slide. We've got – and like everything, it depends on how you count it, but we've got about 9,000 today across the programs.

I think, as you look going forward, it's hard to predict what happens on – as these programs expand. Some of the sub-capitated arrangements are going to – it's going to be a very lumpy sale cycle, so things will be able to change quickly in a

hurry. But I think just given the tailwinds that the ESCOs have and their ability to grow and potentially from what CMS is saying expand going forward if we like them.

I would expect in the near-term as we're getting the other programs like the C-SNP up and running kind of four to one ratio of shared savings to capitation.

Ron Kuerbitz: And we are today definitely in investment mode so ...

William McKinney: Yes.

Ron Kuerbitz: ... because he doesn't have enrolment in his C-SNP. He's just launched his ESCOs. He's got some sub cap deals, but it's the infrastructures had been costing us.

Veronica Dubajova: And how long until you start seeing the profits?

Ron Kuerbitz: That will depend on how rapidly enrolment goes and whether we continue all his ESCO markets.

Since we just got the ESCO started, we have until the end of the year to make a decision whether we continue all of those, and that's an open question. It's going to be a function of, as William said, looking at the claims lag, looking at the claims development, talking to our partners. And then on the C-SNP side, looking at how well open enrolment goes in this first few months of open enrolment. It could be – you know, could be next year.

Rice Powell: Yes. And my only earnings comment I'll make is back mid-year when (Mike) and I took the revenue projection down. It's the two guys in the middle that we were working with because you can see now it is not so predictable depending on the savings and what you're trying to do. It wasn't that we weren't executing. It's the fact that we don't have the data, and we will not have it for a while.

Daniel Wendorff: Daniel Wendorff, Commerzbank. I have a question on your health plan and Fresenius Health Partners. In the 9,000 patients you have now in there, over what time have this number been built up? And what is the structure of these patients and why are they with Fresenius Health Partners? That's something I would be interested in.

William McKinney: So, the – again Ron showed the number. We have about 9,000 today. There are other patients that we manage that drive that number up, but I

think as we look at the structure programs like I walked through today, it's around 9,000. The vast majority, those are coming through the ESCOs, which we just launched.

That being said, I think we have a lot in the pipeline. What I mentioned is a very, very lengthy sale cycle to do more sub capitation arrangements over the next couple of years. And we've got a C-SNP that's growing quickly as well.

So, the health plan, I think is a – is a very high-growth opportunity within the company. But the – that mix is going to be subject to change depending on how ESCOs do, how the C-SNP grows and what we're able to do from a sub capitation arrangement.

Ian Douglas-Pennant: Thanks very much. It's Ian Douglas-Pennant, UBS. Just following up on, I guess, Tom and a little bit of Veronica's questions earlier, I'm actually worried about the other side of things. What happens if – is there a risk that CMS forces something like an ESCO on you before you're ready so that they can meet that 50 percent target that they put out there and that seems very aggressive? You know, we've seen something like this in the orthopedic space already, you know, what were – what were the impacts of that business be?

And as part of that question, you know, would they be looking at the – at the ESCOs and the territories that you've accepted as part of this trial program and accuse you of kind of cherry picking or whatever you might want to call it that the most easy patients to save money on.

William McKinney: Yes, two components there. I think your point is great and it's one we use when talking with our provider partners. At some point, if CMS isn't getting traction on alternative payment models, they'll do like they have done in orthopedics and they will push people down the path. We think the right thing to do for all the reasons we talked about today is to go down that path much more willingly where we can implement that model.

Given the amount of ESCO program we represent, it's kind of a novel experience for me versus what I've done in the past. We actually have a tremendous amount of influence with CMS and how they're designing that program and where it's going forward. You would not have that ability if you waited and let them enforce you into that. So I think it is important that we engaged early and shown CMS we want to work with them on these models that we show success.

As far as you're cherry-picking question, I don't – that's not a component of how ESCOs work. The – we will have a chance to exit markets if what we see in the claims data says that we think the dynamic of that market create program that's not viable. They want a viable program.

One of the issues early on as we told them, guys, we're not going to commit to this if we can't see claims data. We cannot commit to risk without understanding the risk that we're taking. And that -- in their output in giving us this 90-day opportunity that exists in the program today. So, we signed up, which gave them the regulatory ability to provide us the detailed data, but then we have the ability to look at that data, analyze it, and decide whether it makes sense or not. But I think from what we've seen so far, there's a – there's an exciting opportunity with the ESCOs.

Ron Kuerbitz: On the cherry-picking point, I'll just add you got to remember that for this program the whole notion is go find patients who are poorly managed. This is not a case where you can find a relatively healthy patient who's got a mismatch of premium, too much money being spent on them. Because this is all based on historical claims, CMS understands our objectives to go find patients who are poorly managed and medically managed them better to drive down that cost. So there really isn't much of a risk.

I'd be open if there's a clever idea on how to cherry-pick. I'd like to hear about it.

William McKinney: But – and we don't get to pick our patients, right? It's – once you accept the market, it's an attribution, so you get the patients.

Frank Maddux: I think the other thing to add would be that when CMS began talking about this program, they came to us and with Bobby and Ron, myself, and Rice and others. We spent a lot of time helping them try to evolve the program. And I think even recently right up until the October 1st timeframe, they've been engaging and ...

William McKinney: Yes.

Frank Maddux:

The quality thresholds, for example, we know need additional work because some of them are geared towards the general population than the regular population. So there hasn't been any sense that their interest is to just throw it out there, try it, and then turn away from it but actually to evolve it with the industry.

Martin Brunniger: OK, thanks very much. Martin Brunniger from Jefferies. I have one question. You talked a lot about improving patients by better management, et cetera, and you haven't talked much about home care or EHD home care. These patients are too big and more profitable because they're healthier, they are more self-aware, et cetera. And with your managed care program, I assume you can push more people into home. What's your target there and what you're thinking about that?

Frank Maddux: So, I think without specifically talking about targets, I think we know that with about 10 percent or 11 percent of the population today doing home-based ESRD care, I think there is substantial opportunity to improve that as we begin to look at more efficient models and we recognize that there are some clinical advantages for patients who are incident to dialysis that can be on a home therapy regimen from the preservation of residual renal function to their ability to be fully engaged in their therapy.

There is clearly some selection bias in the population of patients that choose home today. But I think making again these devices and therapies more available so that we can keep track of where patients are, what they're doing, and making them easier for patients to use. I think there are clear opportunities to expand the number of patients in which homes a good therapy for whatever period of time they want to use that modality. Yeah.

Ron Kuerbitz: Short-term, you know, our home penetration is growing ballpark twice what the (RH) our total chronic population is growing. And we see that continuing for quite a while, so I would think we got a pretty good pass to get into mid-teens penetration.

To get above that is going to require about changes in technology and we're making investments in better and easier to use both H.D. and P.D. devices. And it's also going to require, I think, more service infrastructure to support patients in the home. It's absolutely something for both experience of care and for convenience and compliance that we think is going to be a big role – play a big role, improving home and self-care not even just focusing specifically on the site of care but focusing on enabling better self-care. That will play a huge role as we get out, you know, four, five years. But we do think we first need to get some technology into the pipeline to enable that.

Rice Powell: And, Martin, there's going to be a lag here. I mean, I think everybody in the room understands, you know, there is limited capacity. Baxter's got issues. We can't absorb all of that capacity issue for them so we've got an investment to make. We've got expansions to do which we're going to do. But there's a little bit of a lag because we've just all kind of come up short on the amount of fluid in the capacity we've got for that, some things we hadn't counted on happening.

Lisa Clive: Ron, I remember a year and a half ago at your Capital Markets Day discussing with you Medicare Advantage and how ESRD patients are in this sort of unfortunate position where they can't sign up for a M.A. program. Is that changing? How much does that matter? I mean, you mentioned you're setting up C-SNP. Who signs up for that?

Ron Kuerbitz: Great, great question. Who won't sign up for it are people in Medicare Advantage already today. So, I'll mention again the – if you have ESRD, it's a checkbox on the enrollment form for Medicare Advantage. You cannot enroll in a Medicare Advantage plan.

If you're in there, you develop the ESRD, they can't kick you out. So what that means is Medicare Advantage is normally a very, very sticky product anyway. Once people get it, they tend not to change with some exceptions.

If you look at this population, they were in there as CKD or at least at the time they developed the ESRD, they are getting subsidized by healthier population. They're not leaving, right? So the people who are in M.A. are going to stay there.

But there's a whole tranche of people who became eligible for Medicare through the ESRD entitlement. So, they were, by definition, day one, they are already ESRD. They never had a chance to enroll. That's the population that we can look at.

Obviously, you saw the growth in Medicare Advantage. A lot of people see it as a very, very attractive alternative to fee-for-service, yet the population that we serve largely has no opportunity to take advantage of that program. We're now offering them an opportunity because the one type of plan in which these people can enroll is a plan designed exclusively for people with ESRD, and that's the kind of plan that we're launching.

Ron Kuerbitz: That said, we see – we see a lot of support in Washington for eliminating that barrier to ESRD beneficiaries enrolling in M.A. He has – both sides of the aisle see value in these integrated organized systems.

The question is, you know, is there a legislative vehicle that that can get implemented in? And, you know, what else are the priorities? But we don't – we don't feel the opposition to that open enrollment. And we actually now see much more support for the notion that dialysis patients like every other Medicare beneficiary ought to have choices available to them. They don't have the choices every beneficiary has, and they can be responsible for their own insurance decisions within the Medicare program. So we're optimistic.

I wish I could tell it would happen this year, but we're optimistic it's going to happen in the next couple of years.

Dan Mahoney – Polar Capital): So, this is a question for Frank. So, when you start doing some of these big data analytics and you're looking at all these parameters, we might find things that are non-intuitive or not best practice, particularly with expensive patients who have loads of comorbidities.

How do you start changing medical practice? And I guess, it's easier and particularly as we go out from the clinics, so in the clinic, the treating nephrologist, and then out to the physician who's actually treating that comorbidity who's probably done this way of medicine for many years. But your – you know, the computer says no, but how do you persuade them that the computer is right ...

Frank Maddux: So the general process that develops as we look at the analytical models, build them, and then we actually go out. We have enough patients that we can build the model and then test the model on two separate groups of people. It's one of the biggest problems in predictive analytics. People will build the model and then test it on the same patients they've trained it on.

We're able to do it on a completely different set of patients, and then we go and take that initial data that we believe. And typically, we'll run a clinical innovation pilot, which, you know, sometimes our pilots are larger than many of our competitive small companies in the dialysis industries. So we'll run a pilot that might be on anywhere from 10 to 300 or 400 units.

When we do that, we have enough data with power. We can then go to the medical staff and say this is what the data actually shows. This is what your performance looks like. This is what our organized performance looks like. And then being able to ask them to say, "Well, if you're better than our performance in an organized fashion, then we need to have a discussion and figure out what you're doing." But if you're not, we've gotten our medical staff to be convinced that they need to

change what they're doing in their performances and up to what the basic standard is with that.

And that's been a fundamental shift as we moved from just talking to them about clinical outcome to talking to them about that value equation that we described earlier. And it's been actually less difficult than I expected it to be. We've done it in ESAs. We've done it in bone and mineral metabolism. We're doing it in vascular access. We're beginning to do it in end of life palliative and supportive care. And so I think there is a – you know, once they get used to this process, the process actually begins to drive the acceptance rate.

And we have some physicians that are – will resist and resist, but more and more we have physicians that actually are looking to us to help provide additional guidance so they can make better decisions because basically they all want to have an organized way in which they can do a better job for what they're – you know, what they're being asked to do.

Some are stuck in the old ways, but a lot of them have moved on at that point. And those are the ones that we want to be embed with when we're doing these value-based arrangements.

David Adlington: Yes, David Adlington from J.P. Morgan. You're clearly on a journey here. I just wondered what elements you think you need to add. Is it just about geographies or the holes you need to plug? And with respect to that, what evaluations of targets potentially looking like at the moment?

Rice Powell: Yes. So, this will probably be where we have a little bit of a global discussion as well. I think when you – you know, and Ron can answer this when you look at where we are in the U.S., we're very comfortable with the asset base that we have, in integrating it, and continuing to move forward.

We will learn as we go through times – or time, there may be other assets that we want to include. Rob may come and say, "Look, I need this to be fundamentally better," or William may.

But what we're also looking at internationally is we are seeing in developed markets there are pieces of hospital treatment that are moving out and they're free-standing clinics. Governments are thinking maybe we can do some things differently not to mimic the U.S., but to do it because they think it makes sense, so we're going to continue to look for those things.

We are looking every month at assets on a global basis. But let me make sure you hear me on this one. We still have things we can do in the core business. We are still going to make acquisitions in the core business be it product or service, so there is no lack of use of our funds for where we want to go. I don't think we want to say much more than that because as soon as I drop a name, evaluation goes up. So we won't do that.

But we have lots to look at and we're very busy at this point looking at those things.

Alex Kleban: Thanks. Hi. Alex Kleban from Barclays. I'm just wondering if you could talk to a bit more of the process around the subcontracted capitated business. And just in terms of overall bidding time line kind of best and worst case, total number of patients you could take, you know, low end, high end, how much margin you need to leave on the table for the base insurers?

And just lastly, I don't know if it's relevant, but is there any exchange business included in that potentially?

William McKinney: Let me – let me start with the last question on exchange. Ultimately, it's something we can do with any payer who's got risk. That payer could even be a state Medicaid agency. So, if there is exchange business and a payer has got an ESRD population in that exchange population, we can certainly work with them.

Generally, because of the nature of the population, you find the largest concentration in Medicare Advantage with Medicaid being somewhat mixed.

I think from what I've seen so far, the sales cycle on dealing with payers is going to be highly variable. It's going to depend on what else they have going on, what their internal drive is for medical savings.

If you've got payers that are talking a whole lot about medical savings initiatives, this fits perfectly into that. And the medical office, and the network folks are primed and ready to embrace this type of program and generally move very quickly. Our goal in designing those programs is to make it as easy for the payer as possible.

There is not a whole lot I need from them. The big thing I need from them is claims data because I can't do this without getting claims data and understanding based on the demographics of their population, the geography of their population, what difference we can make.

So, what needs to – what we think we can drive on each one, what we leave on the table is going to vary for every payer because they all have a different profile when you get the claims data and start looking at the leverage we have, the improvements that we think we can drive, and what it takes to get that payer excited and wanting to move forward.

For some of them, one of the things we do is we just stabilize the cost of a small population. If you got, you know, 100, 200 ESRD patients, which could – you could be a fairly large payer and have that number. There is so much variability in that, that all their actuaries can do is project out based on historical and hope for the best.

And so even if we don't give them any margin back by stabilizing that cost for them by looking at the context of that small population in our whole of, that's got a tremendous advantage to them as well.

Justin Morris: Hi, so Justin Morris. I just wanted to ask Rob a little bit more on contracting in the Sound business. I understand that some hospitalists contract more actively with the payers as opposed to the hospitalists. So I'm just wondering if you could talk through some of the dynamics that are there because I guess while it remains in the fee-for-service system, there's going to be some conflicts where the hospitals want to bill to get more revenue, but that's not necessarily good.

The cost of the systems ...

Robert Bessler: Yes.

Justin Morris: ... if you could talk about that. And then also are there any opportunities to bundle contracting with the wider Fresenius Medical Care organization now that you're obviously part of the group.

Robert Bessler: Yes, good question. So, you know, 10 years ago there are hospitals and there were insurance companies. And I think everyone would agree that there – who is a provider and who is a payer is blending, and it's, you know, if

they're an ACO they're a payer, a hospital, right? There's providers that own – there's payers that own physician groups. Our – we cut our teeth in our core businesses delivering the value to the hospital partner.

Having said that, you know, a month doesn't go by where payers aren't asking us to do work as well. What we like about the bundled payment program is it's perfectly aligned. We don't hurt the – you know, the proverbial one foot in the row boat, one foot on the dock. The hospital can move into a – into a value-based world, but still keep the lights on because they're getting the DRG payment because the episode doesn't start until the patient is admitted, so we like that model.

There's a few markets around the U.S., Southern Cal, South Florida, Las Vegas that are very payer-driven markets. We are very active in those, both working for – usually our way in is still through the hospital. And then once we're with the hospital, the payer sees our results and says, "Hey, can you help us, too?" And the hospital is like because then they get preferential volume to those hospitals, right, so the commercial payer might drive more business to the hospitals we're in. So, kind of it's a win for both the hospital and the payer.

Robert Bessler: So, yes, I mean, obviously, we're only in the 187 hospitals and I last thought it was over 1,500 ...

Robert Bessler: ... I mean, there's a lot of overlap and we're benefiting from that and, you know, it's making sure we're selling to the right customer within that hospital, right? They're not always the same people, but there's a big opportunity there, and we're taking advantage of it.

Ron Kuerbitz: It's more a matter of relationships that we can make introductions and have a good and warm reception as opposed to combining contracts because the objectives of the businesses are focused in different areas.

And it's not – the inpatient and post-acute risk management and high-cost chronic risk management are different enough that it doesn't really make sense to try to contract simultaneously.

Rice Powell: And it's a good thing because we don't want to be the big bad wolf either. It's nice to have these relationships and introduced. But it – if you go at the wrong way you're going to turn your customers off, and it's going to blow up. So, we think this is a better method.

Q&A (New York, Nov. 18, 2015)

Kevin Ellich: Thanks. Kevin Ellich of Piper Jaffray. I guess, first off, for Rice and Ron, I guess, thinking about the care and coordination that you have now, what would you like to add or is there anything else that you need to add to this -- to the equation to really see a benefit here?

And then for Dr. Bessler, thank you for the details on your -- on your business in the overview, but, you know, how much benefit should we expect from BPCI in 2015? How do you guys plan to recognize the revenue and when should we see that? And then now that you're two months into program, where are you driving most of the cost savings from? Is it coming from the acute care setting? Are you guys doing anything differently, or if it's coming from post-acute? Could you give us an attribution as to is it -- you know, reduction in readmissions or where is it coming from? Thanks.

Rice Powel: So, Kevin, I'll say -- let me give you a global comment. I'll turn it over to Ron. When I -- when I look at the other assets we want to look at, I'm very focused globally that as we see opportunities that fall somewhere within this continuum of what we've shown you today. And I'll give you a great example.

We know there assets in Europe today that are looking to take vascular access out of the hospital, be it cardiovascular or renal. And we know how to do that. So, we'll look at those opportunities because we understand them.

So, we're going to look at where those things present themselves. Ron, I'll turn it over for the U.S. view.

Ron Kuerbitz: Yes. Right now, Kevin, we're not looking at -- I don't have any specific area that I've targeted for expansion. I think as (William's) business expands, as we get some ground behind us on the ESCOs, I'm pretty confident we'll see opportunities. We've got a lot to do right now with -- particularly on the vascular and cardiovascular side with MCP, with pharmacy and vascular is -- we've got a lot to do with integration with (Founden) and the hospitals program.

So, I think we need to focus operationally on launching these plans and executing with the -- up the clinical operation assets we've got. But I have no doubt we'll find expansion opportunities as we (take it up). I think the thing I could answer is that,

you know, we -- just like I said, I think that most of the opportunity or where we see the (food) on the floor is, you know, bringing science to the discharge process where patients go and how long they stay there. The answer where we think the opportunity is, I think, too early to give any guidance.

And, you know, Medicare reconciliations, you know, about -- they take time and they need to get massaged after that to confirm.

Rice Powel: All right. Ask us again maybe some time next year, Kevin, on that one.

Holger Blum: (BZ Bank) Question on the different payment systems, be it capitation and shared savings programs. How would you see the split emerging or what time in terms of what is the most important format? It may be -- and that although it links to the question on the long-term revenue target that you have because all they did to save on earnings, it's -- make a big difference on the top line assumption that you have longer term.

Second question, more on the savings. Found all the support function, the (teaching) function, the (inaudible) that you have initially, call centers and whatever, you would have much more potential in the long run in terms of saving money than you have in the first schedule. If you can explain how much where we are today? How that would relate to the contract that you signed, whether you would be more benefiting on the incremental savings per year, or whether your benchmark every year against the industry average.

Franklin Maddux: Right. So, I think the mix of the program, would likely change over time. I think the programs themselves are likely to evolve. And they each have a slightly different dynamic, that I covered to some extent. The program, I feel probably the strongest about, that are actuaries-like, because it's a well-structured program, is Medicare Advantage. We think the CSNP has a lot of potential that it's one where we truly hold our fate in our own hands and is a well-defined program that also does drive revenue.

That being said, when you start looking at Medicare Advantage, you're making plans multiple years out, because of the bid process and the expansion requirements. So, that's when it just takes time. And the good thing is we'll have time to see how the program's performing, perfect our bid, to perfect our interventions, to understand what patient population that has the most value for, and maybe how we change the product over time.

So, I think there's a great opportunity there. The shared savings programs are a fantastic way to align markets. Even if they don't have the same revenue potential, but they do have the potentials to, which I think, will be very profitable for the company, but again, more so bring that Fresenius network to play and find a way to capture value in those improvements that we can make in the outcomes of our patients.

So, they are important, and it is what CMS is pushing today. So, to try to ignore ACOs or to ignore ESCOs, you know, the market's going to move on without you, and we can't do that. We need to find a way to successfully plan those. And the data we get from that is extremely valuable. If nothing else, just to give us the scale and credibility that we need to understand how these programs go together and how they'll change over time.

But you're right, they won't have the same revenue potential. That being said, because of our significant participation in the ESCOs, we have something that's personally unique to me. I've never experienced -- for which is some amount of leverage with CMS, to tell them how we think the program should evolve and where they go with it next.

And they clearly understand some of the tradeoffs of the shared savings program. And I think there is a path to begin to think about like the next gen ACOs and the way that more of the dollars are captured under a premium with things like the ESCOs. And then, today, where I talked about shared savings and working with hospital systems, we had today at shared savings, but more and more of our hospital clients who are maybe pioneers are talking about do we become or are becoming next gen ACOs.

So, the mix is going to change, the programs are going to change. I think they all had potential and they play, because part of what we've got to do is hedge our bets a little bit so that as these programs evolve, we're still able to offer something to the -- to the entire waterfront across our patient base.

Ron Kuerbitz: If I could add on to that, I would -- to quantify it a little bit, I think in the early years, because the ESCO program has the attribution, sold many patients in the market, I think we can look at something in the order of 4-1. Patients in ESCOs versus patients in CSNPs.

And the driver of whether that balance changes is really going to be a function of how effective is the ESCO model and allowing us to reduce administrative expenses in the CSNP and maintain better network control in the geography. If CMS allows the ESCO model to evolve the way we would like it to, I see that as being the preferred model going forward.

Franklin Maddux: Yes. Attribution is awfully nice if you don't have to sell. And a lot of the costs across both programs are that care navigation, that coordination that we have to do. And so, we do -- we do get a nice complement when we combine these programs.

Gary Lieberman(Wells Fargo): Thanks. maybe just to follow up on that, what would some of the changes that you would like to see made the ESCOs or what were some of the aspects that weren't included in the initial plan?

Franklin Maddux: Yes. So, I think it still has one of the challenges that all the shared savings programs have, actually the (lag) triangle. You just have to wait a really long time to get all the claims to know whether you made a difference. Now, the more data we have, the more history we have, the more we can predict that, but we're still not going to get the check from CMS until far after the program.

But, you know, we're in a position, I think we can do that and we can explain that lag to you guys. But obviously, it would be great if we could find a way to move that program, and more of a premium-based program. I think that's a big lift given everything else CMS has on their plate. I think they made a lot of adjustments to the ESCO program over the last couple of years. They made a lot of adjustments over the last six months for this program before of feedback that we've given them.

And they understand that this program doesn't work without us being fully engaged. And so, they've been extremely open to clarifying things that maybe they were a little fuzzy before on how the waiver should work or what we should or shouldn't do. So, I'm pretty happy with where it ended up, and based on history, I think that we can have a big impact on the population. And my hope is that we can show proof of that quickly enough that they allow expansions.

The biggest issue is timing and the share savings on it versus a premium-based model.

Ron Kuerbitz: I think, (Gary), one of the other areas, the quality thresholds within the ESCOs, the original ESCO model still needs some evolution. There are

certainly some of those measures that are not pertinent for this population. So, that's one of the areas that I think also probably will get attention.

Matthew Winters (Manning & Napier): Hi, I have a bunch but I'll just ask two right now. William, you presented a really interesting chart about the growth savings and then the cost of interventions on in that savings.

I guess, thus far, in your experience across all the historical programs that FMC has done in terms of care coordination, I guess, what net savings have you been able to generate from the growth savings?

And then, just one for Dr. Maddux, the different programs you presented, you had like different mortality reductions across each programs like FDRX versus vascular, etc. Are those benefits necessarily additive to each other? Were they all targeting sort of the same intervention, such that like you can necessarily just add them all up and turn it into that present that you put -- around for us? Thanks.

William McKinney: I'll start. The gross versus net savings and the cost of intervention, what's interesting to me is when you talk about track one -- MSSP ACOs, where they don't take losses. They only have upside. They're still taking losses in a way, because they're spending money as an ACO. So, to me, it's not fair to not talk about the cost of intervention. That being said, we have an interesting advantage in the patients that we serve because their costs are so high. And you start to look at the cost of intervention, or in the Medicare Advantage plan, for example, your administrative costs as a percent of premium. You can run incredibly favorable versus what you would see in a normal insurance plan or in an ACO.

So, we're relatively small today for the Medicare Advantage plan. I mean, we're zero patients today because we're just now enrolling. And so -- and there are -- there's required infrastructure, we have that -- you got to have a claim that -- a certain personality you have to have. You've got to have, you know, pl doing compliance and regulatory affairs.

And so, you know, we will, I think, as we get scale over the next two years, be able to come in with an administrative expense for our risk programs and certainly for the Medicare Advantage plan that is well below what you would see for a normal insurer out there because of the large premium on these patients.

Franklin Maddux: And for the -- for the slides that you saw, the mortality advantages are in specific-studied populations that we've matched. So, I think that

although you can't add those two together and get some sum of that, they do recognize that as we have extracted improvements in mortality over the last six years, 6 to 10 years, pretty steadily, every single year, to get down to what we perceive as our best mortality when we look at our positive outliers, we're going to have to be looking at all of these areas in a coordinated fashion, we think, to actually get the average to move down towards what we're seeing as the best mortality.

So, if you look in aggregate across the ESRD system today, you will see somewhere about an 18 percent aggregate annual mortality if you're taking all patients in everyday at risk. If you're looking at our population of prevalent patients, for example, that have survived 90 days and are assessed by CMS, it's a bit lower number. If you look at our home population, it's different than our in-center hemo population.

Ryan Halsted (Wells Fargo): Hi. A question about BPCI, in the models you're participating in, how many is Fresenius in some form the convener, and in those that, maybe you're not the convener, you know, how do you anticipate participating in the economics? Is it gain-sharing, is it incremental business to your hospitalists? You know, doing more home visits, something along those lines? I mean, any color on that would be helpful.

Franklin Maddux: Yes. We're the episode initiator. Whether episodes are initiated, IR physicians that are NTI number for Medicare, this triggers the start of the (app). We're not admitting the patients and we don't get attributed in the episode. And we have up and down risks that we have to guarantee the government and we're sharing that risk with our convener-partner. And that's how it works.

Ryan Halsted: So, you are -- there are gain-sharing arrangements with your convener-partners?

Franklin Maddux: Correct. And we have -- that's the beauty of the program, we can work with a orthopedic group and if you need their cooperation, they can work with a nursing home, they can work with a health system and that's all that in the program. So, there's not one way.

Ron Kuerbitz: We are not a convener.

Matthew Winters: So, out of the chart showing like how, I guess, bad or how low-value some of the care is delivered in the United States, if you sort of put together those charts 10 years ago. Maybe it didn't work that -- I don't know. So, I guess, why is now a good time to invest in care coordination and do the things that you, you know, presented today?

And then, secondly, what are you -- I guess, what are the goals the Fresenius is looking for out to 2020? Not necessarily a revenue, but maybe performance metrics and how is that tied to the compensation of this group here?

Rice Powel: I would say that, I think, the driving force for us to doing this comes from the fact that as you see these guys, you know, just -- in their disciplines or where they come from, we recognize the U.S. Government had made their mind up, they were going to get out of fee-for-service, they were going to push value. Our largest payer is Medicare today, and if they're going to go, we want to go with them. We don't want to get pulled through the process, we want to be, you know, leading the process.

So, that's what really got us thinking about we need to move, we can sit still, we got to go. I would say from, you know, where do we want to go and where do we see this going -- and I appreciate not trying to give you a revenue target. I think what I want to see is all these pieces of care coordination, up and running in programs that we feel good about, the predictability that William is talking about and the growth and the result that, you know, that Rob wants to deliver, if we get to those places in time, we're going to do just fine on revenue and margin and where we need to be.

We need to one time -- I think Ron said it very well, we need the operating time to execute in these areas because some of it is new. We brought -- the good news for you guys should be with rolling in a good talent pool. We're not trying to do this with guys that used to run dialysis clinics and try to morph them and to be something they're not. So, give us, you know, some credit for that.

I think the way we all get paid is looking at what do we deliver to you as a shareholder? Can we hit -- it's just a big thing with us. If we tell you we're going to do it, and damn it, we got to deliver. But if we deliver, we'll get paid appropriately. We have a very long-term view, our compensation in the way we go forward is all going to evolve come May, meaning that the plan we have for quite a while, it has to get shareholder approval.

We are putting in a new plan forward, it's not too dissimilar to what we've done but we're trying to freshen it up and give ourselves some opportunities because we're doing different things now. That's all we're going to have to get improved in our next May shareholder meeting which we expected it will.

So, we're evolving, because we've kind of moved from, and it's interesting that you bring it up and I appreciate it. You can't be the vertical integrated business that we were for all these years and get paid on a certain set of metrics and then moving all of these areas and trying to horizontally, but yet totally take care of patients and get better outcomes and pay people the same way you did when it was just a product business and a clinic business and a clinic business because we've added all of these other things.

And we're taking all that into consideration as we look at how we're going to compensate people going down the road.

Ron Kuerbitz: If I can I'm happy to supplement that a little bit. I see three major reasons for us moving in this -- into the care coordination space, at least within the U.S. But first, as Frank had said, you know, probably about five years ago, our hospitalization rate per patient was 12 to 13 days per patient per year and it's down to 10. I would say going back probably 10 years, the mortality rate was north of 20 percent, the population of the price that it's now down around 18.

What we saw, as we looked at the trend lines for continuing to drive clinical quality improvement, if we only control what we control within the dialysis clinic, we run out of efficiency opportunities. The progress curve was slowed down dramatically. So, just continuing to drive clinical improvements, we had to figure out how do we get access to managing care outside the four walls of a dialysis clinic. So, there was a clinical need.

The second is an operational opportunity. If we coordinate care outside the dialysis clinic, it allowed us to make investments in the pharmacies and in the vascular centers and in the cardiovascular centers and invest in sound. So, it gives us a return on investment opportunity and a growth opportunity that we couldn't get just as running dialysis clinic. It's expanding the footprint of services that we provide for the same population that we're serving.

The third point, and the one that really enables that now, is creation of value-based contracting opportunities within Medicare.

80 percent of our population is Medicare primary. Until Medicare broke down the walls on fee-for-service, reimbursements to individual sides of care, and allowed methods that pool savings, making an investment in a pharmacy or in the vascular center to drive down affordable hospitalization and allowing us to sharing that savings, we didn't have a mechanism. William talked about -- these are payment methodologies that allow us to make investment in places to drive clinical improvements and feel the benefit of -- getting a yield on that investment.

So, five years ago, there was a need. There wasn't, you know, a payment methodology that allowed us to capitalize on it other than Medicare Advantage Chronic Special Needs Plan, which we pursued at that time and were quite successful with.

So, I think those are the drivers of why do it now, where are we going to be? From my perspective, we're partnered in the healthcare transformation task force. By 2020, we'll have 75 percent of our business in (value rates) arrangements.

Frank Morgan RBC Capital) : HiI want to go back to the question on the convener. Like, while it seems like with all your capabilities around an infrastructure around assessing risk and taking a risk, it seems like that would have been a logical other piece and there's sort of a revenue and profit stream with that.

So, what was your thinking about not being a convener and is that something you would reconsider, you know, maybe in the future?

Franklin Maddux: I can answer that one. I think you got to pick where you're going to be good at. I think if there's anything I've learned in 15 years, that is focus and at the time when the opportunity to be convener occurred, we were ready to take on all the people needed from an actuarial standpoint and that was pretty working with Fresenius as well.

So, that -- it was just about focus, I think, we'll see where we are three years from now when the program gets extended.

Patrick Todd (Harding & Loevner) : Just on the M.A. plans, I have slight concern with regards to back -- you're going into competition with your payers, your commercial payers specifically. So, how do you have comfort in the fact that, you know, you're not going to upset the (apple cart) with regards to those relationships?

Ron Kuerbitz: Yes. Great question, and it's one that we did spend time thinking about and talking about and I talk to payers everyday about ways we can work with them on value-based arrangements or other types of programs. They don't see us as competitive. They can't enroll these people without having the same kind of plan, and they can't manage this kind of way that I can. Right? So, it's not competitive. If I -- if I were to launch a general Medicare Advantage product and go into, you know, pick your M.A. plan, Humana's backyard, and sell a general product, yes, they'd be pretty unhappy about that.

But, that's not what I'm doing and they don't see this competitive because the people, they're going to enroll in my plan, never had an option, for the most part, to enroll in M.A. and certainly don't have an option now to enroll in any of the products offered by the plans that are out there today.

Franklin Maddux: It's notable that you don't see general M.A. plans standing up ESRD Chronic Special Needs Plans. They don't see us competitive. They don't want these patients. This is not -- it goes back to the -- what does the health plan do? They manage actuarial risk. The actuarial risk is not manageable in this population. You have to have a network to manage the medical expense ...

Ron Kuerbitz: And scale.

Franklin Maddux: ... at scale. That's what we have. So, fundamentally, they don't want these patients.

Ron Kuerbitz: Now, I will -- I will caveat that in one way, because you guys -- you got there and you look at, are there other ESRD CSNPs? You're going to see a couple. And the ones you're going to see with one exception, there is Care More in L.A. who have a lot of different types of special needs plans as they do to get a very brick-and-mortar focus. They do have a CSNP, or ESRD in that market.

Everything else you're going to see out there is a carrier getting paid a fronting fee by DaVita to run a plan for them as a third-party administrator. So, the Humana plan in Vegas, the one that's launching in Houston and Denver, those are actually plans where Humana's working with DaVita and HCP, who are taking the underlying risk behind those plans.

They don't have an insurance license. DaVita can't do what we're doing (inaudible) because they don't have the infrastructure. So, like, they are forced to do what we

did in the old model and work with fronting carriers and pay fronting carriers to provide services to them.

Rice Powel: And, you know, Patrick, if you guys just think about you go back to -- not that we're going to talk about last quarter, but if you go back to some of the earnings call, (Mike) did a great job of walking you through some of the investments we were going to make in care coordination and some of that investment is doing exactly what William is doing, getting licenses to getting set up, being able to go do the things that he's doing today. We're spending money before the programs kick off. I just want to tie that back to you guys. We're doing exactly what we said we were ...

Ron Kuerbitz: And to that, we're done. I mean, we've built in the infrastructure to be a Medicare Advantage plan and to be, I think, a fantastic Medicare Advantage plan because we got to build up for a specialized population, Greenfield. Actually, we really got to tailor what we're doing. We're now launching that plan, the growth that we'll have from an expanse standpoint as relate to the operational growth to that plan expands.

So, we've done -- the team's done a tremendous amount of hard work over the last 18 months to get things in place extremely quickly to be able to offer that product.

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