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Analyst/Investor Day

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Call Participants

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Vice President of Investor Relations

Jim Rechtin
Senior Vice President of Strategy and President of Healthcare Partners' California Market

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Presentation

Operator

Welcome, and thank you for standing by. [Operator Instructions] This call is being recorded. If you have any objections, you may disconnect at this time.

I would now like to turn the call over to Jim Gustafson. You may begin.

Jim Gustafson
Vice President of Investor Relations

Thank you, and welcome, everybody, to DaVita's 2017 Capital Markets Day. I'm Jim Gustafson, Vice President of Investor Relations. And we have a day planned with a presentation followed by Q&A for those in the room. So very much looking forward to getting your questions and hopefully sharing some good information about our company once again this year.

Before we begin the presentation, I'd just like to point out that online and for those of you in the room, this is an eye test. We have our forward-looking disclosure statements, and also, remind you, we will make some non-GAAP statements today. Reconciliations for those non-GAAP statements to the nearest GAAP financial metrics is available on the presentation that is posted online.

And so now, to begin, I would like to turn the call over to Kent Thiry, our Chairman and Chief Executive Officer. So, Ken?

Kent J. Thiry
Chairman and Chief Executive Officer

Okay, good morning. Good to see many familiar faces. Actually, looking at the last year's economic performance or the current year's economic performance, not much to clap about. And we want to acknowledge that recent and current disappointment on the financial fronts and, obviously, we're bringing a lot of intensity to the task of changing that current trajectory.

Our platform remains uniquely strong, if you think about capabilities that are increasingly in demand, you think about our market positions, which are uniformly strong across the board, and you think of the market value of our assets. So no matter what slice you want to take at it, our platform remains distinctively strong. But the platform also has created the optionality for very serious growth opportunities, some which we'll talk about. Unfortunately, some of those growth opportunities are not going to materialize in a dramatic way overnight. Therefore, the importance of my final and fourth point from an enterprise point of view, which is about cash and share buybacks. The good news is that our platform generates a lot of cash. In addition to that, we are now leaning towards a higher leverage ratio. The combination of those 2 facts leads one to predict that we will be doing nontrivial share buybacks in the near-term future, this what we have at different junctures in our past, both recent and historic.

With those 4 comments with respect to the enterprise overall, we'll now just turn right to Kidney Care, the primary engine of our cash flow and our profit. And I'll just make 3 points before Javier Rodriguez, the CEO of DaVita Kidney Care, comes up. One is that the policy dynamics around healthcare service in general, and this includes dialysis, are as choppy and turbulent as they have ever been and, really, affecting all components of the business, when you think about rate, mix, cost, volume. Policy dynamics could affect those positively or negatively with a breadth and depth that hasn't often been seen in the last 17, 18 years and certainly rivals the time when the Affordable Care Act was being passed. So lots of dynamism on the policy front. The second thing, however, if you look at Kidney Care, the strength of that platform, the strength of the market position, the strength of the capabilities is well established and incredibly financially relevant to the long-term upside versus downside ratio for your capital.

And then the third and final point I'll make about Kidney Care is that, in Kidney Care, as in the rest of healthcare service, policy [wonks] on the left and the right, members of Congress from the left to the right, people at CMS that are experienced or new, are all stumbling their way towards more and more

integrated care, more and more aggregate bundling of reimbursement, et cetera, et cetera, all of which is the playing field that we've been practicing on for many years.

With that, I'll turn it over to Javier.

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Thank you, and hold your applause till after the presentation. I'm excited to share the story for Kidney Care and give you a 3-year guidance outlook. As a source of introduction, we will use the same work that we've used for many years, and this is what the tracker will look like.

First and foremost, let me highlight 6 things that are important when you look at the industry: number one, we are very proud of our leading clinical outcomes, but we're also proud that we're elevating the performance of other people in the industry. And that if you were to look at many outcomes, the one sort of final acid test would be mortality. And you see over years that mortality has gone from 18% to 14%. Point number two on the industry, many of you and many of us track a lot of the metrics that are below this. So what's happening to the Hispanic population that is more affected with kidney? What's happening with the aging population, with the boomers? What's happening with the trends of diabetes and other things? So when you look at all of these individually, they give a different story. But when you aggregate all of these variables, at the top, it looks like a very smooth line and, so volume continues to be quite predictable.

Point number three on the industry, one of the only consolidated industries in health care, which is unique that we can go to policymakers in an organized fashion. And the second point on the consolidated industry is that you'll see that there's a lot less acquisition left in there because we look at that middle pie, a bunch of it -- about half of it is the midsized organizations of which it would not be a good use of capital to buy them because we would have to divest a whole bunch of the assets. So 2 takeaways there. Point number four on the industry, we are very unique in our structure. The only disease state that when you get it, you're Medicare eligible, and so therefore, you can shift the responsibility from the private to the public sector. And in addition, after 30 years, you can transition right back into Medicare. So 2 points where the private pay gets a subsidy and, therefore, our mix is 90% Medicare/government and 10% private, which leverages the economics in a big way and makes the private pay so important.

Point number five. We have gone through a very tough period of time where we've had practically no increase in Medicare for 5 years. And so when you look at 90% of your population not getting an increase because of this, it's been rough. So we're looking forward to it now going back to a time where we get our basket updates. And the last point as it relates to the industry dynamics that I'm going to highlight is that the pharmaceutical environment is more dynamic than it has been in the past years because, as you know, anemia has been a monopoly for a very long time. Now we have competition, and we also have biosimilars coming to market, and we have the potential of hits in 2019. Of course, that date is subject to change.

On the right side, we have calcimimetics. On calcimimetics, just so for those of you that aren't familiar with this space, we've had Sensipar, which is a drug that Amgen sells, and it's been a patented drug and that is taken orally through pharmacies like DaVita Rx or the Walgreens or whatnot. And so now there is a new product Parsabiv. Parsabiv was just approved by the FDA, and it is an IV therapy. We don't have a code yet. We don't know how it will -- when it will happen. We think it's going to happen in January. And we don't have a contract yet. And so people continue to ask us about Parsabiv and we don't know what the prescriptions will be, how the patients will react, it's in center, et cetera. So for now, because it's not going to be part of the bundle, it's just going to be a pass-through, so we're going to get cost plus 4 and change percent on that. And so we have not built it into our forecast neither on the cost, nor on the revenue because it's just not that important right now, but we have it in our OI total.

Now moving on to company overview. I thought it would be useful to -- before we go into the specifics, to give an overview of how much is changed and what is the same or similar. And basically, these dynamics continue to be similar to how they've been in the past. We're going to go into some specifics. The one that's probably worth highlighting the most would be the commercial payer landscape, so we will go into

that in the revenue section, and then Joe will discuss how capital efficient our de novos are, what's more dynamic. Kent already talked about the policy side. We just discussed the pharmacy. And we continue to be very, very excited about the integrated care, so we'll spend some time discussing that.

For those of you who are not familiar with this space, this is what a clinic looks like. While this is empty and it looks a bit sterile, if you were to go to a functioning clinic, it would feel actually quite different. It would feel very human. And the reason why that this is because this is a life-sustaining therapy in which you go for about 12 hours a week, more or less, and you form some very strong bonds with your caregivers. So it is an intense and sometimes beautiful and sometimes sad place, but you see what it feels like. Imagine having 2,000 of these, that's what we have. The challenge in having a fragmented place is how you talk to people and so we talk a lot about our culture. It's an important way because of the disparity of all of our footprint. There's some other reminders here on our guidance and some of the other stuff that is in the snapshot.

We're a clinical company first and foremost, so we talk a lot about how we get better at delivering quality care. This is what we call our quality pyramid with the patient in the middle. For many years, up until 2013, all we did is the fundamentals. And that sounds easy, but in the fundamentals, there's basically all of the metrics that one would track and there's a huge amount of metrics. So what we ended up doing is our medical team started saying, "No. Let's start to have programs." And so in the bottom, you have something like, let's say, anemia management or vascular access management. And then you start to say, "Well, let's get some advanced programs around infection control and diabetes management and so on and so forth." And you see how you go toward the top of the pyramid, which is quality of life and reducing hospitalizations, which is consistent with what we want to do as it relates to integrated care.

That framework has rendered excellent leading results. So if you look at this, there's 2 metrics. On the left, you have the QIP. So that's the quality incentive program. For those of you that are familiar with that, basically, CMS sets a benchmark. If you don't achieve the benchmark, you get a penalty. And you can see -- so lower is better, that means less centers received the penalty. If we were to have our numbers be more like the industry, it would be about $6 million in penalties. So this is where quality is starting to meet the economics. On the right-hand side, you have 5 stars. This is just like you would in hotels or restaurants. Five stars, 5 is the best, 1 is the least best. This is a 3-year running average. If we were to be fair, the last year is less distinctive. And that's because it used to be a forced ranking, and they changed the forced ranking. And so therefore, a lot of us look more similar.

So that's sort of when it comes to the company overhang sort of story. When we get into the specifics of the economic framework, we talk about revenue minus expense times volume, it's a very simple thing, but it's, we think a good way to digest it. On treatments, you will see that we lowered it 1 percentage point from last year. The reason why we did that was because now Renal Ventures has closed. And as we discussed, basically, our non-acquired growth, which we've guided for 3.5% to 4.5% over the years is going to hold and will do some acquisitions. But on any given period, that will be lumpy, but that's the right way to think about it over the last 3 years. So this is our non-acquired growth. Again, on any given quarter, it can fluctuate, but think about it on a yearly range, 3.5% to 4.5% and that's a good number. We continue to build. We're starting to reach equilibrium on the de novos around 90 to 110. Some of you might ask some questions, what could change that? And there's some -- there's a bill in California that we can discuss later, SB-349, that is -- a bill like that, which is not included in our forecast for the past, it would impact the de novos that we would build in California. So that's one of the only things right now that we can see. And if that materializes somewhere else, of course, we would revisit that number.

Now switching on to revenue. On the revenue, I want to say a couple of things that will be hopefully useful to clarify. Number one, we moved the range up 50 bps. The reason why we did that was because now we have visibility towards the Medicare increase. Point number two, last quarter, I was a bit confusing. I was trying to be helpful and sometimes, when you try to be helpful, you're not. And that was the case. And so people talked about the hits on -- I talked about the hits on the back end of the quarter, and I talked about comparisons on Q1 for the rest of the year. And I did not -- I was not sufficiently clear. So let me try and clean it up a bit. Number one, Q1 had some onetime adjustments, nonrecurring adjustments, that had the revenue higher. Point number two, we do have some visibility to some hits and you're trying to

calibrate what those hits are. So I'm going to give you something, try to be useful, and then you can let me know if it works.

We estimate 2017 average revenue per treatment throughout the year to be between 1 and 2 percentage points lower than the average revenue per treatment over 2016, okay? That's absent, of course, any discontinuities with some payer or something like that. So hopefully, that helps you guide the numbers. So let's go into a couple of things underneath revenue. On mix, this is -- we're feeling that mix is stabilizing. Of course, as Kent said, dynamic peer world, and that could change, but for now, we're holding mix steady. As it relates to the payer landscape, many of you have asked. So has your relationship with the payers change? The short answer is no. And in most cases, the payer and us have long-standing relationships, and we try to resolve the tough challenges that this population has while we're trying to contain costs. So we work very hard, very collaboratively.

There is a subset of payers that has a bunch of folks trying to be -- they don't pay for high-risk patients and expensive patients. And they try to do it through benefit designs, the network designs, some are trying to get cute with charitable premiumless systems and other things. And so it's our obligation to tell you about that, but the reality is, that a lot of our portfolio lies on the first. And we will see if there's a migration or bleed into the second, but we haven't seen it. And lastly, again, there will be some policy issues that will unravel as we go through this period. And then in the bundle, what ends up happening, as I told you on the calcimimetics, we have a 2-year pass-through. And so then at the end of that 2-year pass-through, CMS will look to see how the utilization faired out, and they will make an adjustment in the bundle, so we'll see how that plays out and, of course, we'll work hard to make sure that it's a true reflection of what we're experiencing.

The last point on revenue. We gave you in the fall a bunch of data around the patients on the exchange. And when you talk about how many were on charitable premium assistance. And then we revisit those numbers over and over again. And so, obviously, we were saying, "Gosh, we're doing something that is not helpful." Trying to triangulate at something. And so we took a stab at that question, which is instead of going into patient numbers and who's on CPA and whatnot, what is the risk that we have in the ACA for patients receiving charitable premium assistance? It's basically about $90 million. And so, hopefully, that alleviates a bunch of triangulations and questions. So if charitable premium assistance was to get annihilated in the ACA, it would to be up to $90 million. It is crucial, crucial to remember what patients are in that category. These are patients that had insurance before their kidneys failed. Then their kidneys failed, and they stopped working. And they want to have continuity of coverage, which is totally one of the underlying premises of ACA coverage. And then virtually none of these patients are Medicaid. So I hope that, that is useful.

Now moving on to expenses. On expenses, the number looks flattish, and some people would be asking questions. So here's how we broke it out. In essence, if you look at this chart over the last year, what you'll see is a teammate cost, which is now about half of the entire bar has gone up 1%. And that is because the labor markets are tight. If you look at the Bureau of Stats unemployment in the healthcare segment is very close to 2% and change, which is materially lower than the rest of the segments. So we're having to be very thoughtful to stay competitive to have the best teammates. The other cost line, which includes practically everything else, will be going down. And that is a change from the run rate in the past. That used to be going up around 2% to 3%. And G&A will stay in line with treatment. As you've seen, G&A, over the last 3 years, is practically flat. And so we'll continue to work hard, stay efficient and to leverage our resource.

We continue to be very, very excited about integrated care. And the reason is we believe that we're uniquely positioned to be the medical home. We have the patient for 12 hours, and we have that bond between them. And so we thought it would be useful to go through this as we did last year and break it down a bit. So you have Angelica, which is a patient. Half of the patients come to us crashing from the hospital. What that means is that they were not managed before, they did not plan to go to dialysis, this is a way more expensive entry into dialysis. So about half of people enter that way. Then they go to the dialysis clinic. This, up to now, is about a $30,000 per year patient. Except when they start on dialysis, things get pretty complicated. And all of sudden, you start to get a lot of things happen to you. Your prescriptions go up. The likely of hospitalizations go up. The likely of infections and readmits goes up.

You're organizing a whole bunch of pills and every time you're readmitted, they get changed, et cetera. So what ends up happening is, overwhelmed and confused. We have them for 12 hours. We can really help on this.

One of the major ways that we can help on it is DaVita Rx. When we started this, it was very much thinking about endgame and organizing clinical -- medical management of these people's medications. It was economically tough at the beginning, as many of you know, but over time, it got better. If you look at it from a return on capital, it's been a good business, but if you were going to look at the pure mission, it's fantastic. And there's peer reviews that indicates that our thesis holds, that hospitalizations are going down and patients are doing better.

Now we said we'd give you detail on what's going on with the outlook because we discussed it 1 or 2 quarters ago. And so I'm going to give you a bit of detail because we did have the perfect storm. We had price, we had volume and we had cost issues, so let me break it down into the perfect storm. On price, as you know, there's a lot of scrutiny on the pharmaceutical companies. They're not raising their price right now. That used to be a straight pass-through that went from top to bottom. We're not getting those increases and so, therefore, that trajectory has been impacted. Number two, we had a contract which had significant contribution, and that contribution is no longer in that contract, so price has changed in a meaningful way.

Number two (sic) [three], as it relates to volume, we had less patients enrolling, and we had patients that dropped off in coverage because they were getting assistance. And they're no longer getting assistance, therefore, they can't afford their co-pays and, therefore, they can't enroll. And that has impacted volume. In cost, we continue to invest in fortifying our compliance, and that has raised the cost. You can say, "Javier, please translate all of that into a number." You think I'm going to do that? I'm going to do it. So it's included in our guidance, and it's in the range of $70 million to $90 million. And it will be a little fragmented, so let me explain where it will be. $70 million to $90 million will be split between the SIs and corporate G&A. And the reason why there's a line in the corporate G&A is because we have management fee that's impacted relating to revenue and whatnot. So for now, $70 million to $90 million and it'll be -- you will see it in those 2 line items as the year goes by, and that is included in our guidance.

When you put it all together, this is what our mature special needs plans looks like. It's a small end. If you were going to do a peer review, it's about 500 to 600 patients. But the net of it is, hospitalization, readmits, catheters going down. When you translate all of this, it means down on cost for the healthcare system and that it could work. If you were to grab that example where we were having a patient on dialysis for $30,000, when you expanded all that, that cost goes to $90,000. When we do all this, we can start to save on that $60,000, that's hospitalization and other things. And that's where integrated care is good for the patient, good for quality and good for the system. So when you aggregate the trilogy, the financial framework, this is what it comes out to be. Of course, this is probabilistically adjusted. And it's important to know that the beginning starting point is the midpoint of our guidance for 2017.

I'll end where Kent started, which is I am super excited of our management team, the capabilities that we've been building over a decade and continue to build and the clinical and IT infrastructure that will take us into the next chapter.

So with that said, I'll get back to Kent.

Kent J. Thiry
Chairman and Chief Executive Officer

We'll talk about DaVita Medical Group next. I just wanted to say a few words before Jim Rechtin, one of the senior leaders, comes up and establishes a little context. In particular, it's important for us to acknowledge the disappointment, the financial disappointment in this realm. And we are acutely sensitive to the fact that your capital is fatigued after the last 4-plus years. There is an unfortunate natural tension between the fact that your precious capital has been buffeted by all sorts of things over the last 4.5 years, but the new team only took over the place a couple of years ago. And this is a business with long lead times. The prior team, to safely extract them, took a couple of years in order to protect your capital from the downside. And while they had built something very, very distinctive and special, not the right group for

the next chapter to take advantage of it and to deal with all the different changes that are going on. And so we have this fundamental, understandable, unavoidable, but not trivial tension between the cumulative fatigue of 4 years of your capital being buffeted versus the fact that the new team has only been in place for short time in a business with long lead times.

So where do we stand right now, however? And on this subject, I'd like to make 4 points before Jim elaborates on all of them and many others. Where do we stand now? Number one is that we stand with $350 million a year of EBITDA despite all that buffeting about. And the overwhelming majority of this comes from the legacy markets of Healthcare Partners, the entity that we bought, so a remarkable resiliency of cash flow servicing your capital investment. We also have 3 new markets next to those 3 legacy markets. In those 3 new markets, where the significant upside for your capital will come from, converting more of that patient body, patient population into value-based reimbursement. This year, we are very confident we'll sign 1 or 2 and maybe more contracts so we can actually begin that journey, contracts that we had predicted and referred to a year ago and are on track.

The second point I would make about where we stand right now is we made 2 fundamental pivots in how we think about the business. Pivot number one is, in the beginning, despite some of the hardship, we were aggressive investing in new markets, moving from 3 legacy to 6, an aggressive move. The pivot now is we have a very high bar for entering any new markets because we have lots of opportunity in our existing markets. Pivot number two, in the category where we stand right now is we invested very, very significantly in building new value capability within the entity. In so doing, adding quite a bit of expense. And we think, in many cases, the great effect, which will start to manifest itself. None the less, right now, we are pivoting from that orientation where despite all the economic pressure from rate cuts, et cetera, we invested right into the headwind. We're now pivoting and saying it is time to realize and drive the efficiencies that should come from all those investments we made and all these different manifestations. And so the 2 pivots, a very high bar for any significant new market and also a shift from adding capability. Of course, we're not going to stop doing that, to driving efficiencies.

The third and fourth points I would submit in answering the question where do we stand right now is we do stand in a situation where we think in 2019, we will approximately double the operating come from 2017. Not a trivial fact, if it emerges. And fourth and finally is a qualitative point, but it's a very important qualitative point. And I think that will bear itself out over time, which is that after the big payer deals fail, with everything else going on, every single major payer as well as many major health systems are recommitting and redoubling their efforts in the area of integrated care, of utilization management, of population health management, of trying to have tighter integration with physicians, networks, the likes of which we have in a way that no one else does. And literally, every single market, we are engaged in fundamental and new explorations of strategic alternatives with some of these major parties.

So with that, I'll turn it over to Jim Rechtin.

Jim Rechtin
Senior Vice President of Strategy and President of Healthcare Partners' California Market

Thank you for the introduction. Good morning, and it's good to see many of you here again after 12 months. I'm going to do 2 things. One, I'm going to walk through a quick background on what is DaVita Medical Group and why do we like it. And then I'm going to step into what are the 4 primary financial levers within this business, what have we accomplished over the course of last 12 months and what are we expecting over the course of the next roughly 2 years.

First of all, what this business is, is managing medical groups. Managing staff medical groups where we operate the clinics and we employ the clinicians and operating medical networks where we contract with affiliate physicians who then own their own clinics and operate their own clinics. We like this business for 3 reasons: one, we have differentiation in the clinical outcomes delivery. And so part of that is the quality of what we deliver and part of it is that we deliver at a low cost. So it's high quality at a low cost of delivering care. The second is that, to do that, you actually need to have strong positions in each of the service areas that you work in, and we have that. We'll talk about that again in a moment. And the third, the nature of this business is that it is a strong cash contribution business, relatively low capital required in this business, nice cash generation. And we will talk about that.

Let me start with clinical quality. There's no perfect metric for clinical quality. Complex topic. But the general kind of industry benchmark is star metrics or HEDIS metrics. When we bought this business several years ago, Healthcare Partners performed very well on star metrics. Since we have bought it, we have gotten better. Our own performance has improved year-over-year every year. And we continue to outperform the market in a meaningful way. The improvement that we've seen over the course of the last few years, a lot of that has actually come through our affiliate network. So this is a big deal. So roughly half of our membership, half of the lives that we serve, the patients that we take care of are taken care of by affiliate doctors, contracted doctors. There are very few entities, and including even Healthcare Partners, 2 or 3 years ago, that can consistently deliver high-quality care to that population. Why? We don't run the clinic. We don't employ the doctors. We have fewer levers to actually drive this type of performance. Over the last couple of years, we have made investments in that ability. We have found levers that weren't there 2, 3 years ago. And we made investments in those. And you've seen the outcome.

So why does this matter? It matters, of course, for our patients. It matters for the clinical outcomes that we deliver. It also matters to CMS, and it matters to our health plans, the Medicare Advantage health plans that we work with. CMS creates substantial incentives around these metrics that impact our health plans' revenue and bottom line and those health plans pass a meaningful portion of that on to us. So this impacts our economics, it impacts our value proposition, the health plans and the value proposition to CMS.

So where do we do this? We do this today in 6 markets. We manage several thousand clinicians across the 6 markets, and we manage about $5 billion in medical expense. When we think about those markets, we are the leading independent medical group in every one of them. And we divide those markets, as Kent referenced, into 2 groups. What we refer to as our legacy markets, and when we talk about legacy, what we mean is there's a long legacy of operating in a value-based, capitated contract environment, delivering health care with population health capability. And then we have 3 new markets: Colorado, New Mexico and Washington, which, when we talk about new, it is new to population health, it is new to capitated, value-based contracts. These are the markets that we are in the process of converting from a legacy fee-for-service environment into a capitated and population health environment.

And when we think about the economics of this business, on a base of $135 million in adjusted operating income in 2016, we generate $346 million in adjusted EBITDA with a capital -- with maintenance capital requirement of about $35 million to $40 million a year. As we manage the businesses, we think about that we need to accomplish economically. We're quite focused on delivering EBITDA and doing it efficiently with the capital that we invest back into the business.

So what allows us to do this? Let's talk about the economics or financial drivers in this business. And we'll introduce our own trilogy, which is medical margin, the rate we received per capitated patient minus the medical expense that patient requires times the number of patients that we serve in a capitated environment minus the cost of the platform that we have built and operate to make that happen. And then within the patient population, again, as Kent referenced, there are 2 distinct populations that we think about separately. In our legacy market, it is all about attracting or recruiting new patients into a chassis we already have. The contracts -- the value-based contracts we already have and the population health capabilities that we already have. In our new markets, this is all about value conversion. This is we have a patient base. It's about getting the contract and the capabilities in place to serve that population in a value-based environment, in a population health environment.

I will walk through each of these 4 economic drivers one by one. So let me start with medical management. Medical margin, the lever that we have the most control over is medical expense. Within medical expense, the largest bucket of expense is hospital cost. And the most significant lever in driving hospital cost is hospital utilization. So why do we show you a slide that shows a 1% improvement? First, we are roughly 20% to 25% below our competitors and the market as a starting point, as a baseline, in terms of the days per 1,000 patients that are in the hospital. So we start from a position of strength, something that we do quite well, that Healthcare Partners has traditionally done quite well. While there's natural volatility in this metric, there's natural volatility in delivering any health care, we have a consistent trend of eliminating or removing or declining bed days across the population that we serve. Last year, we

saw a 1% decline. That 1% is worth about $12 million to the bottom line. Every 1% is worth about $12 million to the bottom line. So this metric matters a lot, and it's a significant focus area for us.

We talk about growth. In growth, there are 2 things to think about. First is senior growth, Medicare Advantage growth. In Medicare Advantage, if you look at the open enrollment period this past year, the fourth quarter, when most patients are enrolled in Medicare Advantage plans, we did grow faster than the market in all 3 of our legacy markets. We also grew relative to the market better than we did the year before, and yet not good enough. This is an area that we need to continue to get better and better and better at. A lot of our energy and a lot of our focus in the last 12 months has actually been around the commercial patient space. So health plans selling to employers and selling to individual consumers before they become seniors below 65.

So what have we've been doing in this space? The -- about 2 months ago, we announced a new strategic partnership with Cigna. This is one of several conversations around strategic partnerships that we're having with various health plans. This one is the one that has borne fruit earliest. We put a -- what we have done is we've created a new health plan product in Southern California. That health plan product is effectively built around a high-performance network, and that high-performance network is us. It's our network, our doctors serving patients in a way that this product takes advantage of our patient experience, it takes advantage of our clinical quality and it's priced to our clinical cost delivery. Our performance doesn't get diluted in a broader network with a bunch of other providers that can't perform at the level that we do. Introduced 2 months ago, we do have our first account closed. We've got a pipeline of additional accounts. These types of new products do take time to mature and develop and to take hold within a market, but the first one's in place. There would be more in place, and we're excited about the direction that this is taking us.

Let me switch to the third of our financial levers, transitioning to value in our new market. We told you last year that this is a multiyear process, it often requires investment in the first year. We feel good about the progress that we've made. We feel like we are on track relative to the plan that we put in place over the last 12 to 18 months. We have an active pipeline of value-based contracts, as Kent referenced. We will have a value-based contract in place, a capitated contract in all 3 of our new markets by the end of this year and very possibly have multiple contracts in each market.

As we've been negotiating those contracts, we've also been building out the network. We have 200 new primary care physicians in our network, which means that when those contracts are in place, our ability to reach patients quickly is improved. Third, we've been building out our population health capabilities. So again, difficult to land on a single proxy, but if you were going to have a single proxy, it would be, "How are we doing on senior wellness visits?" Over 95% of our seniors in the 3 new markets had senior wellness visits this past year. Why does that matter? And why is 95% a big deal? It matters because, in these senior wellness visits, this is where you accurately diagnose their conditions. This is where you close care gaps, you close -- you enhance your star metrics and your clinical performance. And then when you do that, you help offset or avoid unnecessary hospital admissions. Why is 95% a big deal? It is far more difficult than one might believe to establish contact with all of your seniors, build a dialogue between them and convince them when they're not experiencing an acute episode that they should actually be coming into their primary clinic to do this. So again, building the infrastructure, driving to these results, part of what we've been working on over the course of the last year.

Let me turn to the fourth lever, platform cost. Last year, we talked about investment differentially. This year, we're going to talk about efficiency gains. The -- again, last year, if you look back, we committed to driving $50 million in efficiency gains by 2019, which would be offset by about $40 million in investment for a net of $10 million. As we stare at things now and have better information, have made more progress, the efficiency gains are -- we expect them to come sooner and we expect them to be bigger. And so when we talk about efficiency gains, what exactly are we talking about? I will give you one micro example that has occurred over the last 6 months. Small example but relevant. In our claims department in Southern California, in our claims processing team in Southern California, we have cut the number of claims that require manual adjudication by 60%. Cutting that by 60% is multimillions of dollars in reduced operating cost to drive -- to manage that -- the adjudication of those claims. So we have, in this business, a number of effectively production functions, a number of functions with -- that today are being done through

significant manual labor, where technology and improved process will take cost out. And we expect to see more of that over the course of the next 12 months.

So coming back to the 4 financial levers: medical margin, member growth, value conversion, net efficiencies. There, of course, is a wide range of outcomes that one might expect over the course of the next 2 years. Couple things I'd highlight: one, the odds that we're going to be at the low end of the range in all 4 of these levers, quite low. The odds that we're going to be at the high end of the range across all 4 of these levers, quite low. The -- but within these 4 levers, there are multiple paths to get to $110 million, the midpoint of these -- of this range, $110 million in incremental operating income.

So with that, let me just come back and summarize real quick. Clinical leadership, this is at the heart of what we do. High quality at a low cost. We have strong positions in all the service areas, all the states that we -- where we serve patients that allows us -- that, one, both enables us to drive the clinical leadership and allows us to take advantage of that in working with hospitals and health plans. And third, this is a strong cash contributing business. We don't expect that to change.

With that, I will hand the stage back to Kent.

Kent J. Thiry
Chairman and Chief Executive Officer

Next up is international. It's about 5 years ago, we told you that we were launching this adventure. We passed on a couple of on our opening thoughts that we were going to be conservative in allocating a very tiny percentage of your operating cash flow to this adventure. We're going to be conservative and being very focused on buying things that would have exit value, if we were to stumble excessively along the way. We're going to be aggressive on the other hand in terms of the number of countries that we were going to entertain. So we've moved from the infancy stage with respect to implementing those 3 principles to, I would say, the adolescent stage. And in some countries we're actually probably more like a young adult. And it was time to attract a seasoned international health care and other services executive to lead this effort because we remain quite excited about the potential for you longer term, and we may not be too far away from that being economically relevant as you look at the near and intermediate term.

And so I'll let Robert Lang introduce himself, but we're thrilled that he joined us about 6, 7 weeks ago. Robert?

Robert Lang
President of International Business

Good morning, everyone, and thank you, Kent, for the introduction. As you explained, my name is Robert Lang, I'm the new President for DaVita International. I commenced my role in April of this year. I am an Australian national currently living in the U.K. And during my career with organizations such as HSBC, UBS, and most recently at Bupa, where I was Managing Director of the International Division, I've lived just about everywhere across the world. During that time, I've learned a great deal about the challenges of leading a business that is multi-time zoned, multi-language, multiculture, operates across vastly different regulatory environments, and with your teammates spread out all out over the world. I'm looking forward to helping what has been a terrific start-up, an impressive start-up at DaVita International, mature into a multimarket scaled and global organization.

DaVita now operates across 11 markets worldwide. And in doing so we remain on track to deliver the growth that we had planned for. To be clear, our aggregate contribution remain small at this time, but we're well on our way to developing a platform of attractive assets and partners in countries with a long-term upside potential. It's useful perhaps to step back and talk quickly about where we've come from and where we're headed. And this will help put some of the numbers we're going to discuss today into greater context.

DaVita's plan was always to develop a portfolio approach to market expansion. And this is a theme you'll hear me talk about throughout the presentation today. Health care remains a very localized business. Some markets have immediate potential for investment and return, and some are longer-term plays. DaVita also recognize that expertise in markets is built up over time. And therefore, we've taken measured

bets, where we did not over-deploy resources or capital too soon. The key point to this is that we're now firmly in the second phase, as you see on the slide. Our start-ups are maturing and continuing to grow rapidly. As you will see today, we are starting to see the benefit of some of our scaling businesses in the underlying microeconomics. This contribution will start to become more and more significant for shareholders as we enter this third phase.

As you can see on the slide here, the business started small, but has grown very rapidly. Today, we serve 19,000 patients in 214 clinics across 11 countries. That's about 10% of what we treat in the United States. We're very excited to announce to the market in the last 24 hours the acquisition of Centrum Dializa in Poland, which has added about 1,750 patients to our already impressive position in that market.

Our top line continues to grow steadily year-after-year, and we aim to accelerate this. And this year, we expect to exceed USD 300 million in revenue. At the same time, our margins are also improving, driven by both an improving clinical EBITDA, which is our profitability at clinical level, if you exclude our overhead, and our general and administrative expenses per transaction, which has come down significantly. Something that you would expect in a high-growth business that is now starting to approach scale.

Like in the United States, we've had an unequivocally positive impact on the clinical outcomes in our international market. We understand the importance of demonstrating in each market the positive clinical outcome that DaVita can deliver. This in turn will build our brand and reputation and credibility, and will enable us to go deeper in existing markets and to successfully enter new ones. It's a critical proof point of our value proposition that we're not just a U.S. provider. Our clinical model can be transferred globally.

So let's look to the future. Having started to demonstrate that we can indeed transfer this clinical expertise, the next question is, can we do this in a profitable way? We maintain our expectation to break even at an operating income level by 2018, and then we anticipate generating a positive operating income trajectory from that point, bearing in mind that our OI results are subject to foreign exchange fluctuations. And when this result is normalized for the $7 million currency gain we experienced in 2016, our trajectory towards breakeven looks even more impressive.

Over time, we will look to balance this long-term and immediate operating income growth. And this is done by the portfolio of markets approach I talked about earlier. Each market has its own profit trajectory. Germany stands out as an example, where we're starting to experience proven returns and also got ongoing terrific future growth potential. Our Asia Pacific joint venture is a region where the long-term growth potential is very, very attractive. Just to cite some interesting statistics, in China and India alone, there are nearly 2.5 million patients estimated to have an End-Stage Renal disease condition, which is about 5x the prevalence in the United States. As we manage market entry and capital deployment, we continue to consider the overall mix of our markets in our international portfolio. We now see more and more countries reaching the conclusion that they have to fund dialysis care.

Our thesis for international remains intact. Significant opportunities exist for DaVita to expand our model internationally. With positive signs on clinical outcomes, brand and culture, we're building a solid platform for growth both inside and outside Kidney Care, and we remain optimistic about the long-term upside. Thanks very much, and back to Kent.

Kent J. Thiry
Chairman and Chief Executive Officer

Okay, moving into the enterprise summary. Some of you -- many of you have been with us for quite some time or in and out over an extended period of time. And you would probably share my perspective that one of the root causes of some of our pockets of poor performance with your capital have been a product of my inability to find and recruit the right Chief Financial Officer to be my partner and our partner. I think we've rectified that situation. Joel Ackerman can introduce himself.

Joel Ackerman
Chief Financial Officer

Thank you, Kent, and good morning, everyone. I'm Joel Ackerman, the new Chief Financial Officer. I joined here with 15 years of experience on the buy side. I was a private equity investor in health care services at Warburg Pincus, investing in a broad range of health care services for 15 years. Most recently, I spent 6 years as an entrepreneur. I was the CEO of a small publicly traded, technology-based oncology CRO, here in the New York area.

So today, I'm going to talk about our capital strategy, really focusing on 2 issues. One is how much capital we expect to generate over time; and second, how we plan on allocating that capital. Some of you heard -- as you've heard, we've got a very strong cash flow. You can see over time, it's been strong, it's been steady, and it's been growing. And we expect that to continue going forward. Our leverage ratio has remained relatively steady at the low end of our stated range of 3 to 3.5x EBITDA. We don't expect this range to change over time, but we do expect our leverage level to creep up in the near future. We got about $9 billion of debt outstanding, as you can see here. Nothing from a maturity standpoint of any real significance till 2021.

Looking forward, we expect our strong cash generation to continue. You can see here $7.2 billion of operating cash flow over the next 4 years. After MTI and maintenance CapEx, we are anticipating roughly $5 billion of free cash flow. As we think about how we put this cash flow to work, the first source or the first use is development CapEx. This is capital used for de novos, and maintaining our existing clinics. This is by far the highest return on capital opportunity we have in the village. So as we think about the actual capital available to deploy, we think about it, as you can see here, somewhere between $3.5 billion and $4.5 billion over the next 4 years.

So that's capital availability. As you can imagine with that amount of available capital, we spend a fair bit of time thinking about how we're going to allocate this capital. So let me cover that now. Capital allocation in our minds really is 2 issues. One is business mix, how we put this capital to work in the business with a strong lean towards growth; and second, how we return this capital to our shareholders. So in terms of putting capital to work for the business, you see the criteria here on the left-hand side, they're pretty simple and pretty stable over time. One is we want to generate high returns on capital. And second, we want to generate a wide growth. While we don't see these criteria changing over time, we do see our return thresholds evolving as we enter new businesses and as we've entered new countries.

On the right-hand side, our priorities do evolve over time based on the business opportunities we see. You can see here a strong leaning towards growth in terms of de novos, tuck-ins and adjacencies, but we're also looking at pruning our portfolio, looking for businesses we own that don't meet our return thresholds and won't drive OI growth, and that might be more valuable in the hands of other owners.

That said, despite the opportunities we see ahead of us, we do generate more capital than we have opportunities. So like we have in the past, we expect to buy back shares. You can see here, over the last 9 years, we bought back about $3 billion worth of stock, about half of that having occurred in 2015 and 2016. Looking forward, we're certainly anticipating continuing to be active in the markets for buying back our stock, and as I mentioned before, expecting our leverage levels to creep up as a result.

In terms of reducing the net share count, you can see here we -- over the last of the 15 months from January through March of 2017, we've reduced the net share count by about 7%. I would note, since our earnings call 3 weeks ago, we have been active buyers in the market. We've bought back about $2.5 million worth of stock in the month -- I'm sorry, 2.5 million shares in the month of May, thank you, Jim, and reduced the share count by another 1.25%. So in summary, we've got a lot of free cash. We expect our leverage levels to creep up. We've got a good plan for how to put this capital to work for both acquisitions and potentially divestitures. But net-net, we expect to be strong buyers of the stock over the coming quarters.

Let me finish up with how all this translate into our EPS projections. We anticipate consolidated OI growth of 3% to 8%, over the next few years. Accounting for our relatively conservative leverage levels, that will result in net income forecast of 4% to 9%, adding into that the share count reduction that I've talked about where we are forecasting EPS growth over the next few years of 5% to 12%.

Thank you, and with that, I will hand it back to Kent.

Kent J. Thiry
Chairman and Chief Executive Officer
We're going to go ahead and put chairs up here on the stage so we can have a few of us all prepped for answering questions. So give us a few seconds. Let's just grab some. All right. Come on up, folks. All right. Let's do it.

Question and Answer

Kent J. Thiry
Chairman and Chief Executive Officer

Yes, sir, we got a mic? Or am I repeating?

Jim Gustafson
Vice President of Investor Relations

Two mics for the room for questions. So any questions, we have 2 microphones, 1 up.

Unknown Analyst

So I want to go back to Javier's point about commercial pricing, and how in general it's favorable, but there were some pockets of people who were being a little aggressive. I just want to understand kind of what that dynamic is and the risk if that does expand. I guess, we're hearing a little bit about some payers who are looking at their [primary support] even outside of ACA-related business, so is there any...

Kent J. Thiry
Chairman and Chief Executive Officer

Thanks for the question. So the dynamic had been the same for quite some time, meaning we try to form long-term relationships with constructive long-term contracts that are good for both. And in given times there's pockets where we don't reach agreement. As it relates to EPA, of course, we're very happy with the ruling of the judge that said there's going to be some patient harm and ruled on the injunction. And so we'll see how that unfolds. That was a big, big win for the industry. As it relates to expanding into the commercial, we have not seen it. And I think it's a very different market when you think about it. On the first one, on the exchanges, the government has unilateral power on EGHPs, employer health plans, you have the health plan, you have that compounded by the employer group. And then you have to decide whether you're going to treat dialysis differently than any other segment. If you do that, of course, that's discriminatory. If you ban all premium assistance, I think you'll have some social/political backlash. So while it could happen, we don't see it as probable.

Unknown Analyst

And then just to clarify, you mentioned that the commentary on the call was a little bit confusing. And I guess, we're still struggling a little bit with the commentary about the pricing in the back half of the year being under more pressure than the first half of the year. And just trying understand how that impacts the thought on commercial pricing getting into 2018. Is it fully captured in 2017? Or does that mean that there's some headwind to think about as we enter 2018?

Kent J. Thiry
Chairman and Chief Executive Officer

Yes. Well, what we were trying to give you additional color on is that we had a couple of payers that we were going down the negotiation path, and we had some fairly narrow ranges of what was going to happen. And so we were trying to give you insight into that, and so that's why we gave the map point to try to resolve that today.

Unknown Analyst

But I guess, is there any way to think about that -- how much of that is captured in the 2017 number that we need to think about being a headwind through 2018?

Kent J. Thiry
Chairman and Chief Executive Officer

I think I've given you what's useful. It's take the average, and now you've got a quarter, and you take out the 1% to 2% with the average from last year, and I think you'll have a good number.

Jim Gustafson
Vice President of Investor Relations

What I'd like to add is -- Gustafson Hill Gerry. On the issue of whether or not there's anything we can say about whether or not the end of '17 is the right run rate to look at '18 or not, please contemplate and get back to us here, while we're up here answering other questions if there's anything that we can say about that at this time.

Jim Gustafson
Vice President of Investor Relations

And if you could introduce yourself before you ask your question.

Shubhomoy Mukherjee
Goldman Sachs Group Inc., Research Division

Yes, Shubho Mukherjee, Goldman Sachs. I just wanted to ask about the comment around the leverage target going up. Can you just talk about what your comfort level is, given that you're expecting to ramp up share buybacks?

Kent J. Thiry
Chairman and Chief Executive Officer

The point we wanted to make is that, given we have been at almost exactly 3.0 for some time, we wanted to make clear that we would predict to you, that in the near and/or intermediate term, that number will be higher than what you've seen now for several years in a row. But as to any of the sort of quantitative guidance, it just doesn't make sense. Joel went through the 5 or 6 variables that were used making these decisions on a real-time basis, separate from any directional leaning, which we wanted to be clear about. But as to what the actual math will be, it totally depends on what the world brings us in terms of opportunities.

Okay, one here, please. Go ahead and grab that one there, Jacob, and then we'll head up to the front here.

Justin Lake
Wolfe Research, LLC

You gave us some color on the expense breakdown on the dialysis business. Can you give us some help understanding how much of your cost, if you were to breaking them down, just the percentage that comes from teammates versus the percentage of other. And I think you're breaking out -- break out G&A and corporate separately, anyway. But if you could just, within your cost per treatment break down those 3 buckets, so we understand how to project them going forward?

Jim Gustafson
Vice President of Investor Relations

And can we have everybody introduce themselves too, going forward with questions.

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Justin, I think we gave a bar there, approximately half is the labor, approximately 10% or so G&A, and the rest is in the 40%.

Justin Lake
Wolfe Research, LLC

Got it. And then, Javier, while you're standing there, maybe you can talk a little bit about the $90 million of individual exposure. I'm -- just want to make sure I understand it because you talked about $230 million in 2 buckets, right, last year. I think you said that the $230 million has kind of come through and rolled through the P&L, and you've taken the full hit there. Is that correct that it was $230 million or --

and now there's another $90 million on top of that, just the way this is played out? Or you saying that only $90 million of the original $230 million you talked about in terms of total ACA exposure has -- is left to play out?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Yes, thanks for the question. A couple things. We talked about some categories that I don't want to get into because people end up getting confused. But the $230 million is slightly less. We saw slightly less materialize once we reconciled all of the math. But what we're trying to size now, Justin, in all those categories, you have volume, you have rate, and then you have people leaving, entering and leaving the exchange. So there's a lot of variables in play. And so what we're now just saying is, for now, why don't we focus on what's left with CPA in that and it's an additional $90 million. And the reason why we had a range between $45 million and $90 million is because we think that if there's no charitable premium assistance, it's totally taken out that some of these patients would have access to some tax credits. So we don't think that, that would be a full hit. So that's why we put a range of $45 million to $90 million on the slide.

Justin Lake
Wolfe Research, LLC

Got it. And one more, DaVita Rx, that $70 million, $90 million number was certainly bigger than anything I contemplated, when you first discussed it. So maybe you could just give us some color now on the business in terms of where it stands today. So it takes a $70 million to $90 million hit, is it now at a target margin? Are you making money there? How should we think about that in terms of 2018, 2019?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Yes, I think the way to think about it is, a, it's a new profit going forward. It won't go back to the old way; two, it is -- it does make margin -- low margin; and number three, it has been a good return on capital; and number four, it is critical for integrated care and good for the patient. And so I think that's the category. Does that answer the question?

Justin Lake
Wolfe Research, LLC

So this is the new run rate to think about going forward?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Yes.

Justin Lake
Wolfe Research, LLC

And so what does that mean for the ancillary businesses, in terms of what should we think about as a typical P&L there, in ancillary? I know international is going to get some profitability and you laid that out for us. But that other bucket of ancillary, how should we think about that profit dollar?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Yes, we don't give guidance on that specific category, but right now, it's a negative 21. We anticipate it this year to go into the negative 80, and we won't give multiyear guidance on that. And then you'll see that additional money in that corporate G&A line that I discussed, about 1/3 of that $70 million to $90 million will be in that corporate G&A line.

Kent J. Thiry
Chairman and Chief Executive Officer

Let me just go back with -- for one -- Jacob, there's a gentleman up here -- go backwards. I think the best way to think about the 2018, our PT number is just look within the context of the general guidance we gave, the 0.5% to 2% within the 3-year outlook, so it sort of clearly communicates, whether there could be some to-ing and fro-ing, there's nothing dramatic happening there. And as we look at the 3 years, you can't get to the range we provided for the intermediate-term outlook with any dramatic stuff happening up front. Now there's always discontinuities outside of the norm. And as always, with all our forward-looking numbers, we capture a majority of the probabilistic outcomes, things could be outside, either on the up or the down.

Holger Blum
BZ Bank Aktiengesellschaft, Research Division

Holger Blum from BZ Bank. Just wonder about technology and innovation. I mean, you clearly care about the patient. But basically, for the last 40 years, the treatment as such has been more or less the same. Is there any chance to employ some of your capital to improve technology, help the patient in a different way to improve outcomes, have shorter treatments, more efficient treatments, home treatments. What is your thinking in that direction?

Kent J. Thiry
Chairman and Chief Executive Officer

Yes. Maybe I'll go ahead and take the first cut. And then JR can augment as he sees fit. First of all, we do think that the treatment of kidney failure has not been as technologically dynamic as many other parts of the health care, and kind of fun to – can be kind of intellectually fun to talk about why that has happened, but we can leave that for later if someone's interested. Second, there have been dramatic technological innovations proposed, I think virtually every year the last 18 years, whether it's advances in PD or it's advances in home hemo, whether it's advances in nocturnal, whether it's advances in other wearable kidney forms. And so internally, we pretty much say there's going to be a radical technological disruption in 5 years -- n plus 5 years, where n is the current year. Because it's always 5 years out. And it's been consistently 5 years out for 18 years. And so we do believe that, at some point, some of these technologies are going to get to the point where in fact, they do change things. And we very carefully monitor them. In some cases, we made equity investments in them. In some cases, we developed proprietary contractual terms. So we're very much watching it. But at this point, there's nothing imminent that's going to change the historical dynamic. Anything else to add?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Yes. The only thing I would add is technologically, in our clinics, not as -- how the treatment is delivered, that we are now spending a fair amount of resources in building out an integrated care system. And so in IT, as opposed to technology, which you were alluding to, in home monitoring and other things like that.

Kent J. Thiry
Chairman and Chief Executive Officer

And it's easy to forget how impressive the kidney is. It makes the heart look like a piece of simple plumbing. And so replicating kidney function, and in particular, doing so with patients that are more than half diabetic, 1/3 hypertensive and majority develop cardiovascular disease, this is very serious stuff, operationally and in terms of trying to replicate organ function, which is one of the good reasons or legitimate reasons why there's been less technological innovation. It's much tougher to pull off. We've got one over here.

Joshua Richard Raskin
Barclays PLC, Research Division

Josh Raskin of Barclays. First question on the medical group efficiencies, you guys talked about the $10 million of savings last year, sounds like at the higher number this year. Is that the $50 million going higher or the $40 million coming lower? And then could you just remind us some of the buckets of the investments in that $40 million?

Joel Ackerman
Chief Financial Officer

Yes, it's primarily the $50 million going higher, but it's a little bit of the both. Some of the investments are not going to take as much cash as we had at one point expected. And then the investments are in technology. A lot of that kind of the fundamental platform, by which we do both clinical care and do management of kind of back-office claims, things like that. Some of it is in just kind of capabilities that we didn't have previously around legal compliance and business development, so there's a piece in there. And in some of it is more innovative technology around care delivery, things like we talked last year about, are using Google Glass in the physician's office, et cetera. So those are the 3 big categories. Am I missing a big category?

Joshua Richard Raskin
Barclays PLC, Research Division

Thanks. And then second question just for Javier, on this dialysis business, more around the quality metrics and a couple of that I was curious about. Maybe if you guys have some sort of length of stay or how long people are staying on the dialysis at a DaVita center relative to market? And then what does your transplant rate look like relative to market as well?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Sure. On that first one, I'll have to owe you an answer if someone can look that up. On transplant, there's about 18,000 to 19,000, in that range, of transplants a year. And we're doing above our share in transplants. So we're somewhere in the 37%, 38% of those transplants.

Kent J. Thiry
Chairman and Chief Executive Officer

Was your other question...

Joshua Richard Raskin
Barclays PLC, Research Division

It was more on length of stay, just on...

Kent J. Thiry
Chairman and Chief Executive Officer

Was it length of stay defined as years on dialysis or minutes per treatment?

Joshua Richard Raskin
Barclays PLC, Research Division

No, no, months that patients stay on or years or however...

Kent J. Thiry
Chairman and Chief Executive Officer

Yes, with respect to that, we compare very favorably to the overall market. You can see that in our mortality rates being lower as one of the purest statistical indicators of that fact. And all dialysis providers tend to have a sticky relationship with their patients. And so in terms of patients moving to other providers, we would all look good in that sense. But the fundamental math I think you're getting to, mortality is the best proxy, and we compare favorably to the rest of the market. Does that respond to it?

Joshua Richard Raskin
Barclays PLC, Research Division

Yes, that's perfect.

Kent J. Thiry

Chairman and Chief Executive Officer

There is one -- anyway, we got the right side first, and then we'll move to stage left. Changed his mind? Okay.

Gary Lieberman
Wells Fargo Securities, LLC, Research Division

Gary Lieberman from Wells Fargo. You discussed the increase of leverage about being more comfortable above 3x and share repurchase. Can you give us any more detail around -- to your leverage rate that you guys would feel comfortable and then maybe timing for share repurchases and size of share repurchases?

Kent J. Thiry
Chairman and Chief Executive Officer

Pretty much no. And that's not intended to be difficult, and I'll take, at the risk of being redundant, the -- our job was to clearly indicate that we are -- excuse me, in a world we look at the historical data and the fact that we've been at almost exactly 3.0 for a significant period of time, since delevering from the slight spike when we bought HealthCare Partners. In a context of that historical data, we felt it was important that you would know that we now are leaning towards moving up our leverage ratio. And that it is more likely than not that we will do so in the near and intermediate term. But exactly when it will happen, exactly how much will be determined by continuous evaluation of the 4 or 5 filters and criteria that you could all list as well as us. And we'll see what life brings us, and then we'll decide how to handle that.

Gary Lieberman
Wells Fargo Securities, LLC, Research Division

Okay. I'll take it, try another one. On DMG, you noted that there's been a demand for those assets, and we've seen at least 1 transaction. Is there a scenario where you guys would consider selling the business or exiting the business? Or are you very much committed to it and wouldn't consider doing that?

Kent J. Thiry
Chairman and Chief Executive Officer

I mean, well, I guess, first, a 2-part answer. Number one, if one is contemplating selling something, you don't say it. But I've been saying that same phrase for 25 years now, so that's not news for me to say that sentence. And second, we're a public company. We're owned by you. And so we don't get to make that decision. The market makes it, the Board of Directors makes it. Third, however, in the context of those 2 fundamental realities, nothing new from anything else that's been discussed for 18 years. We really like our current business portfolio and think the probability for impressive cumulative risk-adjusted returns for your capital are very good.

Gary Lieberman
Wells Fargo Securities, LLC, Research Division

All right. Maybe I'll take a third shot. On the ESA front, can you discuss any expectations for -- you mentioned biosimilars, Javier. Could you give us any expectations that you have for biosimilars coming to market and how that might impact what your acquisition price of ESAs would be?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Yes, on biosimilars, it's a little of a moving target. The best date we have right now is 2019. The best way to think about it is that our patients have the right to get any product that is clinically appropriate as prescribed from their physician. So at that time it'll be evaluated.

Unknown Analyst

[Luis Hernandez]. My question is regarding the international business. And basically, I just wanted to have a feel of -- first, have a feel how much capital have you deployed already? How much capital do you intend to deploy over, I don't know, the next 10 years or so? And a range, or a rough range, whatever on

the returns on capital that you guys expect on the ones that obviously you stay, not the ones you pull off, and just to have a feel of how big that could be and how attractive the whole international opportunity is? And obviously, we know the whole reimbursement of government issue here, the deficit, is that also present in those international markets? I mean, how is that -- the reimbursement dynamics, is it the same here as -- I don't think it's the same, but I just wanted to know how that is?

Kent J. Thiry
Chairman and Chief Executive Officer

Yes. I'm going to go ahead and give Robert something new, I'll go ahead and take a stab at that and then Joel might want to supplement. Number one, we haven't discussed our particular capital allocations across businesses historically, and not going to do that now. Suffice it to say, and I'll repeat what I said earlier, it's just a tiny percentage of our annual operating cash flow. And then second, we place a lot of emphasis on where we deploying that capital to making sure that our positions in different markets have very significant market value. So if we ever would have to exit some, that capital investment is not capital exposed because much of it or all of it could be returned if we were to become pessimistic. Third, what kind of returns do we look for really differs by country. You can take a country like Germany, with a very stable microeconomics, stable regulatory environment, stable clinics, highly professional nephrologists and other caregivers, et cetera. You could argue that that's a lower-risk profile than the United States. On the other hand, if you're going to be investing in Brazil, with everything going on there, you want to have a higher threshold for return on capital to take into account the risk premium that should be inserted. Although I do want to share, I had an interesting conversation recently, while we were discussing country risk and sort of the filters one would use conceptually and analytically, to compare risk. And we were comparing other countries, and are thinking about things like compliance, exposure, compliance investments, the risk of penalties, the risk of reimbursement cuts, et cetera, et cetera. And finally this person who was from South America said, "Well, by these filters, I actually think the United States may be one of the higher-risk countries in your portfolio." And so it's ironic because since we're so U.S.-centric, it's easy to see ourselves as the index, when in fact, if you more objectively look at how things unfold versus the current status quo, which, of course, is very healthy reimbursement levels here, from a risk profile, it actually gets -- becomes a fairly interesting comparison to make. Is that -- did I hit each component of the question?

Unknown Analyst

Yes. Well, I mean, if I could have a feel on the number on -- you mentioned Brazil or India, the more risky markets. What -- if you give me a range of the number, it would be helpful and...

Kent J. Thiry
Chairman and Chief Executive Officer

Sure. I mean, the range, from an IRR point of view, would probably in the neighborhood of 10% to the neighborhood of 20%, 22% in that range. But it not only can differ by country, it can differ by deal. If you're buying something that has the leading physician group in a defined market, unambiguous clinical quality, good relationships with the payers, then boom, even within the same country, that'll be different a risk profile than going off into a rural area where you won't have another clinic that's close by, et cetera, et cetera. So we do it not only by the country, but by deal. But it gives you a sense of how broad the range is. Got one there, Jacob? And there we go, let's take their first. Go ahead.

Tejus Bidap Ujjani
Goldman Sachs Group Inc., Research Division

Tejus Ujjani, Goldman Sachs. Just wanted to go back to DaVita RX and some of Javier's comments about the fortified compliance and also impact from losing patients that had premium assistance before. I know that there's a disclosure around CID, it goes back to 2006. So presumably, this premium assistance issue is separate from ACA disruption. So any color there on what you found would be helpful.

Kent J. Thiry
Chairman and Chief Executive Officer

Sure. So a couple of things and then please, correct me if I'm not answering the right thing. The first thing is, as it relates to the CID, we are very, satisfied would be the wrong word, but the process worked. We identified that there was an issue, we self-disclosed and the CID was right behind that, but we had been working on the self-disclosure for quite some time. So we've been working with the government now in a very collaborative basis and so those conversations are ongoing and I shouldn't talk more about those. As it relates to -- you had the second part of that on the premium assistance, that's in the pharmaceutical space. So as you know, that PAM that there's been some drop in the funding of those. And so some of our patients were actually accessing those funds and are no longer accessing the funds. So it had nothing to do with AKF or any of that. It's a different issue. They just happened to impact the pharmaceutical industry at the same time. Does that answer your question?

Tejus Bidap Ujjani
Goldman Sachs Group Inc., Research Division

Kind of. I mean, the CID goes back to 2006, which is the same year that the AKF actually requested and received favorable opinion from the OIG on expanding their funding programs to include Part D premium support as well as waiving or supporting some co-pays on enhanced formulator coverage. And in an internal review disclosure that you have, you've identified some certain processes around maybe issues with billing and handling of write-offs and discounts around co-pays for drugs. So I'm just trying to understand is if there is any relationship?

Kent J. Thiry
Chairman and Chief Executive Officer

Yes. I think with what you're saying, there's no relationship. I shouldn't add more detail than what's on the SEC disclosures. But I think you're mixing dialysis and pharma assistance, and so they're totally unrelated in this particular situation.

Tejus Bidap Ujjani
Goldman Sachs Group Inc., Research Division

Well, the pharmacist [indiscernible] is for Part D drug premiums and co-pays for drugs as well. And so your DaVita Rx just -- I guess there is some relationship between receiving some support there. You mentioned that, that segment's being impacted by loss of patients with premium support there as well?

Kent J. Thiry
Chairman and Chief Executive Officer

Yes. The bulk of the money is on the PAM.

Unknown Analyst

My name is [Dan Baldini]. In Kidney Care, there were a couple of significant financial impacts this year. On the rate side, you had some hits from commercial payers, and on the cost side, you had a -- have a benefit from repricing Amgen, and you have a benefit from sort of an accounting change for your what, retirement plan. And my first question is, are these fully reflected in the 2017 numbers you've laid out or will some of these expenses benefits carry on into 2018?

Kent J. Thiry
Chairman and Chief Executive Officer

The -- it's included in our range, so all of those things that you stated are reflected in our multiyear range.

Unknown Analyst

Sure, okay. Well, will there be any continuing impact, positive or negative, in 2018?

Kent J. Thiry
Chairman and Chief Executive Officer

Well, in some of those -- it depends on which category. Of course. So as you know, the retirement $100 million that we've given you on a change from profit share to 401(k), it's just going to be a switch. So we had a year where we didn't accrue. And then going next year, we will start the accrual again, so that'll be a headwind. As it relates to the Amgen contract, we've given you some sense on what the range of that line is going to do so you can do some math around that. And so I don't know if there's any other line that you're talking about.

Unknown Analyst

Well, the rate hits from the private or the commercial payers.

Kent J. Thiry
Chairman and Chief Executive Officer

Yes, I think we've given enough color on what we expect for that.

Unknown Analyst

Okay. So in the numbers you put up for 2018 and going forward, it implies that the margins in Kidney Care for 2018 will improve over the level for 2017. And I'm just curious in face of this labor cost inflation that you have, how does that happen? What are the additional levers that you have, say, to improve margin next year?

Kent J. Thiry
Chairman and Chief Executive Officer

Well, I think we have a range, right? And so if you look at the trilogy, there is a scenario where you can have margin expansion and there's a scenario where you can have margin compression. And so I don't think that on any given year, we've said exactly that there's going to be margin expansion or contraction but rather how to look at it in a multiyear setting.

Kevin Mark Fischbeck
BofA Merrill Lynch, Research Division

It's Kevin Fischbeck from BofA again. A couple questions -- follow-up questions. You mentioned pruning during the conversation, and I wasn't sure if that was a new focus of emphasis. Is pruning related to narrowing the focus of the existing businesses, like getting out of certain dialysis markets or international markets or DMG markets? Or is that more focused on business lines that might be [separable], and not giving you the return that you're looking for?

Kent J. Thiry
Chairman and Chief Executive Officer

So it could be any of the above. We're just, as good stewards of the capital that our shareholders provide us, we think it's not just about looking at growth. As we think about OI and capital hurdles. We have to look at our existing portfolio, and there are things that we might own that might be more valuable in the hands of other share -- other owners. And as a result, we would think about exiting those.

Kevin Mark Fischbeck
BofA Merrill Lynch, Research Division

Is the fact that you're bringing up meaning that this could be potentially a meaningful or noticeable impact? Or is this pruning around the edges that are...

Kent J. Thiry
Chairman and Chief Executive Officer

I think it's impossible to predict. Again, it depends on how life unfolds.

Kevin Mark Fischbeck
BofA Merrill Lynch, Research Division

Okay. And then within Medicare Advantage, there's been some news recently with United being under DOJ investigation around coding. And I just want to understand how you guys think about coding, because you submit the data to the managed care companies who then do the coding. But want to understand how you guys deal with it, how you think about any potential downstream implications from scrutiny on coding?

Kent J. Thiry
Chairman and Chief Executive Officer

Yes. Well, coding is a very big deal, to state the obvious. And this is an area, one of the reasons when we bought HealthCare Partners, we established a very significant escrow in case there were issues that emerged because it was very clear the federal government was going to begin to be much more engaged with oversight on Medicare Advantage and the details with which Medicare Advantage is run and implemented. And we are on that side, in active discussions with the government, as you know, regarding some of the practices in that industry, including within the HealthCare Partners, and that's been going on now for some years. We were very happy, as you should be, with the fact that we were not -- we are not involved in the United suit. And that's something the government could have decided to do. And so that is unambiguous good news and, we think, a reflection of the constructive work we're doing in that area. And in general, we bring, from our Kidney Care space, a very, very disciplined set of perspectives on how to handle things like coding compared to other folks in the Medicare Advantage space who have not gone through with the kind of reviews that we've been involved with in the dialysis side.

Kevin Mark Fischbeck
BofA Merrill Lynch, Research Division

And then, I guess, maybe a last question. On the pharmacy side, you had a number of buckets as to what was causing that $70 million to $90 million. I guess, one of them was that pharma pricing had slowed down broadly. How much of that was that dynamic, I mean, to the extent that pharma pricing remains under pressure? Should we expect you to continue to talk about additional pressure in that business going forward?

Kent J. Thiry
Chairman and Chief Executive Officer

Yes, I don't think it's productive to go into details as to each one of those categories. We gave you a lot of detail trying to be helpful. But I don't think I want to go into breaking down each one of those categories.

Kevin Mark Fischbeck
BofA Merrill Lynch, Research Division

But I guess, trying to think, to the extent that it is a risk to EBITDA growth heading into 2018 because to an earlier point, the $70 million, $90 million was bigger than we thought when we were thinking about it originally. Just trying to -- is there any color you can give just about the relative size of that?

Joel Ackerman
Chief Financial Officer

Yes, you're seeing the same stuff that I'm seeing in the public market, which is pharmaceutical prices, they're under a lot of scrutiny. Don't know what that conversation will look like in the forward-looking years but what we do know is that, that's a straight drop to the bottom because it's just a price increase, so we don't see it. Of course, it hurts the growth. But can't give you more color than that.

Kent J. Thiry
Chairman and Chief Executive Officer

Yes, and on this one it's really -- it's not a disclosure or sharing issue. We don't know what they're going to do in terms of price increases. We just don't know. And there's a bunch of different scenarios and small number of drugs have significant impact. And so, Kevin, it's not as if we know something we're not sharing. We just don't know.

Justin Lake

Wolfe Research, LLC

Justin Lake from Wolfe Research. Kent, I think previously, when you had discussed some of the other moving parts around the guidance, specifically the headwind to next year from the retiree accounting change, you had said that you expect to be able to grow OI despite that headwind. Can you remind me, is that correct? And if so, can you expand on that at all?

Kent J. Thiry
Chairman and Chief Executive Officer

Yes, my recollection is what I did say -- what we did say is that despite things like the headwinds, some of which you referred to, that we thought 2018 OI was going to be higher than 2017 OI in Kidney Care. And at that point, and I will not be able to recall spontaneously exactly what assumption on 2017 was embedded in that comment at that time. I'd have to go back and look. Suffice it to say, today's comments on the range and the financial trilogy within Kidney Care supersedes any prior statement.

Justin Lake
Wolfe Research, LLC

But today's range is a 3-year range?

Kent J. Thiry
Chairman and Chief Executive Officer

Yes, correct, correct and...

Justin Lake
Wolfe Research, LLC

So does that mean that the specificity around 2018 is no longer...

Kent J. Thiry
Chairman and Chief Executive Officer

Yes, why don't -- without knowing exactly what the setting was the day I said that, and so therefore, what 2017 number was being presumed, I can't answer. But hopefully in the next 15 minutes, we can get you the answer. I'm just not going to know -- given it's a comparison of 2 numbers, while I can know what '18 is, I can't comment spontaneously on how it compares for the definition of 2017 as of that day, whatever that was 9 months ago. So I can remember the phrase, I just don't know the reference point. It is knowable, however, so we can go find out and get back to you hopefully while we're still all here together.

Justin Lake
Wolfe Research, LLC

Okay. Maybe we can talk about the ancillary business for a second again. I just want to make sure, you've got a bunch of stuff in there. You talked about some moving parts. So if I'm -- just to make sure I'm framing this correctly, Javier, you talked about $80 million of loss, about 1/3 which sits at corporate, so let's just forget that and say maybe it's $50 million altogether. And I think what you've delineated for people is, Part D is profitable and international is not. International is going to get better. But within that, let's just say those 2 offset, you still got $50 million of losses. Can you tell us what's driving that $50 million and can that get better going forward? Or is that just an investment spend that we've got to kind of build in?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Yes, it's all our strategic initiatives. So you've got the Vascular Access business, you've got -- anything that we do, you've got -- I'm trying to go through -- Falcon, which is our integrated health care system. We've got VillageHealth, which is a bunch of the relationships we have in integrated care, et cetera, so

there's a portfolio in there. And the bulk of the difference that you're going to notice from one point to the next is going to be the shift in Rx, although all of them are moving somewhat.

Justin Lake
Wolfe Research, LLC

Okay. But is that -- we talked about Rx being normal. Is that other $50 million, let's just say, outside of Rx and international, is that other investment spend likely to be the number we should think about for the next 3 years or should that likely increase or decrease?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Yes, we're not giving you guidance on that line but I don't foresee any substantial change in that line item right now. But that's strategic initiative, so of course, who knows?

Justin Lake
Wolfe Research, LLC

And then lastly, just on the dialysis business and reimbursement, in particular. Obviously, you don't make any money or maybe even lose money on the Medicare side. LeAnne here has done a great job in D.C. of -- with the Patients' Choice Act on 2021 you have this opportunity to move -- or patients will have an opportunity to move to Medicare Advantage plans where you can help them more and hopefully get reimbursed more by plans. So I think you said that you get paid 20% more by Medicare Advantage plans right now versus traditional fee-for-service. Can you just reiterate that to make sure that number is ballpark correct? Do you think that's sustainable going forward? Do you think it could increase or decrease? And could you talk about some of the initiatives what you're doing working with plans? I know you signed a deal for a number of patients with Humana, for instance. Can you give us some details on how you expect to do more for plans on the Medicare Advantage side and help creating value, and therefore, capturing some of that economics?

Kent J. Thiry
Chairman and Chief Executive Officer

Yes, if someone could look up what we've said on rates because I don't think we've disclosed rates, but I could be wrong so if someone could check that. So I don't want to provide detail on the rate differential. Obviously, now that the payers see that in 2021, Medicare Advantage will be eligible for dialysis patients, they're going to pay more attention in negotiations. And so I don't know what will happen to the premium, and of course, we don't know how many patients will want to enroll depending on how their financial situation and their doctors and all the local decisions that you get made. But we do know is that approximately, right now, about 1/3 of Americans are in Medicare Advantage plans, give or take, and ours are materially smaller because they don't have that right and it's very hard to predict. But from now until 2021, there's a lot of road ahead and so we're not building anything into it, and we'll see how it plays out.

Justin Lake
Wolfe Research, LLC

Can you give us any color on what you're doing with Medicare Advantage plans right now to try to create that bridge to creating more value? I mean, for instance, that Humana contract, is there anything you could share with us in terms of how you're working with managed care? Maybe savings you can drive for them?

Kent J. Thiry
Chairman and Chief Executive Officer

Sure. I mean, what we're trying to do is make sure that we talk about the holistic care. We're starting to move into CKD, not only ESRD. The contracts are starting to have more of a -- both a fee-for-service and a value proposition of shared savings and other vehicles to make sure that we provide value to the

network. And so we're being more thoughtful, they're being more thoughtful, and we're having good conversations.

Ian Anthony Rosenthal
TimesSquare Capital Management, LLC

Tony Rosenthal, TimesSquare Capital. Kent, I just want to go back to the leverage question. Why are you taking leverage higher? It seems a big counterintuitive given rates seem to be at a bottom, maybe going up. And while the business is more diversified today, the cash flows don't seem to be as predictable as the core dialysis business. So why take leverage up?

Kent J. Thiry
Chairman and Chief Executive Officer

You want to take it or you want me to? The answer is going to be fairly generic, Tony. I mean, you look across the 5, 6 criteria of -- and even though maybe interest rates are bumping up a bit from a historical perspective, rates and equally importantly, the terms associated with the rates are still, from a historical perspective, quite attractive. In addition, if you look at what's happened throughout the world in terms of capital abundance and the ratio of financial assets to GDP in the world, separate from whatever our government decides to do with interest rates, it's dramatically different than any time in history, and that ratio is dramatically higher than before, which again bodes very well for continued healthy debt markets for people like us. And then you can continue to watch what other companies, in particular, ever-growing private equity portfolios, and how they deal with their leverage situations. And then you stare at the durability of our cash flow. And while on the one hand, you can point to some choppiness on the surface in recent years, which is greater than prior years, the choppiness on the surface should not detract from our appreciating the depth of the ocean. And the fact that we've been able to maintain the cash flows we have with an unusual spurt of superficial choppiness at the top is, we think, noteworthy. So to kind of put all that together, it's partly analytical, it's part qualitative. And we're looking in the rearview mirror and saying "Gee, if we could do it over again, perhaps we would have had more in the past." So it's not necessarily that the past was right and now we're changing something. It could be that in retrospect, we said, "Gosh, we could have done better for you by certain opportune times being more aggressive on the leverage side." So kind of put all that together and we drew a conclusion. As many of you know, they've been with us a while. We don't flip every about 4 months or 6 months on how we think about share buybacks and how we think about leverage ratios, but we think about it every 6 months. It's not just that often that we have sort of a directional shift in our leaning. Is that responsive?

Ian Anthony Rosenthal
TimesSquare Capital Management, LLC

More or less.

Kent J. Thiry
Chairman and Chief Executive Officer

Okay. Jim, do you want to comment on the -- rather to have me try to read it. This is -- Justin, I think this is going to get to your...

Jim Rechtin
Senior Vice President of Strategy and President of Healthcare Partners' California Market

Yes. I mean, you asked about 2018 and we said it back in January 1, and Kent said based on the context then, when the guidance was the same for 2017 as it is now, that it's more likely than not if you had to bet at the time, it would be up in '18. That comment was really looking at the midpoint of our guidance. And so that's kind of the look. The degree to which we may outperform this year depending on the reasons for the outperformance could make that relative year-on-year tougher. That's about, I think, all that we would want to say on that.

Justin Lake
Wolfe Research, LLC

Do you still feel that way again, Kent? [indiscernible].

Kent J. Thiry
Chairman and Chief Executive Officer

Yes, I would rely on what Jim says.

Jim Rechtin
Senior Vice President of Strategy and President of Healthcare Partners' California Market

Can we tape -- we have that on tape.

Kent J. Thiry
Chairman and Chief Executive Officer

But hopefully -- but more likely than not, I was using the mid-2017 guidance, which evidently is the same now as it was then, and of course, to the extent we do better in '17, that makes that more difficult, but you should be happy with that. So maybe in a perfect world, we would not achieve it because we do so well in '17. And then -- and I'm – and we haven't disclosed any specific number. All we've said consistently is the average rate in MA is higher than the average rate in Medicare fee-for-service. And in this case, it is literally not in your best interest for us to start pinpointing exact rates because anybody who's paying more of that amount is more likely to come after us. And the people we are contracting with on the MA side are a relatively consolidated set of folks, so it's a very different dynamic than you have in other negotiating spheres. Over here.

Holger Blum
BZ Bank Aktiengesellschaft, Research Division

Holger Blum, BZ Bank again. Just a question on your anemia management strategy. I think you mentioned before that the first HIF inhibitors might be filed next year. Maybe today, we get the first EPO biosimilar recommended for approval. How flexible really is your Amgen contract if these things on the medical side do change and prices come down and maybe even oral drugs become an option for patients?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

I think the fair answer is we took all those things into account when we were negotiating the contract. And again, if it's clinically appropriate, our patients can have access to what the medical community deems appropriate. And so I think that should...

Holger Blum
BZ Bank Aktiengesellschaft, Research Division

They don't have any limitations like 90% of your EPO business goes to Amgen.

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

I don't know what I can and can't say because the contract has a confidentiality clause and so is that as good as I should get? Okay. Looking at the legal department right next to me. And so that's as good as it's going to get. Thank you.

Unknown Analyst

[Ari Herman]. You gave very helpful disclosure in terms of the AKF exposure within the ACA. Can you do the same for the AKF funding of the commercial plans outside of the ACA?

Kent J. Thiry
Chairman and Chief Executive Officer

We're not -- have not and it would not be in your best interest for us to start providing all sorts of detail on that other chunk. JR did appropriately characterize the dramatic difference in scenarios of what goes

on versus employer group health plans versus what goes on in the Affordable Care Act and exchange in 2 different worlds.

Unknown Analyst

I appreciate why it's different. I'm just looking -- I was hoping maybe you could just confirm the spend. The AKF has public disclosures. It seems that they are paying for 20,000 commercial members outside of the ACA. So if you just look at the market shares, it would seem that, that would be 40% to 50% of your commercial exposure. Are those numbers roughly right?

Kent J. Thiry
Chairman and Chief Executive Officer

Yes, I don't know anything about the AKF numbers, and so I can't comment on whatever they're publishing. Sorry, I just don't have any idea what numbers they put out or how they calculate them.

Unknown Analyst

Yes, just to follow up on the leverage question once again. Could you just tell us what your current restricted payment capacity is?

Kent J. Thiry
Chairman and Chief Executive Officer

Current what?

Unknown Analyst

RP capacity is? The credit agreement and the indentures?

Kent J. Thiry
Chairman and Chief Executive Officer

Did you understand the question? Pardon? Okay [Kitra] do you know? Can we hand the mic?

Unknown Executive

As long as we're under 3.5x leverage, we have unlimited share buyback capability. If you go above that, we have a net income builder that started in 2010, so we can do the math but it's a fairly large basket. And we also have another $1.2 billion of share buyback capability and another $500 million of general RP basket. The general's right, the net income?

Kent J. Thiry
Chairman and Chief Executive Officer

But [Kitra], make sure -- 2 things: number one, make sure you repeat the question; and number two, make sure we're not launching into new areas of disclosure.

Unknown Executive

Yes. Sorry, go ahead?

Unknown Analyst

[indiscernible]

Unknown Executive

It's basically a net income basket but I don't have that calculation, but we can do the calculation based on public information and get back to you.

Kent J. Thiry
Chairman and Chief Executive Officer

Thank you.

Ari Singh

Ari Singh, Neuberger Berman. Javier, can you just give a lay of the land of the commercial marketplace in the sense of when a commercial plan signs up with a managed care plan, what is the network adequacy requirements for dialysis in general? Are there laws that dictate that they have to have x number of dialysis clinics within a certain mile radius? And in general, are -- would you consider most managed care plans on the commercial side to be open networks or very narrow networks, where they try to get to the floor?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Yes, I'll start with the second part. Most of them have a healthy network. So if you were to look at our portfolio, the bulk of our portfolio is in network. And as it relates to the contracting piece, the first part, can you try that piece again? I didn't understand the question.

Ari Singh

Well, I'm just trying to understand like how open network, like do most plans like United, when they're contracting with a big employer like GE, do they have, in terms of dialysis clinics, they would have DaVita, Fresenius, all the hospitals, or b, are they basically starting to narrow that down to a DaVita only?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Yes, it varies by payer, but on the state guidelines, different states have different rules, but there are some that are time to travel and some that are mileage, some that are not as thorough. But at the end of the day, we're not seeing employer designs on that. We're usually seeing a payer that wants to solve its issue with us and enter into a long-standing relation.

Ari Singh

Got it. And then also in terms of your commercial rates, can you give us some perspective in terms of the outliers that are still there or maybe the percentage of the big 5 that are under contract for a multiyear period going forward? My understanding was part of the commercial headwinds that you incurred this year was the fact that you had an outlier plan that recognizes they were an outlier and they basically wanted to do something about it and they did it. So the question is any sense -- can you give us any perspective in terms of how many more outlier plans there might be, or if your commercial rates are very much tightly – they're around the means of very tight standard deviation?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Let me try to be as useful as I can. That piece that you're wondering about has shrunk materially year-over-year, so it's small. But when you have an outlier rate, even though it's small, it's an outlier rate. It hurts when it reverts to the mean. The good thing or the positive thing is that, that tends to be fragmented into a lot of payers now as opposed to concentrated, although they're small concentrations, it's mainly fragmented. And so it's unlikely that you would feel a big swing. It could happen but unlikely.

Kent J. Thiry
Chairman and Chief Executive Officer

I want to go backwards one second and go back to the first question to explain why Javier's answer is correct and importantly correct about narrow networks. The -- in general, providers only want to sign up for a narrow network if you're going to get differential volume because you're obviously giving something to the payer that would typically be a lower rate in exchange for higher volume. So our beautiful Cigna co-branded product in Southern California on the DaVita Medical Group side, that's the case where we have a fundamental cost advantage over a bunch of the rest of the market. We got a payer with a serious

brand and market share and by going together, we can actually, with a lower rate, gain significant share and both come out with more aggregate profit and return on capital. Now flip over to dialysis where those dynamics don't work, that if I go to a payer and offer a discount in exchange for moving volume, that payer has a very difficult time actually moving any of the volume. The -- for all sorts of reasons, first, existing patients, dialysis patients are not going to leave their center, and there's tremendous disruption if you -- the history books are filled with failed attempts at trying any wholesale movement. And even trying to say that new patients can only go to one place is very, very difficult. When you are a dialysis patient, you find out your kidney has failed and you're going to start going to a center, someone can't threaten you by saying you're going to have a higher co-pay or a higher deductible, you're going to blow through all those anyway. You're also afraid you're going to die. And so this is not the time where you're spending a lot of time looking for what's out of network and in network because you're going to be at the maxes anyway and you want to go where your nephrologist and to whom you entrusted your life tells you to go practices, et cetera. And so the entire dynamic of why narrow networks happen, in some cases, because you can move share versus in dialysis where the empirical data is clear, it's very, very difficult, is why no provider wants to offer the discount because the payer can't say, in exchange for that, you'll probably get hundreds more patients. So there's a reason for the disparity, the reason why that answer is correct, which is very important because these architectural elements of the dialysis ecosystem are highly protected for us, which is essential in a world where 10% of our patients subsidize the other 90%. Which is, if I can elaborate again for a moment because it's so important, which is another reason why it doesn't happen that everybody who provides dialysis knows they rely on that tiny fraction to support the big mass of government pay. And so at great peril do you start playing with that. In addition, and finally, we're almost a pure variable cost of business. So if you're a hospital, you might want to do some significant pricing on hip replacements, because even at Medicare fee-for-service rates, your contribution to cover fixed costs is massive because your fixed costs are massive and you have to worry about rebuilding the edifice 8 years later, whereas in our business, we're almost pure variable cost if you look at the cost structure. And so there's no such thing as making it up on volume in order to get more contribution in total through lower contribution per unit. That math simply doesn't work in dialysis. Next question.

Jim Gustafson
Vice President of Investor Relations

Actually got a question from outside the room and then we can go back to the room here. With respect to the approval of IV Sensipar, what percent of patients need Sensipar and how are nephrologists responding? And can you comment on the process for CMS, including in the bundle going forward?

Javier J. Rodriguez
Chief Executive Officer of Kidney Care

Yes. As to how many patients are in Sensipar, it's about 30% of our patients on Sensipar. As to nephrology practices, very few people have access to it, so we don't know is the short answer. We'll be looking at it. Again, we're waiting for the reimbursement code. And then we'll monitor and we'll have basically a 2-year period to evaluate with a pass-through, and we'll give you more color as we get it.

Kent J. Thiry
Chairman and Chief Executive Officer

I'll make one closing comment and take any additional questions that come after. It's one final opportunity to think. I just want to emphasize, one thing I usually do upfront but thought better today to wait until the end. That one of the important recurring themes as you look at our portfolio of business units, whether it's DaVita Kidney Care, DaVita Medical Group or DaVita International, is our leading clinical outcomes. And this is what we're about from a mission point of view. And in many, many instances, our excellent clinical outcomes earn no additional return and in some cases, come at the cost of additional expense. However, we do think over the grand march of time, and we are seeing more and more signs of this, that quality actually does matter. Increasingly, of course, payers are just very sensitive to the total cost, including hospitalizations. But also in general, consumers/patients, employers, et cetera, are becoming more sensitive to quality metrics where they apply and they're relevant and they're credible. And so just hopefully you know that, that's one of the fundamental common denominators across each of our spheres of operation. Any other questions about anything? Kevin?

Kevin Mark Fischbeck
BofA Merrill Lynch, Research Division

Can't avoid asking questions when I'm given the opportunity. So you mentioned the trilogy on the DMG side, medical margin being one of them. What is the right way to think about medical margin over time? And where is the -- is there opportunity in the core 3 markets or if you see medical margin expand, is that going to be mostly on the new 3 markets?

Joel Ackerman
Chief Financial Officer

Yes, so [indiscernible] medical margin is the rate that we're receiving minus the medical costs for [indiscernible] medical cost. Over time, we expect the rates and the medical costs to roughly track [indiscernible] given year you will see some volatility. There are times when [indiscernible] how much of our business is in the government sector where you will see [indiscernible] we're going to have to adjust to that over a period of a couple of years. But over time those [indiscernible] in our new markets, we do expect margins to expand as we convert to value-based -- we do expect margins to expand as we convert to value-based care. And the -- but the medical margin per member will vary by market because of the local characteristics of those markets.

Kevin Mark Fischbeck
BofA Merrill Lynch, Research Division

And I guess when you had that layout, that breakout of 4 drivers to the EBITDA growth or operating income growth, the value conversion, when you say value conversion, you mean going from a fee-for-service contract to a capitated contract on a broader range of service, that's what the EBIT boost is from?

Joel Ackerman
Chief Financial Officer

That's correct. Yes.

Kevin Mark Fischbeck
BofA Merrill Lynch, Research Division

Okay. And then if you, after that contract, improve margins on that contract, that would fall into the medical margin bucket of improvement?

Joel Ackerman
Chief Financial Officer

That's correct as well. Yes.

Kevin Mark Fischbeck
BofA Merrill Lynch, Research Division

Okay. And so you mentioned that on the core business that the rates and the costs to grow at the same line, does that mean that those are kind of at peak margins but correct margins long term that there's not an opportunity to improve margins on the core business?

Kent J. Thiry
Chairman and Chief Executive Officer

I want to -- at this point, I'd like to -- I would give a different answer to the question that with respect to the legacy markets, I would either expect that: a, the margins will be enhanced; or b, volume will begin to gain share at a significantly greater clip; or c, we'll have to eliminate fixed costs. But that the status quo is not what I would accept as the long-term reality. So it's a slightly different answer. Any other final -- got another one, Justin? It's almost like an auction.

Justin Lake
Wolfe Research, LLC

Maybe we can talk a little bit about the DaVita Medical Group discussion we had in the first quarter, just in terms of an update there. The -- I think your last comments on the first quarter call were that you expected to be at the lower end of the range for this year and that you had a $30 million [bag out] for next year that hadn't been fully contemplated within the $250 million target for 2019 because of that $30 million being rates being worse than expected. So when you look at the 4 pieces of that OI chart that you put up for DMG, it would seem like the medical underwriting piece would be probably getting worse than -- towards the worse end of that range that you put out there. Is there a viewpoint that -- you talked about the efficiency gains being better and faster. So do you feel like you're still on track or -- because in the first quarter, it sounded like you felt like there were some hurdles to getting there, or at least some things you had to overcome.

Kent J. Thiry
Chairman and Chief Executive Officer

Yes, let me take a stab and then we'll see if it's adequate. The -- number one is we had baked into our model that we had shared with you a certain assumption about Medicare rate increases just like we have done for years on the Kidney Care side. Number two, when the government makes a decision better or worse than what we predicted, that affects the model and in some cases, a rate cut can be partially offset, in some cases, it can't. And in all cases, you have to be careful before you start claiming that you can make up for things like that. And so yes, when the government decision and translating to flat rates for us in a year where we thought we would get a slight increase, that incremental math, a percentage point, comes right off the top and the bottom lines. And so we shared that with you. And then with respect to 2019, you can see the interplay across the 4 variables. And if you take the midpoint, it kind of depends again where we finish 2017, it probably put you at a number lower than the $250 million that we had said we had a good shot at before. And so that is the net reality is something lower than that. And at this point going any further in specificity would just be misleading. I think the much more important thing from an investment thesis point of view is that independent of whether it's $220 million or $230 million or $240 million or $250 million is it would be nice to be higher rather than lower. The important thing is that it's not $120 million, $130 million. The important thing is that it's significantly higher and trending up, which will be a reflection not just of happenstance but it would be a reflection of fundamental operating progress, either in terms of negotiated rates or value conversion or reduction in medical management or reduction in G&A. So it will be an earned material increase in operating income, based on increasing command and differential execution of the business, which then will bode well for that next phase. And so part of the significance is the math and equally significant is the variables that are driving the math separate from exactly what number it is.

Justin Lake
Wolfe Research, LLC

And while you're -- while we're talking about just the profitability, maybe we can go back to the dialysis business for a second. It would be -- obviously, you get -- it's acknowledged you make all your money in the commercial side. So can you talk about to the extent that there is pressure on commercial over time, whether it's rates or mix or what have you, what are you doing in DC to -- or within your business to make more money on Medicare one way or the other? It would seem inevitable that there's going to be pressure on this cross subsidization. And if there is, what factors do you think or what do you think is the tipping point on which you're going to start getting better Medicare rates than even maybe just full market basket to offset the commercial mix or into the -- or you could change your business model to make money on Medicare?

Joel Ackerman
Chief Financial Officer

Yes, I think the answer is, obviously, we're trying to take different cuts at it in a world where there's not a lot of excess funding around DC and people aren't wanting to pay you more for anything. One is the Medicare rates are a nice bump. Number two, the Medicare Advantage, what we discussed starting in 2021 will be somewhat part of the solution. But number three and the one that we think is somewhat of a game changer is to talk about integrated care. And that's why we're pursuing the Patient Act so aggressively because you start to say, "Okay, in a world where you don't want to pay me more, I can change the value

proposition and say, 'Give me some part of the savings if we grow the pie.'" And so that's the potential game changer, and we agree with you that we have to make Medicare more attractive.

Kent J. Thiry
Chairman and Chief Executive Officer
5, 4, 3, 2, 1. So thank you all very much for your interest in our company. We will do our best for you until we see you the next time. Thank you.