Company Name: DaVita Inc
Company Ticker: DVA US
Date: 2017-09-07
Event Description: Robert W. Baird Global Health Care Conference

Market Cap: 10,997.82
Current PX: 57.52
YTD Change($): -6.68
YTD Change(%): -10.405

Bloomberg Estimates - EPS
Current Quarter: 0.960
Current Year: 3.633
Bloomberg Estimates - Sales
Current Quarter: 3882.250
Current Year: 15332.100

Robert W. Baird Global Health Care Conference

Company Participants

- Whit Mayo
- Kent J. Thiry
- Jim Gustafson

MANAGEMENT DISCUSSION SECTION

Whit Mayo

Good afternoon, everyone. I'm Whit Mayo, the Senior Facilities Analyst at Robert Baird. It's my pleasure to have the leadership team from DaVita representing the company. We have Kent Thiry, Chairman and CEO. Joel Ackerman is in the audience as is Jim Gustafson. With that, I didn't know if you had any prepared or we can just get right into...

Kent J. Thiry

Right into it.

Q&A

<Q - Whit Mayo>: Okay. Great. Or maybe just start with recent bill, H.R.2644. I know this is a little bit of wish list for the industry, but maybe talk a little bit about the contents of the legislation, some of the important aspects of that, and any hope that any of these provisions could be tacked on to so any legislation later this year.

<A - Kent J. Thiry>: I'd say, right now, the odds that anything – first of all, the bill itself is not designed that will be passed in and of itself.

<Q - Whit Mayo>: Correct.

<A - Kent J. Thiry>: And yet it is a very important way of trying to build legislative momentum towards getting some of the items attached at some point to some other legislation. And I would say, right now, the odds that anything material, economically material to you from that bill gets attached this year are very low.

<Q - Whit Mayo>: Right. Very helpful. Maybe just to...

<A - Kent J. Thiry>: Maybe I got to just add...

<Q - Whit Mayo>: Yeah.

<A - Kent J. Thiry>: There are one or two that are important where my answer would be more positive if you extend the timeframe into the next year or the year after. But in the near term, it's just not going to happen.

<Q - Whit Mayo>: Elaborate on what those key elements would be, those key provisions?

<A - Kent J. Thiry>: Well, the most significant would be the extension of MSP or the acceleration of allowing Medicare Advantage patients to enroll, and those you would still bet against next year, but should we decide to put our weight behind the Medicare Advantage one in particular, there is this chance.

<Q - Whit Mayo>: Okay. Good. There has been a lot of discussion in the past year on the charitable assistance programs CMS has been. Last week, CMS hosted a webinar where they were educating some of the navigators that

they believe that patients that had ESRD should enroll in premium-free Medicare Part A plans as opposed to Marketplace plans, and I'm just curious what your perspective is on that specific guidance.

<A - Kent J. Thiry>: Yeah. On that specific guidance, I could not opine unless I heard exactly what was said and how it was said, so I don't want to say anything, commenting on what CMS said in the webinar without knowing. But in general, what is true is that for a whole lot of these patients being in commercial insurance is it's not even close. It is vastly superior in terms of coverage and not only for them but importantly, for their families. And in many cases, without charitable premium assistance, they're going to be in real trouble trying to get all the care that they need. So that I can state with assurance, but I don't want to comment on CMS's comments unless I know they've got my ducks in a row quite completely.

<Q - Whit Mayo>: Just so that you know that Jim said he'll follow up.

<A - Kent J. Thiry>: Okay.

<Q - Whit Mayo>: Maybe just to retrace the events last year.

<A - Kent J. Thiry>: If I can go and provide a little more context...

<Q - Whit Mayo>: Sure.

<A - Kent J. Thiry>: ...just for a second. The Federal Government made a conscious decision 25 years ago to have the American Kidney Fund. [ph] We're on two cases (03:56) where the OIG literally issued a special opinion saying, this is okay. And we know that providers are going to fund it, and we're saying, it's okay because for a lot of these patients, when your kidney fails, even though you've been in private insurance for many years, in many cases, you stop working. And so after all of that time, when the condition hits, you're going to stop working. You could lose your insurance. That's quote-unquote not fair and introduces true risk of disruptions in continuity of care.

So it's a very conscious decision to say, this is okay including provider of funding. When Obamacare passed, all of that was consciously reaffirmed that CPA was okay, and in fact, that's when it got6 expanded to apply to Medicaid. So all of this was done with full awareness and explicit intention by the government. Then it became an issue because the exchanges became an issue and expensive patients on the exchanges became an issue.

<Q - Whit Mayo>: Correct.

<A - Kent J. Thiry>: And some of our patients became the poster child for something that was totally above board and totally intentional and explicit. Then it became part of a very heated political football. So in terms of sort of ethical behavior, compliant behavior, this story is absolutely pure. Having said that, it's precipitating quite a political football.

<Q - Whit Mayo>: Yeah. So it takes us to the interim final rule or the – first, the RFI then the interim final rule then the industry was successful suing. What's next, what's the next steps that the industry can take?

<A - Kent J. Thiry>: Right. Well, first of all, this was a huge victory. And if you read the decision, you'll see how strongly the judge felt. I mean, it is not that often that a Federal judge will stop the implementation of a nationwide regulatory change like that. And if you read the [ph] opinion (05:51), you will see just how critical the court was of their logic and how substantive the court felt we had been in presenting the other side of the story, which is basically one of protecting patients and maintaining rights that they had always had.

What's next is probably a new CMS ruling, and that probably will come out of the next nine months, could be sooner, could be later within that timeframe. And within that, there is a very good chance that there will be a differential CPA policy for ESRD versus other conditions in the same way that there has been a unique CPA policy for ESRD for 20 years. But exactly what will be contained, we, of course, have no idea. We have been happy that we've gotten some audiences in order to educate folks as to exactly what the practical implications are of different policy decisions.

<Q - Whit Mayo>: This year, you've pointed to some very specific headwinds from commercial pricing. In my head, the way that I sort of visualize this is there were a number of lingering high price contracts that you have perhaps the payers on the fringe hadn't really paid attention to it and perhaps recent events may have forced them to look back at all

of their contracts. And those who have come in perhaps you decided to forego a public [indiscernible] (07:21). What's the right way to characterize the rate headwinds that you're experiencing this year and how you think about that going into 2018 without providing any guidance?

<A - Kent J. Thiry>: Exactly. 2016 was a very tough year in terms of private payer contracting, and we've talked about that. 2017 so far is a much more normal year if you look at this from a historical context the last 15 years.

<Q - Whit Mayo>: Okay. In California, there are two bills, 251 and 359, one that caps on profitability and another on staffing ratios, been driven by the unions [indiscernible] (08:03) very well publicized. It's had a little bit of momentum. Can you just provide some color as to how we as investors should think about the risk around those two specific pieces of legislation?

<A - Kent J. Thiry>: Well, first of all, it's worthy of attention. If they were to pass, then it would be very bad in a whole number of ways, and it is not at all unusual for a bill like that within the State of California to move along because the Democrats have a supermajority in both houses of legislature. So, the fact that there's been a bunch of preliminary votes and favors is, in and of itself, not that significant because it's pretty much business as usual.

We do think, however, that in the last month, we have succeeded after several months of preparatory work in significantly increasing appreciation on the part of the relevant parts of the legislature, which is to say the moderates, and the offices of the governor and the people in the healthcare agencies, but there's a much deep appreciation of the mess that would be created if and particularly the staffing ratio if that was to be passed.

The other one is sort of a bizarre bill. I don't know whether or not that has any serious traction, so we'd have to come back and talk about that another time. But the staffing ratio, one, there are a lot of people now who appreciate what a mess it will create for them and for medical expenses and for hospital burdens in the emergency room. All of that, there's a much greater appreciation than there was six weeks ago. And what does that mean is going to happen? Who knows? It's very difficult, almost impossible to handicap these things, but we've made some very nice progress as a community I educating people in a very rational, professional, fact-based way. And the fact is that if they were to pass and there will be tremendous problems, we would stop, literally we and the community would stop building most centers that are in process, not to mention new ones, some centers would be shut down, you'd have shifts closing down, you couldn't afford to do third shifts anymore. That will lead to patients having to go to the hospital.

The hospital association and others are very much on our side. The LA Times came out with an editorial against it, the San Diego paper came out as well against it. So the good news, forget the community complaining, a whole bunch of objective parties that are not owners of dialysis centers have also weighed in saying this is bad healthcare policy.

<Q - Whit Mayo>: Just to understand that a little bit better, has the FCA – have they organized with your nurses, I mean what if – what leverage do they have at the table?

<A - Kent J. Thiry>: They were, and I assume still are, working hard for a long time trying to organize folks in a number of our clinics and other dialysis clinics non-DaVita. And it was clear after a while given there was no vote being called that they were not as optimistic as they had want them to be, and therefore, this legislation emerged. And in some cases, I can't comment on this, in some cases this is what you do to try to force a negotiated settlement. And who knows if that was their motivation in this case or not, but we and others at this point have not agreed to any negotiated settlement and have just focused on fighting the legislation.

<Q - Whit Mayo>: Late last year or early this year, I can't remember when it was, you signed a new contract with Amgen to buy EPO. Can you talk about some of the logic and the forces that brought the two parties to the table?

<A - Kent J. Thiry>: I think, first to the broader point – well, let me answer the question first that we've worked with Amgen now for [indiscernible] (12:04) kind of 18 years that I've been around and it is the drug that has the most extensive track record and the most extensive familiarity. And it was time for us in the relationship to move one step beyond sort of classic vendor-customer and become more aligned. And so that was the twist in the road after many years of a more conventional relationship. And we've been very pleased with how it's worked so far. And I think looking forward, the broader point that you provoked is, we may very well have opportunities to do directionally

similar things with other pharma and biotech companies over the next five, 10 years.

The obvious statement is we have an awful lot of presence and we can generate more refined assessments of the clinical aspect of different drugs and different protocols than virtually anybody else in the world. And so we're quite attractive as a partner.

<Q - Whit Mayo>: Great. The details of the – your prior contract had a provision where you could buy about 10% of your ESAs away from Amgen. Is there an existing clause within your current contract? I don't know if that's been disclosed or not.

<A - Kent J. Thiry>: I can't remember.

<A - Jim Gustafson>: We've disclosed that we have requirements in different years [indiscernible] (13:34).

<A - Kent J. Thiry>: And so there's some people that are on the web can hear that, we do have a requirement that it's...

<Q - Whit Mayo>: At least 90%...

<A - Kent J. Thiry>: ...at least 90%...

<A - Jim Gustafson>: Of ESA.

<A - Kent J. Thiry>: ...of ESAs.

<Q - Whit Mayo>: Okay. I don't know the intelligent way to ask this question other than we've all been trying to figure out what the tail is on this contract, and whether if we look at the second quarter, your acquisition cost per unit, does this continue to give you a tailwind going into 2018 or is this the new run rate of your cost per treatment of this specific drug?

<A - Kent J. Thiry>: I think as many of you know, there are very significant restrictions on what can be disclosed regarding the contract. So we would love to provide more detail, we cannot do it and we understand why our partner prefer to negotiate those restrictions. So we're not complaining about it, we're just trying to explain why we're not more forthcoming. And I think what I would just say is that, as you look out past this year, there are parts of our cost structure where we have some upside and in the broad area of pharma/biotech that's one of those areas where we have the potential for some upside in the near and intermediate term.

<Q - Whit Mayo>: Okay. Maybe sticking on the subject to pharma and biosimilars, you've got Fresenius' partnership with Vifor, Galenica they have Mircera, Pfizer, do they have a biosimilar now?

<A - Jim Gustafson>: [indiscernible] (15:19). It's not approved.

<Q - Whit Mayo>: How do you think about your ability to begin to look at biosimilars as an opportunity going forward? I mean, it's not clear that anyone really has the access to Mircera other the Fresenius right now?

<A - Kent J. Thiry>: Right. The basic trends, in terms of biosimilars and the [ph] hips (15:44) and these things that are emerging that although there is lots of – lot of us – you have to make assumptions, you have to – [indiscernible] (15:55) is going to get approved when and who is going to price things where and all this. But in general, if you look at the world that's emerging now and over the next five years, versus one that's existed in the last 10 years, it is more provider-friendly.

There are going to be more alternatives. Some of them could have very significant positive implications for the cost structure. Also there's kind of more interaction now between what's happening in other countries and what's happening here, more of a conversation, more data flowing back and forth, more clinical results. So in general, the world looks better for us and other providers in the next five, six years because of what's going on in the space. Even though you have to make a lot of assumptions, there is no doubt that there's going to be more alternatives and more competition in the next years.

<Q - Whit Mayo>: Yeah. This year we saw the first IV version of Sensipar. And I don't know if it's on your formulary yet. I know that Medicare is paying ASP. I don't know how it gets included into the bundle, but can you just talk about the clinical benefits of using this specific drug and perhaps just the compliance level, under the conversations we're having with nephrologists overwhelmingly suggest that they would prefer this over Sensipar.

<A - Kent J. Thiry>: I think, I guess, Jim will do a better job of answering that one than I will, go ahead Jim.

<A - Jim Gustafson>: Yeah, it's really too soon to tell. The drug is more likely to be available starting beginning in next year and be in wider use. And we'll just have to see what the view is from nephrologists, we'll have to do our own tests to look at it, but this is something where there will now be a choice between the oral. And we do already distribute a lot of the oral because we do some of that through DaVita Rx so it's not that this will be entirely new for us. It's just now it will all go under the bundled reimbursement, probably for two years on a cost plus basis.

<A - Kent J. Thiry>: And we, and as Jim said, we've done quite a bit with it because of all our work in DaVita Rx. And at the same time we remain intensely objective, whereas sometimes subsets of the nephrology community can be influenced by marketing.

<Q - Whit Mayo>: Correct.

<A - Kent J. Thiry>: And the selective discussion of certain studies, and a lot of these areas these areas we have better data than anyone and we're more objective about it. So sometimes this early excitement turns out to be a little overblown.

<Q - Whit Mayo>: Maybe turning to just ESCOs for a moment, your experience in that program. And there's also the, was it the Patient Act in Medicare and I'm curious how and why it's important to have that in addition to ESCOs. I think I know the answer, but I want to hear sort of your thought process.

<A - Kent J. Thiry>: Yeah, this is important. The ESCO program as it's currently configured is not scalable. And we were very clear with CMS in the very beginning that we would do some to be a good citizen and help them, but unless they introduced radical architectural change, it was not scalable. And this is a – the absence of a scalable integrated care program is a farce. It cost tax payers, stunning amounts of money and it deprives patients of proven integrated care that makes a big difference in their health and in their social support. So, it is sad that there is no, right now, a program that's scalable providing this proven improvement to the patients. The Patient Act would take care of that. If the Patient Act passes, now we have a real shot. Within a very short period of time, most kidney care in all of America will be transformed.

Because people like us will infuse private capital in a way that the government cannot afford to somehow manipulate their way through adding the expense you must add in order to coordinate the care, which then brings down hospital expenses in particular, that are a multiple of the amount of money you have to spend, and there is absolute causality. It's actually proven. There's no risk. It will happen. It doesn't take that long, but it does take a significant amount of organizational emphasis and some amount of capital and expense.

And so the [indiscernible] (20:18) right now are almost a distraction that I think is sad because you might have some people thinking that they can be scaled and therefore, less likely to pass The Patient Act. So, whether you're a patient or you're a taxpayer, whether you're a shareholder, it is not close. The Patient Act is vastly superior in terms of the amount of change it will drive, the transparency of the change, and the benefits of the change.

<Q - Whit Mayo>: Got it. Shifting gears to DMG, I think you've been very public in your disappointment on the performance of the company over the years. You've had to consistently make a lot of investments into the infrastructure in order to get the organization in a position where it can really grow and has great long-term prospects, and there has been an argument for and against keeping the asset. Can you maybe frame up how the company, the board is thinking about the importance of DMG, and the long-term strategy of DaVita?

<A - Kent J. Thiry>: Well, what I would do is answer this way, and then you might want to come back and do a follow-up question or two, because I'd first pull back and answer it from an enterprise point of view that our recent stock price performance is as disappointing to us as it is to some of you. And when you're in a situation like that, you

step back and take a look at your entire portfolio. So that's every business, every market, and evaluate what strategic alternatives you have. And so we're doing that in a fundamental and rigorous way, and that is a healthy thing without prejudging any answers that would come from it. But when you are at our size level and complexity, you must retain objectivity about what stuff fits best and what does not.

Having said that, we absolutely believe in the DaVita Kidney Care model, the DaVita Medical Group model, and the value we're adding with kidney care overseas as well. And so I would just say that we, I think, are doing the right kind of work and retaining the right kind of objectivity and absolutely, are proud of the value DMG is bringing to the system, which is reflected in the fact that every year for five years, people have approached us willing to buy all or part of it.

And at the same time, we have not done a good job of monetizing that value in the first couple of years is because of massive rate cuts and then because of the dislocation of taking out all the founders, but we've got some very, very nice operating momentum now pretty much across the board, yet we totally respect shareholders and patients as to when that positive momentum would show up in numbers.

<Q - Whit Mayo>: Your disappointment and the disappointment of your shareholders and the disappointment of what you've messaged on your last call about keeping, I guess, the importance of retaining DMG, that seems like a bit of a shift in stance.

<A - Kent J. Thiry>: In what sense [indiscernible] (23:21)?

<Q - Whit Mayo>: You were disappointed that the stock price sold off in a way that it did, and you and shareholders that were disappointed because it seemed like you were wed more towards retaining DMG and it seems like that's now a change in stance for you.

<A - Kent J. Thiry>: No, I would say maybe people's perceptions have moved around a year ago versus six months ago...

<Q - Whit Mayo>: Yeah.

<A - Kent J. Thiry>: ...versus two months ago versus yesterday at lunch. I think we have retained the right level of objectivity on this...

<Q - Whit Mayo>: Yeah.

<A - Kent J. Thiry>: ... subject, and we try to be strikingly consistent with how we talk about it. At the same time, in any business, each quarter or a chunk of time in which you have disappointing performance...

<Q - Whit Mayo>: Yeah.

<A - Kent J. Thiry>: ...should appropriately challenge the way one thinks about the business, and we're certainly no different. So in that sense...

<Q - Whit Mayo>: Yeah.

<A - Kent J. Thiry>: ...you would say, guys, wherever you are in the spectrum of negative versus positive, that after some more disappointing time, you would move...

<Q - Whit Mayo>: Yeah.

<A - Kent J. Thiry>: ...in a negative direction. So maybe in that sense, there is some shift, but that's just being rationale.

<Q - Whit Mayo>: Makes sense. Now that the payer mergers have largely collapsed and as we see anything come back to market, are you feeling like they are engaging more with DaVita Medical Group, more with the capabilities and solutions that you can offer and partner with them?

<A - Kent J. Thiry>: I think directionally that is true. Every payer that was totally consumed for two years who were either trying to get a deal done or trying to prevent it from getting done...

<Q - Whit Mayo>: Yeah.

<A - Kent J. Thiry>: ...is now facing the question of what is their delivery system strategy for this next 10 years. And there is quite a set of those if you compare United versus Humana versus Anthem versus Cigna versus Aetna versus some of the Blues. And so, yes, I'd say the quality and quantity of conversations we're having with a number of them is different and better, but that isn't anything that's going sort of magically monetize itself in the next nine months. It's much more tectonic plates shifting than anything else.

<Q - Whit Mayo>: Yeah. A few months ago, you alluded to maybe more – I don't say aggressive but in the near term in leverage maybe going up versus down. Can you maybe provide a little bit more context around the thought process for why it makes sense in this environment for leverage to go up and maybe just corollary to that is buybacks been very active?

<A - Kent J. Thiry>: Good. And also, Jim, I'd remind you to do – should you do the forward-looking commentary, please?

<A - Jim Gustafson>: Yeah. I mean, we just want to make sure that one, Kent will make forward-looking statements within the meaning of Federal Securities Laws, and so we will not update the statements in the future. Second, per our normal disclosures, we also have non-GAAP disclosures that we may make here, and so reconciliations are available on our website. So, for the full disclosure on this, you can go to our website for the disclosures there.

<Q - Whit Mayo>: That's good.

<A - Kent J. Thiry>: And that, I assume it implies to everything that I have talked about prior to this moment and subsequent to this, [ph] make it (26:43) retroactive. So, on to the debt, we, for the last 18 years have said between 3 and 3.5 times leverage and occasionally go above, which we've done, like when we bought Gambro, occasionally go below and sometimes that's when we're thinking we might do something significant and wanted to create the capacity or any other reason. You could list all the sub points and the filters one would put through. And consistency is important on things like that.

At the same time, foolish consistency is not so important. And our businesses right now are generating more excess cash than they have in the past, and part of this because in things like kidney care, there's not as many acquisitions to do and in part, just because we're bigger. And so, you look at our cash generating capacity is higher. It is also, in both DKC and DMG, quite resilient and stable, and people can often forget that as you look at the operating income number in DMG, it's equally important to look at the EBITDA number, which is with all the trials and tribulations, still at the [ph] $315 million (28:01) level or so. And if you tax adjust it, $500 million or so because of the [ph] 15-year high dollar (28:07) tax benefit.

So, it is a really big deal for shareholders to know what is the actual operating and free cash flow and net free cash flow numbers and are people willing to use it to buy back stock and get you that sort of guaranteed return. And so, number one is the actual amount of excess cash flow is higher. Number two, the stability of that cash flow on a relative basis feels like a real shareholder asset. Number three, despite recent changes the overall debt markets, from a historical perspective, are quite attractive. And so, while we might be looking at some earnings choppiness within a given period, there is not going to be any cash flow choppiness.

And so, putting all that together, we said our classic attitude may need to be nudged – it does need to be nudged – and that we need to lean towards having a bit more leverage than we have on average in the past for those reasons, so very analytically based, not anything radical, and not that we're going to rush out there and do it no matter what the stock price is. We take that into account. But directionally, that was a changed conclusion, reflecting changed internal and external reality, and that position holds.

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Whit Mayo

Thank you, Kent. We are out of time. I really appreciate you joining me, and please join me in thanking Kent.

Kent J. Thiry

All right. Thank you very much.