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# DaVita Inc. (DVA) CEO Javier Rodriguez on Q3 2019 Results - Earnings Call Transcript

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Q3: 11-05-19 Earnings Summary

*Press Release* *10-Q*

EPS of $1.53 beats by $0.29 | Revenue of $2.9B (1.99% Y/Y) beats by $54.14M

## Earning Call Audio

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DaVita Inc. (NYSE:DVA) Q3 2019 Earnings Conference Call November 5, 2019 5:00 PM ET

### Company Participants

Jim Gustafson - Vice President, Investor Relations

Javier Rodriguez - Chief Executive Officer

Joel Ackerman - Chief Financial Officer

LeAnne Zumwalt - Group Vice President

Jim Hilger - Chief Accounting Officer

### Conference Call Participants

Stephen Tanal - Goldman Sachs

Kevin Fischbeck - Bank of America

Justin Lake - Wolfe Research

Pito Chickering - Deutsche Bank

Whit Mayo - UBS

Gary Taylor - JPMorgan

John Ransom - Raymond James

Matt Larew - William Blair

**Operator**

Good evening. My name is Debbie, and I will be your conference facilitator for today. At this time, I would like to welcome everyone to the DaVita Third Quarter 2019 Earnings Call. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. [Operator Instructions] Mr. Gustafson you may begin your conference.

**Jim Gustafson**

Thank you Debbie, and welcome everyone to our third quarter conference call. We appreciate your continued interest in our company. I'm Jim Gustafson, Vice President of Investor Relations, and with me today are Javier Rodriguez, our CEO; Joel Ackerman, our CFO; LeAnne Zumwalt, Group Vice President; and Jim Hilger, our Chief Accounting Officer.

Please note that during this call, we may make forward-looking statements within the meaning of the federal securities laws. All of these statements are subject to known and unknown risks and uncertainties that could cause the actual results to differ materially from those described in the forward-looking statements. For further details concerning these risks and uncertainties please refer to our third quarter earnings press release and our SEC filings, including our quarterly report on Form 10-Q for the second quarter of 2019 as updated by our quarterly report for Form 10-Q for the third quarter of 2019.

Our forward-looking statements are based on the information currently available to us and we do not intend and undertake no duty to update these statements. Additionally, we'd like to remind you during this call we will discuss some non-GAAP financial measures. The reconciliation of these non-GAAP measures to the most comparable GAAP financial measures is included in our press release submitted to the SEC and available on our website.

I'll now turn the call over to our CEO, Javier Rodriguez.

**Javier Rodriguez**

Thank you, Jim and thank you for joining the call today. And as always, I will start with the clinical highlights to remind us that clinical is at the heart of what we do here at DaVita. As we talked about at Capital Markets, over 50% of our patients begin dialysis treatments through the hospital setting, which is bad for the patients and expensive for the system.

We're working hard to lower the number by helping the people better manage their chronic kidney disease through two efforts. First Kidney Smart, which is DaVita's community education program that provides free education on what the kidneys do, diet, medication, and treatment options, including home modalities and transplant.

I'm pleased to report that, we have educated over 180,000 people through Kidney Smart and we're making a difference. Based on our tracking, we know that Kidney Smart education individuals who transitioned to ESRD have better clinical outcomes both during and after the transition.

Additionally, 32% of Kidney Smart-educated individuals begin dialysis on a home modality, which is almost five times better than the general population. Our other key effort to improve chronic kidney care is our new nephrology-led entity the Nephrology Care Alliance, which will enable nephrologists to come together with DaVita to improve the care coordination for patients.

In this model, DaVita will create patient education and predictive analytics while the physicians will contribute clinical expertise to help the patients slow kidney disease progression and start on-home modality. These capabilities are important in both fee-for-

service environment and as we continue to grow our value-based care arrangements.

We're off to a good start. Two supporting points, first over 500 nephrologists have joined the alliance; and second, Dr. Leslie Wong from the Cleveland Clinic has agreed to join DaVita to lead the way.

Next a few comments on our Q3 performance and results. Our adjusted operating income results continue to outperform our original estimates at the beginning of the year, and we have raised our 2019 adjusted operating income guidance for the second time this year. Calcimimetics has contributed to our OI performance, and we have delivered a great outcome.

In addition to resulting in positive financial results, our clinical and operational protocols have both improved health outcomes and driven savings to the health care system. While we expect at least one more quarter of positive economics, we continue to expect operating income from calcimimetics to be near breakeven over the long-term.

Regarding our financial goal of capital efficient growth our discipline on cost and capital continues with our goal of margin stability. We have delivered strong performance on labor productivity all year, while actively managing our capital expenditures spend down. These efforts have generated strong cash flow a lot of which we have deployed toward share buyback.

Now, let me comment on some longer-term issues and developments since our last earnings call. First up California, we're disappointed that Governor Newsom signed AB 290 into law, despite clear evidence of the harm this union-backed legislation will cause for many of our most vulnerable patients in California. Because of the law the American Kidney Fund has made it clear, it will have to cease operation -- operating its patient assistance program in California as of January 2020.

To remind you this will leave nearly 4,000 low-income primarily minority patients without financial support that they rely upon to afford health insurance. We along with other kidney care community filed today a legal challenge to AB 290 in federal court in California because we believe it violates the United States constitution.

Also in California, we recently learned that the SEIU-UHW has introduced another ballot initiative which could be voted on in November 2020 election. You may recall that in 2018 they sponsored Proposition 8 which was rejected by the majority of California voters. The Union has until April to gather enough signatures to put the proposition on the ballot. We will oppose this new ballot initiative which is simply another attempt to inflict harm on providers, physicians and patients and we believe would add significant unnecessary cost to the system and the taxpayers.

Now on to more constructive development, two weeks ago, CMMI released application for 4 voluntary integrated care models for CKD and ESRD. I won't get into the significant detail today, but let me make a few points. These models are nephrologists-centric. The models are complex and we will work to educate the nephrologists to help them evaluate, if these models make sense for their practice.

For us the model appeared quite challenging in their current form and they will require significant investments that are unlikely to move the needle on the economics. In partnership with the community, we will continue to share the feedback with the government on ways to improve the model design and quality outcomes for patients.

Finally, it's been a busy 6 months and as many of you heard in capital markets we laid our strategies for long-term success including a new set of financial metrics and goals. I'll be the first to acknowledge that we have more work to do to achieve our longer-term objectives. And yet as I interact with our caregivers, I'm even more confident that we're on a path to improve kidney care for our patients.

In closing, we also announced today that Peter Grauer, the Lead Independent Director on our board since 2003 and a member of our Board since 1994 after he took Total Renal Care public, plans to retire from the Board effective at our annual meeting in 2020.

After helping to lead the Board through the Chief Executive transition and the sale of DMG, he believes it is now time to step down. We are forever grateful for his tremendous leadership and role in our organization.

Now on to Joel, who will provide additional details on the quarter?

**Joel Ackerman**

Thank you, Javier. Let me start by providing our Q3 enterprise results for revenue, adjusted operating margins and adjusted earnings per share from continuing operations attributable to DaVita. We generated $2.9 billion of revenue in the quarter, an increase of 2% over Q3, 2018.

As a reminder in Q3 2018, DaVita Rx contributed approximately $100 million of revenue. Our adjusted operating income was $462 million resulting in adjusted operating margin of 15.9%, which includes approximately $74 million related to calcimimetics. Adjusted earnings per share from continuing operations attributable to DaVita was $1.53.

Now let me walk you through some of the underlying drivers starting with the components of the U.S. dialysis and lab segment. Non-acquired growth for the third quarter was 2.2% effectively flat compared to NAG in the prior two quarters. While we believe, we are starting to see some progress in the leading indicators of NAG, it's too early to give any guidance on the timing or magnitude of potential improvement.

Revenue per treatment was down sequentially by $0.56, driven by normal quarterly fluctuations in revenue. We continue to expect RPT for the full year to be in line with our guidance of up 0% to 1% compared to 2018. Combined patient care costs and dialysis and lab segment G&A were up approximately $1 per treatment quarter-over-quarter, driven primarily by higher compensation and benefits costs offset by lower calcimimetics acquisitions costs.

Focusing on calcimimetics. We generated operating income from calcimimetics of approximately $74 million this quarter, as ASP remained relatively flat over Q2, while acquisition prices fell significantly. Revenue per treatment and cost per treatment for calcimimetics were $14.54 and $4.87 respectively. For full year 2019, we now expect to generate approximately $220 million in profit from calcimimetics.

Now turning to international. For the quarter, adjusted operating income was approximately $1 million including an FX gain of $3 million and excluding an $84 million goodwill impairment to our German operations. For the full year, we continue to expect to generate positive adjusted operating income, excluding goodwill impairments and

currency adjustments. Our effective tax rate on adjusted income attributable to DaVita from continuing operations for the quarter was 27.6%. We continue to expect our adjusted tax rate attributable to DaVita for the full year to be between 28.5% and 29.5%.

Now on to cash flow. In the third quarter, operating cash flow from continuing operations was $648 million and our newly defined free cash flow was $437 million. DSOs for the U.S. dialysis and lab business declined sequentially by three days to 60 days in Q3 2019 in line with the improvement we forecasted early in 2019 and back to the level it was at this time last year.

CapEx for the quarter was $173 million. We are revising full year CapEx guidance down by $60 million to $740 million to $780 million. Two primary factors are driving the change. First, we managed down our spend on de novo clinics; and second, we delayed spend on some self-development projects that will shift into 2020. We expect to see continued progress on reducing CapEx in 2020. Since Capital Markets Day, we purchased an additional 8.9 million shares at an average price of $58.90 per share. As a result of these purchases, we've reduced our share count by approximately 36.9 million shares or 22% since the close of the DMG transaction.

I'll conclude with some comments on our guidance range. As Javier referenced, we're increasing our adjusted operating income guidance for the year to $1.74 billion to $1.77 billion which includes our expectation of approximately $220 million of operating income from calcimimetics. We're also increasing our operating cash flow guidance from continuing operations for 2019 to $1.525 billion to $1.675 billion. For 2020 we're planning to give full guidance next quarter.

In the interim we are updating the 2020 adjusted EPS guidance we gave at our Capital Markets Day in September. As a reminder, our guidance at Capital Markets Day was $5 to $5.50 per share and excluded any costs associated with ballot initiatives in 2020. At that time, we did not know if there would be any ballot initiatives introduced. Now that we know there is one being proposed, we've decided to incorporate the current estimated cost of opposing the initiative in our adjusted EPS range. Even after adding in this additional cost, we're increasing the range by $0.25 to $5.25 to $5.75 per share. As a reminder, this range incorporates the estimated impact of AB 290.

Operator, let's now open the line for questions.

**Question-and-Answer Session**

**Operator**

Thank you. [Operator Instructions] And our first question will come from Stephen Tanal with Goldman Sachs. Your line is now open.

**Stephen Tanal**

Good afternoon guys. Thanks for the question. I guess just the first thing to follow-up on, I guess the new guidance for calcimimetics profit for the year implies about I guess $68 million or so in Q4 if we've been tracking this right. And I think the reimbursement for the oral drug is flat sequentially from CMS. So I just want to understand why this contribution would step down sequentially. Is cost going up? Or am I missing something else in that?

**Joel Ackerman**

It's -- there's -- I'd say there's a bit of noise in the system. The reduction -- I wouldn't read anything material into the reduction.

**Stephen Tanal**

Got it, okay. And I guess like kind of thinking through that a little bit further, so the final rule came out on TDAPA and it looks like calcimimetics will go to ASP plus zero for next year. It would seem like you guys are potentially buying better than the market. So I guess like shouldn't this leave room for a profit just given your scale? Or how should we think about that?

**Joel Ackerman**

Yeah, so I would say there certainly might be a little bit of profit. There could be a little bit of loss. There's some noise in the system associated with bad debt that we may not get reimbursed for and some other costs. So I don't think you'll see a big number in either side of zero, but I think zero is a reasonable starting point.

**Stephen Tanal**

Got it, okay. And then last for me I guess on the patient care cost side per treatment was down pretty significantly year-on-year. Wondered if you could flush out some of the bigger drivers there, maybe touch on Epogen costs in that and whether that's still favorable sequentially versus 2Q? Thank you.

**Joel Ackerman**

Yeah. So year-over-year pharma costs did come down and that is an important driver. Sequentially it's not -- there's very little difference between Q2 and Q3 as it relates to Epo.

**Jim Gustafson**

Debbie, do you have another question?

**Operator**

Yes. The next question is from Kevin Fischbeck with Bank of America. Your line is now open.

**Jim Gustafson**

Hey, Kevin.

**Kevin Fischbeck**

Great. Thanks. Hey. So, just wanted to clarify the 2020 guidance change, it wasn't clear to me exactly why you were raising the EPS number. You're including AB, but your is the rest -- what is the rest? Is it that there will be some calcimimetics benefit next -- into the beginning of next year or share repurchase? What was the...

**Joel Ackerman**

Yeah. So Kevin, I think the best way to think about the change in 2020 is a better share count number to some extent offset by the ballot initiative costs. As you would imagine there are a bunch of moving pieces in there, and we're not ready to give 2020 guidance yet. Our budget isn't finished. So there are other moving pieces. But if you want to think about the dominant dynamics, it's share count driving it up offset by ballot initiatives driving it down.

**Kevin Fischbeck**

Okay. And just to think about how we should be modeling calcimimetics into next year, does that kind of break even? Is that for the full year? Or did it kind of trend down towards breakeven as the year goes on there maybe a benefit at the beginning of the year moving down to zero?

**Joel Ackerman**

It could trend down a bit. It's hard to know. Because of the trajectory of ASP, it's hard to figure out some of the cost issues. But I'd say it's fair to say zero for the full year trending down from a little bit positive at the beginning, potentially a little bit negative towards the end.

**Kevin Fischbeck**

Okay. And then, as far as the volume numbers that you talked about. I think you said that you're -- it's early. You're starting to see some leading indicators of NAG going positive. What are you -- exactly are you looking for when you talk about leading indicators? And what are you seeing that's giving you some optimism?

**Javier Rodriguez**

There's a couple of things that we look at Kevin. But in essence, what we're doing is we're monitoring that the right shifts and the right capacity is going online in our centers and that our admissions execution are -- we're monitoring the demand into our centralized missions and that's looking to stabilize right there.

**Kevin Fischbeck**

Okay. And then maybe last question ifs versus as. It seemed like the big delta in the quarter was calcimimetics and excluding that the quarter was pretty much in line. Is that how you were thinking about it internally? Or how did this quarter come in versus your internal expectations?

**Joel Ackerman**

Kevin, I think that's a reasonably fair way to look at it. There is a little bit of cost relating to LTIP that is elevated as a result of calcimimetics. So, you can think about that in different ways. You could attribute it to calcimimetics. You could say it's noise in the comp line as we always have noise in the comp line, but I think yours is a reasonably good starting point.

**Kevin Fischbeck**

That's great. Thanks.

**Operator**

The next question will come from Justin Lake with Wolfe Research. Your line is now open.

**Joel Ackerman**

Hello, Justin.

**Justin Lake**

Thanks. Hi. How are you doing? Good evening. So, just wanted to go through a few things here. First, your share repurchase assumptions, so you ended the quarter I think with a little over $1.2 billion. You bought back $250 million, so call it $1 billion, plus cash flow this quarter. I think you typically like to run around $500 million. So should we think about kind of the dry powder that's left $500 million kind of plus whatever free cash flow you generate going forward? Is that a reasonable way to think about it?

**Joel Ackerman**

So, I start thinking about our share buyback philosophy, thinking about our leverage range and our comments about intrinsic value and all that kind of stuff. If your question is narrow, how much excess cash is on the balance sheet right now net of the buybacks that have happened since September 30, I think your math is pretty spot on.

**Justin Lake**

Okay. That's helpful. And then, the ballot initiative, appreciate you kind of putting that in the 2020 numbers. Is it reasonable to think of that spend that you've built in there, in a similar ballpark to the incremental spend you had in 2018 to fight off that ballot initiative?

**Joel Ackerman**

Yes. So, I'll tell you, it's a tough number to predict from where we are right now. That said, I think, that's a reasonable number to start with. As we've kind of played with it, we would say kind of a max of $0.50 a share -- $0.50 of EPS would be the maximum impact that we're looking at right now. But again, it's still pretty early to try and put a definitive range around that.

**Justin Lake**

Okay. And so then, if we just do some simple math, if the business is doing what you expected it to do and to your point you took up the EPS by $0.25 plus offset, let's call it $0.25 to $0.50 of the ballot initiative costs, you basically assume that the share count -- the share count is ending up, let's call it, 10% to 12% better than what you previously expected, just because you're buying the stock materially cheaper. Is that a reasonable kind of bow to put on this package?

**Joel Ackerman**

Is your question, Justin, what are our assumptions today relative to at capital -- to the assumptions we're using at Capital Markets Day? Or are you asking where do we think we'll be relative to today's share count next year?

**Justin Lake**

No. I guess what I'm asking is more the former, right? At the Capital Markets Day your share assumptions got you to $5 to $5.50. Now effectively, they're getting you, if I exclude the ballot initiative, they're getting you more to like $5.50, $5.75 to $6, $6.25. So it's just, you're taking up the -- I'm just trying to make sure I understand the magnitude of the share repurchase improvement relative to what you thought is that entire movement, which is, again, north of 10% of EPS ex ballot?

**Joel Ackerman**

Justin, let's come back to this question in a couple of minutes. There are some heads nodding yes and some heads nodding no. So we'll do some quick math here and I'll come back to you in a couple of minutes.

**Justin Lake**

All right. I'll get back in the queue then. Thanks guys.

**Operator**

The next question comes from Pito Chickering with Deutsche Bank. Your line is now open.

**Pito Chickering**

Hey, guys. Thanks for taking my questions. If you go over the patient care costs in the quarter, it sounds like calcimimetics moved about $4 sequentially. So excluding that, it's still down $6.20 year-over-year. Epo was part of that. Can you break out how much of that decline came from nursing costs?

**Joel Ackerman**

So you're -- I'm sorry. You're asking year-over-year on --

**Pito Chickering**

On patient care costs, excluding --

**Joel Ackerman**

On cost per treatment, just from nursing? Pito, I don't have that number. I don't think we've ever disclosed anything anywhere near that level of granularity.

**Pito Chickering**

So look is it fair to think that if we look at the year-over-year decline in patient care costs, excluding sequentially what are favorable impact from calcimimetics $6.20, is it fair to think that half of that is labor and half of that is areas like drugs like Epo? Or is there any

sort of detail you can give us sort of why that would keep on declining so well?

**Joel Ackerman**

Yeah. So Pito, I'm thinking about year-over-year. So not in the quarter specifically and I think it year-over-year gives you a cleaner number takes out some of the noise. As we think about patient care costs, our expectations are we'll come inside the guidance range, which is remember up 0.5% to 1%.

And if you think about how do we get there, it's comp pressure. So maybe that's what you're asking about and that comp pressure comes largely in the form of wage rate pressure and that's offset by the Epo decline. I mean, there are a bunch of other things going on in there. But at a very high level, I think that's a reasonable way of thinking about it, but year-over-year the cost per treatment is up not down.

**Pito Chickering**

Okay. Fair enough. The organic treatment growth looks to have stabilized this quarter. Is there a sense you can talk about sort of possible headwinds you face from facilities hitting max capacity in states like California?

**Joel Ackerman**

So, I mean, we've -- I guess, we've talked about this before in terms of the pressure that can come on admissions growth if you're running labor too efficiently. And you can think about it as max capacity. You can think about it as shifts being full and the pressure to not open a new shift, because of the negative impact that can have on labor productivity.

So that's a dynamic that we're keeping a careful eye on. I wouldn't necessarily attribute it to any specific market, but the dynamic you're calling out is certainly one that we're keeping a careful eye on.

**Pito Chickering**

Great. And then last question for me. As there's more and more focus on treating patients at home versus in the center, can you sort of break out what percent of your patients are treated at home and if we're seeing nephrologists begin to sort of change their behavior to

treated at home and if we're seeing nephrologists begin to sort of change their behavior to get more patients now?

**Javier Rodriguez**

Yeah, Pito, this is Javier. The mix is roughly 12% PD and a little below that 2% on HHD. So we're a little below the 14% if you combine the two modalities. The PD is growing at a nice healthy trend and it's similar to what it was before we had the shortage. And so there is clearly an interest in making sure that the patients go to the right modality, but we've seen this in years in the past.

**Pito Chickering**

Great. Thanks so much.

**Javier Rodriguez**

Thank you.

**Operator**

The next question comes from with Whit Mayo with UBS. Your line is now open.

**Whit Mayo**

Hey, thanks.

**Javier Rodriguez**

Hey, Whit.

**Whit Mayo**

Hey, afternoon. So in the final ESRD rule admittedly, I haven't read the whole thing. But was there anything that surprised you with QIP, AKI anything? I know there's this innovative transitional drug add-on change for supplies equipment. Just wasn't sure if that means anything for you?

**Javier Rodriguez**

LeAnne, do you want to comment on that?

**LeAnne Zumwalt**

Sure. First the final rule is very similar almost exactly to the preliminary rule. And so they had teed up that certain medical supplies which will be truly innovative could get some partial incremental reimbursement. So that's positive for sure but it was not a surprise. Does that answer your question?

**Whit Mayo**

I think so. Maybe it would be helpful to explain elaborate a little bit more with maybe an example of how the TDAPA work for this new supply and equipment. I guess I don't fully understand how it works.

**LeAnne Zumwalt**

Well I don't think they gave complete detail. But what I can tell you is that in the final rule they said the equipment or supply must represent an advancement that has substantially improved renal dialysis services. So that's kind of their orientation. There is going to be a process to which these devices will be asked to introduce after 1/1/2020 and it will be the decisions will be made through the FDA marketing authorization. So I'm not sure what exactly you're looking for. I'd be happy to answer specific questions or take it offline with you if you'd like.

**Whit Mayo**

No that's really helpful LeAnne. My other question I just wanted to kind of talk about California for a second. And let's assume that you and the industry the AKF were unsuccessful getting perhaps an injunction filed and we actually see the AKF pull out of the state altogether. What are the other options for patients at this point? I mean presumably you've thought some about this. I'm just sort of curious come January 1 like what ultimately may happen?

**Javier Rodriguez**

Yes it's going to be very interesting to see how it plays out and then of course there are different categories. In some instances the patients will be able to get funding in some other way. And in some instances they're going to lose their coverage. And so we're trying to do math around it and that's why we try to be helpful with the range that we provided and we embedded in our guidance. But the reality is is that we've never been in a situation like this and that's why the range is a bit wide.

**Whit Mayo**

Yes. I mean is there another -- when I'm thinking about other ways to obtain premium support the only thing that comes to mind is tax credits premium support and the exchange marketplaces. Is there any other obvious substitution for premium support?

**Javier Rodriguez**

Not that we are aware of. Of course we are pursuing all options. Some might qualify for Medicare and other things. So that's why the math is a little tricky and again the range is a bit wide.

**Whit Mayo**

Okay. No that's helpful. And maybe two real quick ones. Joel I don't know if you commented on commercial mix. If not can you? And then can we get the actual ending share count on September 30? I don't know if you gave that either.

**Joel DaVita**

Yes. Well we didn't comment on commercial mix. There's not a lot to talk about. Q3 tends to be seasonally a little bit weaker because of Medicare open enrollment but nothing significant.

**Whit Mayo**

Ending share count?

**Joel DaVita**

So the ending share count at the end of Q3 was just under 134 million, 133.9 million. Remember that excludes the shares we bought back since the quarter ended.

**Whit Mayo**

Great. Helpful. Thanks guys.

**Joel DaVita**

I'm sorry. Before the next question, Justin I want to get back to you. It's always hard to compare ranges. But roughly speaking, I think you can think of our share count forecast being down about 10% relative to what we talked about at Capital Markets Day.

**Operator**

And our next question will come from Gary Taylor with JPMorgan. Your line is now open.

**Javier Rodriguez**

Hi, Gary.

**Gary Taylor**

Hey, good afternoon. Just a few quick ones. For the 2020 ballot initiative, did I miss that? Did you size what you thought that would be?

**Joel Ackerman**

Yes Gary, we -- I'd say two ways to think about it. One is using what we spent in 2018 as a potential proxy. The second is we were thinking if you want to think about it on an earnings per share basis, we would say $0.50 impact on 2020 would be at a kind of a max.

**Gary Taylor**

Got you. And will you call that out for us in the quarterlies like you did in 2018 what that spend is in the quarter?

**Joel Ackerman**

I expect we will. I think we'll -- we're trying to develop a pattern of calling out things that are unusual like calcimimetics and the ballot initiatives. So the answer is, yes. I do want to remind everyone on the call that the spend on the ballot initiatives is not tax deductible. So as you're modeling the impact on EPS keep that in mind.

**Gary Taylor**

Just another one. When I look at full year from where we started the year in January, your OI guidance is up $130 million to $200 million. Am I right that calcimimetics started the year at the $80 million OI assumption that's now a $220 million? So the low-end of that is covered by the calcimimetics increase?

**Joel Ackerman**

Yes, so Gary, I don't think we gave a specific calcimimetics number at the beginning of the year. If I were to think about a number for early year calcimimetics, I think your number is a bit high. So if you're trying to say of the OI increase from the beginning of the year, how much of that is the result of calcimimetics. And therefore, what's been the -- what's our thinking about core OI now relative to the beginning of the year, I think it is safe to say that the vast majority of the increase is the result of calcimimetics. Core OI is up a bit, but not a lot.

**Gary Taylor**

Thank you. Last question. I know last quarter we were surprised by the magnitude of labor productivity you had in the quarter. And I know your thoughts at that time were that was going to reverse to some degree. So as I sit here and sort of adjust for the decline in the calcimimetics costs in the quarter et cetera, I mean, it looks like labor productivity wasn't as good as you experienced in the 2Q, but still looks very attractive on a year-over-year basis. Is that the way you're looking at it? Is there anything else -- any other color on those 2Q productivity gains and how they carried into the third quarter?

**Javier Rodriguez**

You're directionally – sorry, Gary, you're directionally correct on the math that you said. A couple things to call out as well is as our volumes decrease, we did a great job of adjusting and I think we explained the interdependencies between sometimes having labor and volume, and the correlation of managing both of those pieces.

So we did go up over 2Q. And we do -- with what we're seeing we expect it to go up even further in Q4, as we're seeing the hiring numbers. And the training costs for the fourth quarter.

**Gary Taylor**

Okay. Thank you.

**Joel Ackerman**

Thank you.

**Operator**

The next question will come from Justin Lake with Wolfe Research. Your line is now open.

**Justin Lake**

Thanks for the questions. I have a couple of follow-ups. You mentioned the impact of the benefit from -- or the impact of LTIP this year, should reverse next year. Is there any kind of number you want to throw out for that that we should kind of keep in mind?

**Joel Ackerman**

Not really. It's relatively small. And I think they're -- it's not something I would call out as a significant headwind or tailwind going from 2019 to 2020.

**Justin Lake**

Okay. And then, obviously, we're now looking out to 2020 and thinking about 2021. First, just for a second, it's just simple to say that 2020 earnings that you've got out there now are depressed by about $0.50 because of the ballot.

Is there -- there's no offsetting good guide there to think about such that 2021 there would be effectively a $0.50 tailwind as the ballot initiative costs go away, just because there's no ballots that year?

And earnings are automatically $0.50 higher before you kind of think about capital deployment and core growth. Is there any kind of offsets you want to throw out there before we kind of think about that?

**Joel Ackerman**

No. I think the $0.50 is a pretty clean headwind into next year and tailwind into 2021.

**Justin Lake**

That's helpful. And then just a couple of follow-ups, I think Pito, asked about home starts. Clearly, I think, yourselves and others are pushing to accelerate home. So, I think, the number you gave there of 12% and 2%, was your current number.

Would it be helpful maybe to share with us the new starts? And how that might have changed over the last couple of years? Or even just the last three to six months as it seems to become a bigger push? Have you seen any kind of meaningful change there?

**Javier Rodriguez**

The reality Justin is, that we had a bit of a disruption with the shortage of supply. So it's hard to connect. But pre-supply shortage, we were running around the same rates, that we are now, which are in the low double digits, so anywhere between 12% -- sorry 10% and 13% on PD.

The HHD has been more in the flattish range. So the people that fall out are roughly replaced with the newcomers.

**Justin Lake**

Okay.

**Javier Rodriguez**

Did that answer your question?

**Justin Lake**

So the new starts really isn't any different is your point.

**Javier Rodriguez**

Well, they're different than they were a couple years ago because we had the shortage. And then of course you have to staff up. And you got to tell people that you're ready in. You got to get the market to be confident that you can supply it et cetera.

And so, we are actually quite energized by how quickly the market reacted. And how much interest there is. And again, I think with what we said in Capital Markets, it's also not looking like there's going to be transformational but rather evolutionary change.

**Justin Lake**

Got it, and then, Javier you guys put in an 8-K yesterday that kind of talked about your new compensation agreement and it looked pretty unique in that it looks like you're pulling forward about five years of stock comp into one. And so I just wanted to know if there's -- I know in the -- there was a strike price number in that I think in the high-67s before you're in the money on those RSUs.

But is there anything else in terms that we should know about in terms of vesting that? Do you have to hit certain hurdle rates? Is that in a proxy I can go dig out, number one? And maybe you could just give us some color on kind of given this is fairly unique from what I've seen in my time, I just love to kind of hear kind of how you thought about this and how the Board thought about it. And I know you ran it by shareholders as well so maybe just spend a minute on that? Thanks.

**Joel Ackerman**

Hey, Justin, it's Joel. I'll take this. On the narrow question of vesting, it vest 50% at the end of year three and 50% at the end of year four. There is no performance vesting. I think, the concept here is creating a premium price is effectively what's used to ensure that Javier gets significant value when the shareholders get significant value. And that's really what

gets significant value when the shareholders get significant value. And that's really what the Board was trying to create here was an alignment of incentives between the new CEO and the long-term shareholders of the company. And I think there was a lot of support as we went out to talk to shareholders.

And I would add this will be put to a vote by the shareholders so all the shareholders would get the opportunity to approve this. So really the guiding principle here was aligning incentives for the new CEO, for the long-term shareholders. And I would -- one other point, I'd highlight is that there is a five-year holding period here. So this isn't about driving the stock price up towards a single or two separate vesting events. Javier has to hold the stock that he gets here for five years.

**Justin Lake**

Thanks for all the color there. Appreciate it.

**Operator**

The next question comes from Pito Chickering with Deutsche Bank. Your line is now open.

**Pito Chickering**

Hey, thanks. At this point, all the questions had been answered. So thanks so much.

**Joel Ackerman**

All right. Thanks to you.

**Operator**

The next question will come from John Ransom with Raymond James. Your line is now open.

**Joel Ackerman**

Hi, John.

**John Ransom**

Hey, guys. Hey, let's pick a point in time a couple years ago where all the payers were mad at you about the exchanges and you had some tough negotiations and let's say, that was the non year. Where are you -- I mean this is a qualitative question, but where are you kind of long-term with some of your key payers? And I know it's always going to be somewhat adversarial just because of the structure of the industry, but what steps are you taking to maybe dial down some of that contention? Thanks.

**Javier Rodriguez**

Yes, thanks, John. In general I think you've stated we had some issues on understanding what happened with the exchanges in relation to our industry and the economics of the dialysis industry. I've gone on, on a CEO roadshow with several of the largest payers and continue to reach out to many to make sure that; A, they understand the dynamics and the framework that we have and how unique it is. Two, I want to make sure that they're clear that we are very, very into long-term, sort of, value arrangement and that we are open to being creative in a new structure that we are not married to some kind of fee-for-service old structure. That we are confident that we are the best to be the primary care for our patients because of the amount of time they spend with us and all the comorbidities conditions that we can impact and that we can structure something that is both good for the patient, good for the payers, and good for us.

And so that's why we're excited to build the capabilities of integrated care. That message is resonating. But as you know it takes two to dance and it's a complicated systems, arrangements, and math to make sure that you get holistic cost across a commercial population, et cetera to establish benchmarks and trends, so they can do good risk arrangement.

So, we're up and running. I think the conversations will take years. So, you're not going to wake up one day and say, wow, there was a tectonic shift. I might be wrong in that, but it looks like it will be a slower transition, but the payers are reacting quite well to it.

**John Ransom**

Okay. And yes, it's your fate in life to be between difficult people. So, speaking of difficult people physicians one of the things we hear is this move to home and you guys have said it too is a bit of it is culture and a physician training issue. And you have some markets where you have very little. You have some markets where it's 25%.

So, again, qualitative question where are you in your charm initiative with the doctors to get some of them maybe to think a little more about PD as a first alternative versus maybe what some of them might be defaulting to the clinic?

**Javier Rodriguez**

Yes, our physicians are actually quite reasonable in that what they want to do is make sure they do what's right for the patient. And they really worry about what's right for the patient and what's right for the system, and they're very independent in their nature and in their thinking.

And so what we have to do is make sure that we put the right science and the right specific and the right analytics, so they could train and encourage the right patients to go home. And once we do that the doctors are quite onboard to do whatever is right for the patient and the system. So, we're working on that. And of course we have thousands of them so it takes some time. And as you said some are more bullish and some would want to wait to see how it plays out.

**John Ransom**

Okay, that's it for me. Thank you.

**Javier Rodriguez**

Thank you, John.

**Operator**

The next question comes from Matt Larew with William Blair. Your line is now open.

**Javier Rodriguez**

Hi Matt.

**Matt Larew**

Hi, good afternoon. Thanks for taking my question. Javier I wanted to follow-up on your comments around some of the CMMI models. You mentioned that they would require significant investment upfront and that maybe not quite like move the needle for you in the near-term. Are there things in particular that you're providing feedback to for CMS things you'd like to see change that would make them more compelling both for you and the -- your nephrologist partners?

**Javier Rodriguez**

We are and the industry is actually very well-aligned including MedPAC. So, there's a lot of comments out there that try to make sure that people understand how these work. If I were to use -- something to be useful for you Matt is they're a little like -- the frameworks are a little like the ESCOs and then more complicated.

And so we now have experience on how surprising it is and let's call it difficult to understand how and what you're going to get paid because of benchmark changes and there's little visibility to it. So, imagine adding all that risk but now you have a physician practice instead of a well-capitalized corporation.

And so physician practice would have to be out-of-pocket and not know exactly what its cash flows would be. And so that's really an uncomfortable position for a small business. And so we have a lot of more detail, but in general, I think that's a good healthy way to think about it.

**Matt Larew**

Okay. Thanks.

**Javier Rodriguez**

Thank you.

**Operator**

We show no further questions in queue at this time.

We show no further questions in queue at this time.

**Javier Rodriguez**

Well, I want to close out by thanking all of you. We will continue to work hard for you and for our patients. Talk to you next quarter.

**Operator**

And that concludes today's conference. Thank you for your participation. You may now disconnect.