2021 DaVita Inc. Capital Markets Day

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Jim Gustafson, DaVita Inc. – VP, Investor Relations
Hello. I'm Jim Gustafson, DaVita's Vice President of Investor Relations, and I'd like to welcome everyone to DaVita's 2021 Virtual Capital Markets Day.

We appreciate your interest in the company. This presentation is available on our website at investors.davita.com and will also be available for replay on the same website.

Today, you will hear from our Chief Executive Officer, Javier Rodriguez; and our Chief Financial Officer, Joel Ackerman. We're excited to have the opportunity to update you on the current status of our business and the progress we have made in executing against the strategy that we laid out in our 2019 Capital Markets Day. We'll also go into greater detail on a few topics of investor interest, including the growth of our Integrated Kidney Care platform. We will share a multiyear financial outlook and we'll leave plenty of time at the end to take your questions.

Please note that during today's presentation and Q&A, we expect to discuss some non-GAAP financial measures. A reconciliation of these non-GAAP measures to the most comparable GAAP financial measures is included in the appendix of the presentation and available on our website.

Additionally, I'd like to point out that during the presentation and Q&A, we expect to make forward-looking statements within the meanings of the federal securities laws, including statements regarding our financial guidance. All of these statements are subject to known and unknown risks and uncertainties that could cause the actual results and other events 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 most recent annual report on Form 10-K and all subsequent quarterly report on Form 10-Q, as well as any subsequent filings that we make with the SEC. Our forward-looking statements are based upon information currently available to us and we do not intend and undertake no duty to update these statements except as they may otherwise be required by law.

And now, I'd like to turn it over to our Chief Executive Officer, Javier Rodriguez.

Javier Rodriguez, DaVita, Inc. – CEO & Executive Director
Thank you, Jim, and good morning, everyone. It is a privilege to join you virtually today and share our story, our long-term vision, where we are today and to bridge into the future.

There are many different people out there in the audience, some new to the story, and some have been around for a while, so we thought it would be useful to divide the presentation into three segments. First, who we are, and then transition to where we're going, and what does that mean for our financial outlook?

First, who we are is, we are 67,000 people strong that wake up every single morning to take care of our fellow human beings. The pandemic has highlighted just the amazing attributes; the empathy, the love, the dedication that we have for our patients has just absolutely shined and has been a beacon of light and an inspiration to what's been going on in our world, so I want to start off with a huge appreciation to all our physicians, dieticians, social workers, nurses, all of our caregivers that have been relentlessly committed to taking care of our patients.

And you might ask: Well, how are the outcomes? With the pandemic, of course, the outcomes have shifted. And so we thought it would be more useful to give you in steady state, prepandemic, and there

are two outcomes that matter most to me as a CEO. Number one is, what is the quality of life that we're offering our patients? And a good proxy for that can be hospitalizations, and what I can tell you is, I am so proud that we've lowered our hospitalizations. While it might seem like a number, 7%, it's much better when you translate it into 100,000 days that have been out of the hospital because of the improvement in hospitalization. And then, of course, we talk about mortality, which is pre-COVID, we kept improving year after year, decade after decade, on how much longer our patients could live because of the quality of care and the commitment of our caregivers.

And you might say, well, Javier, did you pick, conveniently, two outcomes that serve you well? The short answer is, absolutely not. We are measured by a five-star system that has publicly reported data; in 2020 it was delayed because of COVID, but we deliver, year after year, leading outcomes and five stars, and now we are proud to say that we're taking our leading quality around the globe. And now you see that we're in 10 countries that are serving, now, 38,000 patients, but more importantly, we continue to improve their quality of life and the care that they are receiving, which is, of course, an enormous source of pride for us here at DaVita.

If we continue to say, who are we, we begin by saying, quality of care, love and empathy for our patients, and then if you continue to lens up, you'd say, we have a focus on ESG from the get-go. Many companies are talking about ESG in a new framework. For us, it is absolutely not new. We've been talking about ESG in one form or another for about two decades. The way we talk about it is actually the trilogy of care: taking care of our patient, taking care of one another, and then taking care of our society and our globe.

I actually have so many things that we're working on and inspirational things that we have, that we put out a brochure, so please read that. A couple of things that really energize me is, we've made a commitment to equal pay for an equal job, and we're measuring it, and we're relentless on it. Number two: We talk about clean energy, and I'm happy to say that our entire U.S. footprint will be clean energy, renewable energy, by 2022 because we did some purchase power agreements, and that is all set. That was a big, big accomplishment for us. And then lastly, we just entered an agreement with the National Kidney Foundation to work on disparities in transplants, and so we are excited to make sure that everybody has an equal shot at getting a transplant.

What does all that translate into there? Many people view us as clinics and buildings and labs and whatnot; I hope that I cleared it with you that while all of those things are great, and that we have a great platform, a decentralized business that is at the community where the patients are, the heart of our village, the heart of our caregiving, is a human one, and that's what the most important part of DaVita care is all about.

Lastly, when you answer, who are we, we are a company that takes our commitments incredibly seriously. We want to be accountable to all our constituents, including our investor community, of course. We put a slide two years ago and made these commitments to you; we've met them all. Of course, the landscape changed and patient demand changed due to the pandemic, and it is not lost on me that in the presentation going forward here, Joel and I will talk about patient volume; we, of course, know that behind those numbers and behind those words, there's been a lot of tragedy, a lot of emotion and a lot of sadness. But of course, in the presentation, we won't be repetitive with that sentiment, so please bear with us as we continue to use that kind of a dialogue.

So that's a little about who we are, but now let's talk about our future. Where are we going? And I know, since you got the presentation early, many of you went to the back to try to get the numbers. But I -- in all honesty, I do think that it is important to start off with the answer. Does our strategy give an exciting economic return? The short answer is: Yes, it gives you a very sustainable outlook for the future. And so now, let's jump in and see how we're going to accomplish these results.

Instead of talking about strategy with sort of a business term, I find it much better and more relatable to talk about it through an individual. Meet José. I had the privilege of meeting José over a year ago and hearing his amazing story. This was a 15-year-old boy that is out racing and is doing quite well in the races, but at the end, he gets [gassed] and isn't winning the races and isn't, at times, finishing. He goes to the doctor; the doctor says, you should check your kidneys. He does not listen to the advice. He's 15 years old, and he thinks it's going to be fine. Then, at 20 years old, he gets incredibly sick. They say, you have end-stage renal disease. Your kidneys have failed. He literally cannot hear a thing thereafter. It is so traumatic. When they start talking about modality choices and how he could take his renal replacement therapy, literally can't hear.

So then he goes to one of our centers and he meets [Cheryl], and there his life changed. They had a bond. Cheryl could see the energy that he had, the lack of understanding and the fear of blood and the fear of needles. So then she right away got him into education again on PD. He did the therapy at home and started to thrive, and then he actually started to live, and he asked his mother for a transplant; was given a transplant, and unfortunately, it failed. Then he got sick with COVID. During the entire time, Nurse Cheryl would take the medicine to the hospital to make sure that all his renal needs were being taken care of.

So I tell you that story because it is a common story, meaning a patient goes through a long journey, but it is totally fragmented. It has all these ins and out of the system, hospitalizations and other things that happen. We need to do better by our patients. In this particular instance, Cheryl literally saved his life. That's what José wrote to her, and now, by the way, happy ending. José has a new transplant and is studying to be a nurse because Cheryl inspired him.

So what does that mean for us? What it means is that we were focused on treatment for a very long time, and now we're going to shift that whole energy. We're going to expand our energy because we can do more for our patients. We can do more for José in prevention, making sure that he understands all those signals, and if there is a transition to care, that he's well prepared, both psychologically and educationally, and so that that person can get the right treatment and, if possible, the gift of a transplant. So that's what this is all about. That's what we're going to be discussing about our future model of care.

If you remember from last capital markets, we talked about this in the platform. That has not changed. We are still talking about a kidney care platform. Now, I'm going to update you, because we've made some exciting improvements.

Let's start off with clinical, because that's what it's all about. It is all about clinical. Many people talk about AI and algorithms and just sort of drop this thing all over the place as breadcrumbs to a successful business. I've got to be honest with you; that really annoys me. We have literally millions of data points coming in so that we have these successful algorithms that you see here, and it is impacting the way that we treat our patients. It is absolutely improving. There are two that I want to spend a little time on because they matter so much.

So there are 30 million people, 30 million people in the United States, that suffer from one form of kidney disease, but only 100,000 or so will have their kidneys fail. And so the question here is, what do you do and how do you manage the population so you can identify the people that are actually going to get sicker? And that is one of our algorithms that is having very, very good success, and it is critical, because it will let us know who to intervene on and what to do for them.

The second one is hospitalization risk. For those of you that are not familiar, our patients go to the hospital roughly eight to 10 days a year, which is dramatically lower than what it used to be, but the main reason why they're hospitalized is fluid overload. And so we could actually start to track a lot of things and make sure that we avoid the hospitalization, improving the quality of life, and of course, not burdening the system. So really, really, this shifts from IT and talk about algorithms to life-changing care.

If you move on the continuum and you say, right site of care -- we get a lot of questions about this. Are you enamored with having a patient in your center? Why aren't there more at home? What is that going to look like? It is an important topic, and I want to make sure that we talk about it and really understand it.

If you or I were a dialysis patient, we would not be asking, what site of care do you have; we would want the entire suite. Because the reality is that you're likely to switch in and out of the different modalities. And so take, for example, 50% of our patients that are home started in-center. Why is that, you might add? Remember José; when you're told that your kidneys have failed, all of a sudden your ears just go numb. It's very hard to comprehend when you're about to go to, and so what you opt to is to have someone take care of you, in-center, with our nurse professionals, our caregivers, and to surround yourself until you can actually listen, comprehend and take care of -- more control of your care.

And so then, the question becomes, if you go home, why would you go back in-center? We'll talk about that shortly. But the -- you might notice there's a new slide here: the skilled nursing centers in the bottom. And what that is, is 10% of our patients or so are in a skilled nursing center, and they used to go to our centers and be transported. And what we're doing is to just make sure that we avoid another movement back and forth and we're actually going to their site. So this is just pure convenience. And again, the most important thing to remember here, it's very fluid from one site of care to the other.

You can see in this slide that basically mix continues to shift toward home, but most people continue to ask, well, why isn't it moving faster? And the reality is that there's a lot of dynamics. We talked about this two years ago. And so let me try to explain it. So you start off with a patient population, but then there's about half of them drop off in any given year. And it's a variety of reasons why people would drop off: number one, they could get a transplant, but number two, maybe the therapy isn't cleaning their blood at the sufficient rate, so they have to go back to in-center, and then of course, there's some mortality. So really what you have to understand is that any given year, you have to grow the half that dropped off the therapy and then continue from there. And so you see that the 13% to 15% is actually materially more new patients, but you have to account for the people that drop out.

The question continues to be, how big can the therapy be? And we, of course, want it to be to as many people as possible. We want our patients to have the therapy of their choice for their lifestyle, and so we continue to invest heavily, heavily, heavily on it. What we've seen from integrated care systems that are really focused on it in other countries is that that number could get into the mid-25% or so, but we're not putting a ceiling on it. We want to continue to get as many patients at home as possible.

And so our investments are around three things: Number one is, we've got to get our patients to have a therapy that's convenient. If it's not convenient, if it's too clunky or if they've got to do a lot of things, they're just not going to opt for the therapy, so we've got to make it, number one, convenient. But number two is that we notice that people need confidence, because if you're insecure or if you're scared, you're likely to drop from the therapy. And so what we have found is, in order for patients to be confident, they need to be connected. They need to know that they've got the eyes and ears, that our care team are watching over them even though they're at home.

So we're doing all sorts of investments in virtual care. We're doing investments in telehealth. We're really watching remote monitoring, and other things that people continue to talk about it, but when put in as a suite, our patients are giving us the big thumbs up, that they feel a lot more comfortable going home and staying home, which of course brings a big smile to my face. But I think it's so much better to hear it from a patient than to hear it from me.

[Presentation]

Voiceover
DaVita teammates are committed to working with and educating each patient to support the treatment option that's best for them. [Terry] is an example of a DaVita patient who, after working with their nephrologist, was identified as a candidate for home dialysis.

Terry, DaVita Patient
The nurse really walked me through not only what to do but why we were doing it, and all of the pieces that I needed to do to do it myself. It took a little bit of time to get used to the catheter, and now, two years into it, I realize I could do this the rest of my life.

Voiceover
[Sherry] is another patient who transitioned to peritoneal dialysis, or PD, at home with the help of DaVita teammates and her nephrologist.

Sherry, DaVita Patient
I was already in-center in dialysis, and they started talking about PD, and the nurses there showed me everything that I needed to do.

Voiceover
PD is a needle-free treatment that can be performed at home. Dialysate solution goes into the patient's abdomen through a catheter, pulling out waste and cleaning the blood. With the right support, PD can be a great treatment option.

Terry, DaVita Patient
I'm doing everything that I could imagine that I would want to do, and that, to me, is just an absolute miracle to be able to do this after your kidneys have failed.

Sherry, DaVita Patient
Doing PD at home, it opened up a whole new world for me. A whole new world. I could go to the school to see my grandson.

Voiceover
For many patients, home dialysis offers more flexibility in their schedules and more time to do the things they enjoy.

Jeffrey Giullian, DaVita Inc. – CMO
As a physician, I recognize the many benefits of home dialysis, and in my own practice, we had a robust home dialysis program, and now, as DaVita's Chief Medical Officer, I continue to advocate for home dialysis as a choice for all of our patients. However, not every patient will choose to dialyze at home, or even tolerate the therapy, and that's why I'm really passionate about ensuring that DaVita provides an entire platform for our patients. So whether home dialysis is optimal right now or in the future, we provide the highest quality of care to help our patients thrive.

[Presentation ends]

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
The last frontier in what every patient would want is a transplant. There are two challenges. One is the main driver of it, and that is supply of organs. Last year we had about 23,000 transplants, so of course, not enough to the demand of the transplants, so what we're doing is investing to try and make sure that we have access to other organs, nonhuman organs, that can serve in the human body. That's a long journey, but you've got to start somewhere, and we want to be part of the solution.

The second investment that we've made is around a therapy that actually lets you know how the organ is performing, and that normally has to be done right now through a biopsy, which is quite painful for the patient and, of course, expensive. What we'd like to do is to have a test -- it's a urine test that would tell you in advance so you could do an intervention in a much easier way for the system. So again, we continue to work on having a better system for our patients, to have more transplanted and for those transplants to function better, because 10% of the transplants fail within three years.

Now, shifting on to integrated care. Hopefully you get it by now. You heard José's story: total fragmented. Now it's about putting it all together. And so what are we doing? Let me start off by giving you some statistics, because I find it helpful. Remember: 30 million plus have some form of kidney disease, of which 91% or so will not move on, will not progress. And so the critical part is to find that late-stage CKD and ESRD so we can actually intervene. And you see, by the right side of this chart, that the dollars match, of course, the progression, because they need more care and they have a lot more opportunity in those transitions of care for us to add value and to improve their quality of life through our interventions.

We talk about two models. One is with the private payors, which of course is a negotiated outcome, and they're very customized to the payor negotiation. And then there's a new model of care through CMMI, which is called the CKCC government model, which we're very excited about, but they're new in 2022, and so we'll continue to grow with the government, innovate and see how those work out.

But if you say, why are you so optimistic? Why are you so excited about integrated care? It's, number one, for the patient. We've highlighted through José; there are literally hundreds of thousands of Josés out there. And the other thing is that we are so well equipped. We think that we are uniquely equipped, because if you were to ask me, what do you need to succeed in integrated care, I'd say the first thing is you need access. What I mean by that is, you need time with the patient. There are so many disease management companies and other interventions that have never worked because they can't even get ahold of the patient. They can't engage the patient. We, of course, spend 500 hours a year with those patients in-center, and we now have connectivity daily to our home patients.

The second thing you would ask me is, what do you need, is data. And boy, do we have data. Not only do we have 200,000-plus patients in the United States, plus our international patients, but we literally have over 2 million records over a very long period of time that can make those analytics that we talked about earlier really, really matter and have a significant impact on the quality of care and the quality of life of our patients.

The third thing would be technology. There's too many sites of care. There's too much information flow in our operability. We're going to talk about that in a second, but probably the most important part in the connection there is the access to nephrologists. We have over 4,500 nephrologists that are using our IT, so it's not something that you've got to introduce into their workflows and see if they're going to do it or not; they're already doing it.

And then the last thing you need is relationships and connectivity to other sites of care, which we have, with over 1,000 hospitals that we know their admits, we know when they're discharged, and that is so critical to make sure that we connect and no one gets dropped into the system. So again, access, data, technology and relationships are critical, and we are well positioned across the board.

And we also have some history, right? We had the ESCO program. For those of you not familiar, this was the first-generation program of integrated care with the government. And what you can see is that we were very successful. We were actually the most successful, and we have some learnings, even though these were subscale, and now we've got to take it to scale, which really excites us.

The way to think about it right now is through the stages, which is: The first one was, learn the model. Get confident. Can you have the impact that you think you can? And the short answer is yes. The next stage is: Do the payors and the government have the right vehicles? And right now they're saying yes, so we're going to go through some very rapid growth. And then of course, the tipping point comes post-2023, and Joel is going to cover some of the timing and how the economic model composes and connects to what I just talked about.

So many of you have asked: So what does the economic model look like? I think it'd be easier to look at one patient. So you start off with the entire cost of care, and then you make major interventions that help in the quality of life of that patient. And then you have to split it up amongst the constituents that participate that create that value, the nephrologists and your payor partners, and then you put your model of care costs. And so you get to a contribution that is actually meaningful, but the reality of life is that you need scale, because that model of care cost has a lot of infrastructure that is fixed expense, and so you need scale, and so many of you are asking, why does it take time to get the economic model to manifest itself in our financials? And that is the reason why.

So the question is, over the longer period of time, what could this look like? And the short answer is, it could be meaningful. It could be very exciting. So again, good for the patient, good for the system, and it could actually contribute very meaningful economics for us. So that's why the prize is absolutely worth pursuing.

People continue to ask, though, what are the swing factors? And the reality is, I'm not going to go through them. It's a new business model. It's getting scaled. So it's all the normal swing factors that one would anticipate in a new program with the government and with new contracts with a payor. A lot to play for, a lot of execution, and we're confident in our performance and what we can bring of value to the system.

Lastly, technology. Well, we all know, because we can read it everywhere, technology in healthcare -- why is it so behind everywhere else? Why isn't it consumer friendly? Why isn't it intuitive? Why is it not connected? Well, we're here to solve for that. We've been working incredibly hard. We've been benchmarking all over for years, and what we've found is that there isn't a system that could do all of the things that we want to do for us. And so we built our own system. And I want to give you a sense for it. So I could show you a little video, and then I'll come back and discuss it.

[Presentation]

Voiceover
DaVita has created new technology that connects all aspects of kidney care for patients like José. Unlike traditional systems, our custom platform addresses the unique needs of kidney care and delivers the right information at the right time to streamline teammate workflows and coordinate clinical interactions from day one of CKD to transplant.

Built in the cloud, our system leverages AI and predictive analytics to generate clinical insights based on data from more than 30 million treatments a year. Using this information, we can drive collaboration between physicians, hospitals, patients and care teams, and execute personalized care plans that improve outcomes and lower the cost of care. And because it was created specifically for kidney care, we've developed tailored workflows that are intuitive for our teammates and allow us to monitor the evolution of each patient's condition in real time.

[Presentation ends]

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
I hope you enjoyed that, and I hope you feel my excitement about the system. And I started out with a lot of skepticism. I'm like, can't we buy something off the shelf? Do we really want to build this huge piece of software? And the answer is, absolutely, and now I totally get it. We are connecting so many different sites of care and we have so many different constituents from a social worker to a dietician to a doctor, and the problem with today's systems is that the health records are so dense that you have to scroll and scroll and scroll and click and click and click, and we're avoiding that. It will be role-specific, and they will get the right information at the right time so that they can make the right intervention. And if you're going to look at that, that has clinical implications. If you're going to look at it with an economic lens, 0.01 of an hour across our system is worth $13 million. So you better know that we want our patients to get the right care and at the efficient and effective way.

So there you have it, the kidney care platform strategy. We started talking about it two years ago, and boy, have we made a lot of progress. I am so energized at creating more value for our patients, more value for the system and a better quality of life.

And now I'm going to hand it over to Joel so he can talk about the financial outlook.

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Thanks, Javier, and hello, everyone. Good morning and thank you for joining us. Now that Javier has explained the different components of our strategy, I'd like to spend the next few minutes showing how we translate this into our financial outlook. Before I dive into the numbers, let me highlight the four dynamics that drive our OI and EPS growth for the next four years.

First is core OI growth. We have a strong platform, a resilient business model and a great team that we expect will continue to deliver core growth. Second is COVID. It is a complicated dynamic. It impacts volume, it impacts RPT, it impacts cost per treatment. I expect near-term headwinds but overall, a net contribution to growth as the impact of COVID on mortality eventually disappears. Third is IKC. Javier talked a lot about this; I'll give some more details later. And finally is capital. Same story as the last few years: strong cash flow generation and disciplined capital deployment. While we expect to see some headwinds in 2022, I've got confidence that we can overcome these quickly and deliver on our financial strategy of capital-efficient growth.

Now let me dive into the numbers. Let's start with volume. So before COVID, we were growing our U.S. dialysis patient count about 2% a year. Then, higher mortality from COVID caused some impact in 2020, but it was relatively small. The real impact came in 2021. The winter surge hit early in the year and then the Delta surge came in the late summer. The cumulative impact was a swing on treatment growth from about positive 2% to about negative 2%.

For 2022, we expect to see continued volume pressure from COVID for two reasons. First, the impact of higher mortality is cumulative, and so there's an annualizing effect in 2022, and second, we're building in

a surge in January of 2022 that we think will impact full year NAG in 2022. Once the mortality of COVID goes away -- and we are hoping that that will be in 2022 -- we expect mortality be lower than normal for a sustained period of time. It's hard to predict when this will start and it's hard to know how long it will last. That said, I think it's reasonable to expect at least 6% higher growth spread over the next few years. So after the headwind in 2022, we would expect to get some, but not all of this benefit, by 2025.

Next is revenue per treatment. Historically, our PT growth was driven by a complex set of dynamics. Some recurred most years; think Medicare rate updates or gradual increases in MA mix as examples.

And some were nonrecurring or sporadic; think here about calcimimetics or Medicare rebasing. For the next few years, we think the list of nonrecurring drivers is going to be longer than usual, mostly because of COVID. Depending on different scenarios, some of these could even result in RPT changes outside of our outlook range. If these bigger swings do happen, there's a good chance they'll have little or no impact on profitability.

Let me give you a couple of examples. As the impact of COVID on mortality goes away, it's likely to drive our commercial mix down, and normally this would have a negative impact on operating income. But in this case, it's the result of more Medicare patients, not fewer commercial patients, so there should be no net impact on OI. Similarly with inflation: It could drive RPT up, but higher costs would offset the positive impact. After taking all these dynamics into account, we think a range of 0.5% to 1.5% CAGR is reasonable, and this is consistent with what we've seen in the past.

Now let's move on to cost per treatment. As I've said many times in the past, cost management is a core competency at DaVita, and it's been instrumental in our financial success. We expect this to continue over the next few years. That said, I would like to highlight a couple of differences that we are anticipating.

First, the implementation and depreciation of our new clinical system will be a near-term headwind. We called this out on our earnings call, and it's likely to be somewhere in the $35-million to $40-million range. Second, as higher mortality from COVID goes away, higher growth will be a tailwind on cost per treatment as we re-leverage our fixed costs in the centers. Net-net, we're expecting a CAGR in the range of 1% to 2%, similar to what we've seen in the past. I would note, though: The midpoint of the cost per treatment range is slightly above the midpoint of the RPT range. This implies a bit of margin pressure that we've built into the middle of the range of our forecast. Despite this, we certainly see opportunities to potentially offset this pressure over the next few years.

So I covered volume, rate and cost for U.S. dialysis. Now let me move to international. Javier talked about the strong clinical progress we've made across our international footprint, and what you can see from the slide here is, the financial progress has been strong as well. How'd we achieve this? Through a combination of organic growth, leveraging fixed costs and acquisitions. I'd also note that as you'd expect, COVID had a financial impact on our international business as well. Without COVID, the 2021 results would have been better. Looking forward, we're expecting continued growth on par with what we've seen in the past over the last few years.

Now I'm going to shift gears to IKC. Javier covered a lot here, so I'm going to fill in some details. Let's start with the expected economics of an individual contract. I'm going to highlight a few things. First, for most contracts, we don't recognize revenue until savings have been confirmed, and that generally starts in Year 2. Second, the revenue grows over time as the savings we generate increase. The result is top line growth for the -- as the contract matures even without any increase in membership. And finally, the variable costs are relatively stable. This is largely our model of care costs, and these do not change much

over the life of the contract. The net result is losses in Year 1 of a contract, roughly breakeven in Year 2, real profit in Year 3, with full profitability in Year 5. On a per-member basis, this Year 5 profit is the $2,000 per member per year to $4,000 per member per year that Javier referenced in his presentation.

Now, the profit I showed on the last slide was before fixed costs. Fixed costs in the IKC business today are about $100 million, and we expect these will continue to grow, although at a much slower rate than membership. As you can see on the chart, IT and analytics make up about half our spend. The next big bucket relates to our efforts to support our nephrologist partners. They're key to delivering the full savings potential. Ensuring we can support their efforts is crucial to our success. So overall, this fixed cost is a big reason for the losses in the business today and why scale-up is so important to reaching profitability.

Now let me pull this all together and show how this plays out over the next couple of years in our IKC segment. Let's start with where we are today in 2021. Existing membership is roughly breakeven. Profit from older cohorts offset by losses from new membership. So the net loss that we expect in 2021 is largely a result of the fixed costs.

Rolling forward into 2022, we expect to see improving profitability from a small number of existing patients offset by Year 1 losses from a much larger cohort of new enrollment in 2022 from both CKCC and MA starts. The result is increasing losses next year, which we've estimated at about $50 million. For 2023, we expect a similar dynamic as in 2022, but the cohort of existing patients driving OI growth is bigger and the new cohort of patients causing Year 1 losses is smaller. The net result is improving OI, but still not enough to cover the fixed cost. Looking past 2023, we expect this trend to continue and potentially accelerate, depending on how quickly we can generate savings and how much profit drag we see from new patient growth.

Now onto OI outlook. Javier covered this, but it's worth revisiting. IKC is a fast-growing business with Year 1 losses, growing profitability for each member over time and a high fixed cost. The result is, we expect it to take a few years to get to breakeven. After we get to breakeven, we expect continued membership growth and program economics to mature. The result would be a new business that could make significant contribution to OI growth for the next decade.

So here you can see how this all comes together in our OI outlook and the expected contribution from our different businesses. A few points to highlight: First, 3% to 7% growth is not evenly spread between now and 2025. We anticipate negative growth in 2022 and significantly higher growth in the three years after that. Second, COVID will be a net tailwind over the period: negative in 2022 and positive in 2023 and beyond. This is built into the U.S. dialysis line on the slide. Depending on the timing of the mortality dynamic, there is some upside to this range. Third, this is capital-efficient growth. We don't rely on growing CapEx or M&A to achieve our outlook. Finally, we see the underlying dynamics driving this growth as sustainable. The benefits from the end of COVID should last beyond 2025 but will eventually go away. Other than that, core growth, as well as international and IKC growth, are sustainable.

I mentioned the growth in 2022 was expected to be negative, so let me give a little bit more color on that. Before I get started, I will note that there is nothing here that I didn't cover on the earnings call. That said, I thought a reminder would be helpful. As you see, we segmented the impact between core and other factors. In 2022, we expect the underlying core business to continue to perform well with OI negatively impacted by labor pressure, COVID mortality and IT depreciation. The bigger pressure in 2022 comes from the other items, including ballot initiatives, sequestration and the IKC loss I talked about. Now, looking forward to 2023, we see three of the headwinds in 2022 turning into tailwinds. The result is very strong OI growth for 2023. Overall, a lot of puts and takes next year, but we are confident that we can overcome them and deliver an average 3% to 7% OI growth through 2025.

For the sake of completeness, here are a few quick notes on other inputs to our outlook. Overall, nothing significantly different here from what you've seen in the recent past.

Now let's shift gears to capital, and I'm going to start with CapEx. Bringing our CapEx number down was an important lever we talked about at our last Capital Markets Day, and we delivered on the goal. The big driver was a reduction in development CapEx as we built fewer de novo clinics. The result of this trend, which we expect to continue, is a higher percent of our CapEx going to things like IT, facility maintenance and new dialysis machines. The overall result looking forward is a stable CapEx number expectation. This could vary year to year, but we don't expect it to go up or down by much for the next few years.

Now on to free cash flow. As you probably know, this has been a positive for us over the last few years. Let me highlight two things. First, free cash flow has grown as net income has grown and as we've brought down CapEx. Second, free cash flow as a percentage of net income has been strong, averaging well above 100% for the last few years. This shows the power of capital-efficient growth and I believe is a sign of quality of earnings. For the next few years, we expect free cash flow to trend above net income on average, although the gap will shrink. 2022 should be another strong year. After that, I think free cash flow of 100% to 110% of net income on average is a reasonable estimate.

Now briefly on M&A: We've been disciplined about deploying cash through M&A with a focus on two things: strategic alignment and return on capital. In terms of where we expect to deploy capital in the future, we see limited opportunities in U.S. dialysis clinic acquisitions. International continues to see good opportunities, and we've been delivering strong returns on capital. We plan to continue deploying capital in our priority international markets.

Finally, we talked in the past about looking outside kidney care for acquisitions. While I'd never say never, we've refocused our efforts and are unlikely to do something without a strong strategic link to either kidney care, dialysis or IKC.

On leverage, nothing really new to say. Our leverage today is right in the middle of our target range of 3x to 3.5x EBITDA. We do reevaluate this range from time to time and we're certainly willing to go above or below it, but from where we stand now, I don't expect we're going to move the range in the near future.

From a debt maturity standpoint, we're in good shape: no significant maturities for almost three years.

Finally, on share repurchases, our philosophy has not changed. We ensure liquidity and focus on intrinsic value to guide our plan. The result of this has been a reduction of our share count by more than 40% in less than four years. Looking forward, we don't expect any change to our philosophy or plan, and we're likely to use a significant amount of our free cash flow for share repurchases.

That brings us back to the outlook Javier shared at the beginning. The net result is expected EPS growth of 8% to 14%. We get this with a roughly 50-50 balance of OI growth and share buybacks. Overall, we have a strong and resilient business that we expect will absorb some near-term financial headwinds as we invest in our future and deliver a strong and sustainable performance.

With that, I'll hand it back to Javier.

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Thank you, Joel. Well, we've been through a lot. If I had to summarize it, I'd say three things. Number one, we have a very strong and resilient business. Point two, we're setting a new standard of what it means to deliver kidney care. And point three, we have an exciting and healthy financial outlook.

With that said, love to open it up and hear from you on Q&A.

Operator
And our first question comes from Kevin Fischbeck from Bank of America.

Kevin Fischbeck, BofA Securities
Wanted to better understand the value-based-care opportunity. I guess, it's widely understood that MA rates historically have been above fee-for-service rates, so when you measure the savings that you generate, are you still getting that same premium on your base dialysis part of the business, and then the savings are on top of that, or are you getting something less than what you got before but the savings opportunity allows you to get back to, if not above, where you were before? I'm just trying to understand if the savings number that you guys outlined is kind of a gross number or if it's net of a higher rate on the dialysis path.

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Yes, thanks for the question, Kevin. It's a good one. Right now, the assumption is that basically, we would keep the dialysis rates where they are overall and then you would calculate from there what we showed on the slides.

Kevin Fischbeck, BofA Securities
Okay. So when you -- the savings that you have on that slide are kind of net of the fact that maybe you're -- if it was a 10% premium, you'd be $4,000 more than the benchmark spending just on the dialysis cost, and you're saving on top of that, those numbers.

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Correct. And we have not disclosed what the premium rate is for Medicare because every contract is different, but the assumption is the one we just spoke about.

Kevin Fischbeck, BofA Securities
Okay. And then just maybe a second question and I'll jump back in the queue. You mentioned that the savings that you generated under the ESCO was done kind of sub-scale. I guess -- and that there's a lot of benefits of scale. Can you just talk a little bit more about what exactly the benefits of scale are and how we should think about those platform costs as a percentage of revenue once the business becomes mature?

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Yes. I'll talk about the concept, and then maybe, Joel, you can add a couple of more details on the numbers. So think about subscale as an issue in -- if you go to a center, how many patients can someone actually treat and have an impact on? And if someone is hospitalized, can we send someone to the hospital? Is there enough scale or density in every local market? So that's one. Two is, when you think of IT and your investments in IT, and so since our markets were subscale, we had to do some things that were manual that over time we would want to do, of course, in a technologically advanced way that connects to others. And so those are two of the biggest ones.

As you start to learn in the ESCO models, which wasn't in your question, we also learn about making sure that in the transitions of care, in and out of the hospital, that it was a critical place to have a human intervention to make sure that the transition from the hospital back to the center was a good one. And so all those things are much harder when they're subscale than when you get to scalability.

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Yes, I'd add two things on the numbers, Kevin. So scale in this context can play out in two ways in the income statement. One is it can just drive higher savings. As we get better, as we have a local density and a national density, the total savings as a percentage of the value-based-care dollars can go up. So that's number one. The second is the cost of delivering those savings; what we call the model of care costs can come down, as you just have economies of scale associated with more patients, again, both locally as well as nationally.

In terms of order of magnitude, I think, on the second one, the model of care cost can vary a lot. It varies by patients, it varies by contracts for a whole bunch of different reasons. If you wanted to grab a number -- and this is around ESKD; the CKD numbers are a lot lower -- somewhere in the $2,000 to $2,500 per patient per year would be a reasonable estimate of what model of care costs are.

Operator
Our next question comes from Lisa Clive with Sanford Bernstein.

Lisa Clive, Sanford C. Bernstein & Co
A few questions on integrated care. Your savings at ESCO were quite a bit higher than the industry. Number one, seeing as you got most of those savings from the first year, why did you not decide to scale up that platform?

And number two, what do you think you did right? Were there certain metrics that you focused on, medication compliance, managing diabetes? How did you manage to keep patients out of the hospital? It would just be helpful to get some insights there.

And -- yes, and then I guess the last question I have I that we have a little over a month until CKCC starts; I would just love your thoughts on expectations for enrollment in the first year.

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Sure, Lisa. Well, I'll try to remember all of them, and if not, please come back at me. So the first question, if we had success on the ESCOs, why didn't we go to more markets? We were very explicit with the government to say, we want to be great partners with you. We want to innovate, we want to make sure that our patients get integrated care.

And we were also very clear in saying that there were some architectural things that we didn't like about the program. In particular, the benchmark was a little of a black box, and there was a reconciliation. It had a very long lag. So you actually never how you were doing economically. So that had a component that we didn't like. In addition, it has a complexity architecturally that you'd have to do a joint venture with some physicians, and the physicians had some downside risks that many practices didn't care for. So that's a big difference between the CKCC model in which the physicians now are highly incented to participate.

And so point number one, why didn't we grow it? It was innovation. It had some architectural things that we were very explicit, and we talked to the government about changing it, and we waited to see if they were going to change, and then of course the ESKOs were sunset.

As it relates to the value we created, there's a couple of things. Number one, the benchmark is so important. We had a couple markets that had a high benchmark, which means, of course, that there's more room for improvement. And so we did that. Number two is, we got better at really coordinating what happens in the center and what has to be done with additional resources. So we did have some of the

invention done with our caregivers, and then point number 3, what I talked about earlier, is we got really good at saying when is a patient going to leave the hospital and how can we intervene to make sure that there's no readmit? So those were some of the major value creations.

As it relates to CKCC enrollment, I think is the last part of your question; we are in the process of seeing how those patient enrollments come in. We are estimating, and what we've talked about publicly, is sort of a doubling of the numbers of what we have now, and so that should put us somewhere in the -- well, I probably shouldn't say a number because there's going to be, for the first time, CKD and ESKD, but we've talked about doubling of the risk dollars and we said around $1.6 billion up to now. So that gives you a little sense of where we are estimating the census to be.

Lisa Clive, Sanford C. Bernstein & Co
And sorry, just when you -- on those risk numbers, do those include the cost of dialysis or just the other costs?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
It includes everything.

Operator
Our next question comes from Pito Chickering from Deutsche Bank.

Pito Chickering, Deutsche Bank
Some questions for you guys on just the economics of IKC, and I'll bounce around here a little bit. If I go to Page 50 and look at the operating income you guys are guiding to in the long term, so roughly it's $150 million to $300 million of OI. If I go to Page 34, you guys are saying on average, the long-term patients are 250,000 patients. Page 33, you guys talk about $107,000 per patient, and then the margins you talk about on Page 33 are sort of 2.8% margins. So when I sort of take the average patients on the long term here, and the cost per patient at the 2.8% margin, it gets me an OI of $750 million. Take out the fixed cost of $125 million, gets me an OI of sort of $625 million versus sort of the $225 million that you guys are talking about on the slides. Just trying to figure out sort of how I -- how those numbers sort of tie up.

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
You want to grab it?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Yes, I'll take this one. Pito, I didn't follow every step of your math. I think one thing that's important is the membership numbers there are half CKD and half ESKD approximately. As we look at the long term, ESKD is really going to drive the vast majority of the economics. The CKD lives have much lower value-based-care dollars. It is harder to engage them, and we think the ultimate savings percentage will be lower there as well. So I think it's reasonable to start by cutting everything in half in order to take into account the fact that it's really the ESKD lives which drive the economics.

Pito Chickering, Deutsche Bank
Okay, okay. I guess for your 2025 numbers, are those also -- are those CKD or are those ESRD patients that you're talking about on those numbers?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
It's the same 50-50 number.

Pito Chickering, Deutsche Bank
Okay, okay. Fair enough. For Medicare Advantage, can you sort of walk us through what the penetration was beginning of this year, where it's exiting, or I guess where it is today, and how should we think about open enrollment sort of for 2022, and then maybe 2023 as well?

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Sure. Medicare Advantage started out the year in the high 30s percentage, and now has gotten into the low 40s. As it relates to the future, we don't have any magic crystal ball, but we anticipate that it'll continue to grow organically. The estimates that Medicare Advantage has into the future is roughly at 50% in the regular market, and we don't have any information that would lead us to think that we shouldn't be around those rates.

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Just to clean that up quickly, Javier said it started the year in the high 30s; he meant the high 20s.

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Sorry.

Pito Chickering, Deutsche Bank
Okay, great. And then one more follow-up here. Can you walk us through the cohort of patients on IKC you've seen during 2021? I understand sort of the fixed-cost nature of these patients and that you added a bunch of patients throughout the year, so specifically looking at the patients you added or that joined beginning of 2021 in IKC, I guess, how have those patients or costs progressed throughout the year, and kind of where are those patients sort of today in November versus where they were in January of last year?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Yes, I'll take that. Yes, so Pito, it's a complicated story. Some patients have been around for a while, some added at the beginning of the year, some in the middle of the year, and COVID has certainly impacted the overall numbers. You can think about the SNF patients who've been around for a while; MLRs for them are running in the kind of mid-90s right now, but we think there's a significant COVID impact on that. In terms of the rest of the cohort, it's really too new to have a view on it given they haven't been around with us for very long, plus because of COVID. So not a lot to update in terms of the progress over the course of the year on medical costs.

Pito Chickering, Deutsche Bank
Okay. And then last one from me: With all the labor issues facing the whole sector right now, so if you think about home penetration of 1% a year going forward, just as a way to optimize the labor as well as margins?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Pito, I'm not sure I understood the question.

Pito Chickering, Deutsche Bank
Okay. So the last few years you've seen the increase of patients at home grow about 1% a year, plus or minus. Is that just the right pace to -- going forward?

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
I think we are very excited about what we've discussed with our suite with in-home, and before the pandemic, as you know, that was growing very close to double digits, and now that's been impacted

overall. But we continue to be very bullish on home. We continue to think, for the right population, it will be very attractive. And we have high aspirations that we can get into the 20-some-odd percent in the long term of patients treating at home.

Operator
Our next question is from Justin Lake with Wolfe Research.

Justin Lake, Wolfe Research
So maybe just a follow-up here on the coordinated care questions. The -- you gave us the patient base and the profitability. So Javier, you talked about $1.6 billion, and then that number doubling in 2022, correct? In terms of the cost -- how should we think about that, that 2025 number you have out there, in terms of patients or profitability? What would be the revenue associated with that, just so we can kind of model this thing? Is there a ballpark you could share with us?

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Well, again, I'm grabbing simple math, just to grab the ease of it, and if you grab the midpoint of the range that we put out there, it's roughly 115,000 patients. And again, you divide that by two, as Joel talked about, for CKD patients, so you get to roughly 60,000, and you put those at $100,000, and you get to that simple math of $6 billion. Again, it just -- for simplicity's sake, I think that's a good number.

Justin Lake, Wolfe Research
Okay. And then --

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Hey, Justin, let me jump in, because I agree with everything Javier said, but that's the value-based-care dollar, and now's maybe a good time to help educate everyone on how we think about GAAP revenue. Because value-based-care dollars do not necessarily translate into GAAP revenue.

So the GAAP revenue is dependent, obviously, on a bunch of variables in terms of the membership number, whether it's CKD or ESKD, how much of that savings we share with our partners -- namely, the payors. But there's also a big accounting aspect to it. So before I dive into the details, I'll give you a number. I would say a reasonable estimate, although there could be a big range around this, for 2025, IKC GAAP revenue would be $700 million. That's a reasonable estimate, again, with a big range.

Justin Lake, Wolfe Research
For what year?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
For 2025. And let me explain this. With two caveats: One, there's no real economic significance to whether the revenue is that $700 million or a much higher number that more approximates our value-based-care dollars. That's what shows up on the face of the P&L, but the actual economics, the profitability, the free cash flow, are not impacted by that. So that's one. And second, the way a company accounts for this is dependent on the contract, it's dependent on the model of care, it's depending on the operating model. So two companies with the exact same contract, with the exact same CKCC contract, could account for these differently from a revenue standpoint because of their different models of care.

So here's the way I anticipate this to play out. Our SNF volume, which is about 3,000 members today, will be what I would call gross revenue accounting. We will take the full benchmark, including all the medical expenses, through our P&L, both at the revenue line and at the expense line. And then I would expect most of our other contracts to be what I will deem net accounting, and in those, the medical expense does

not come through revenue or through the expense, and our revenue is really our portion of the shared savings dollar. So it could be $0.10 on the dollar, maybe even less. So that -- but just to come back, that impacts GAAP revenue. It has no impact on the bottom line. That $2,000 to $4,000 that Javier referenced in his presentation, that is not impacted by gross or net revenue.

So again, $6 billion of value-based-care dollars, maybe $700 million of GAAP revenue -- those do not impact the bottom line.

Justin Lake, Wolfe Research
Okay. And how big is that SNF business looking to be in 2025? Do you expect to grow that, or is that 3,000 going to be pretty stable?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
For the sake of the $700-million number I gave you to help out, I would expect that to be stable.

Justin Lake, Wolfe Research
Okay. And to be clear, when you think about Medicare Advantage versus CKCC, obviously today I would assume outside of the SNF business, all of the membership is Medicare Advantage in that business? Those are MA [indiscernible] contracts?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
The vast majority, yes.

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Justin? Justin, we might have lost you or got disconnected. Can you hear us? Chris, we can't hear Justin, so can we go to the next caller and see if he can dial back in?

Operator
Yes. Our next question comes from Gary Taylor with Cowen.

Gary Taylor, Cowen and Company
Two questions. First, I just want to make sure I understand: For the Integrated Kidney business, both the gross dollars you're talking about managing and the net revenue accounting that you're just discussing, I mean, the vast majority of that is where you're taking a capitated contract from MA plan, right? Like, how do we think about, of that $6 billion, how much of that is where you're directly contracting with an MA plan versus, I guess, SNF as in gross dollars there, and then also you have CKCC? How do we think about that breakdown?

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Yes, obviously that's an estimate that we will see how the market plays out. For now, we're using roughly half and half, CKCC versus MA. And of course, we'll keep you posted to see how that plays out.

Gary Taylor, Cowen and Company
Okay, that's helpful. And then my second question is: Can you just explain a little more the clinical model that you're deploying to create these savings? When I look at your Slide 48 of your $100 million $125 million of fixed costs, half of that's in data analytics, 20% of that is nephrologist engagement. And so are you saying the clinical model really is the nephrologist primarily is playing a larger role in managing care and the primary way you're enabling that is with this IT platform that's putting new, better, different data in front of him, or are there other elements to the clinical model that maybe I'm not understanding?

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
That's a part of it, but it's obviously broader. We're making sure that we take care of the holistic patients. So think of it as, first, analytics, making sure that we intervene in the right patient at the right time. And so there is obviously data analytics technology. So then you get into the human intervention, which is making sure that the caregiver has the right information to do the right activity to make sure that that patient has or avoids the transition of care, and if, for whatever reason, they are hospitalized, that we intervene right away to make sure that they get everything connected between the center or their home dialysis and what happened in the hospital. So it's all about making sure that there are no additional hospitalizations or transition of care that don't need to happen, and so you do have, in essence, the technology, the nephrologist and the care team all connected, and analytics and data driving all of that.

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Gary, let me -- I'm sorry. Let me just finish up and help you understand where in the P&L this shows up, because you're referencing the fixed costs, and you're right about that; there is a variable component, what we call the model of care costs. And the nurse practitioners, the clinical care coordinators show up in that line item, not in the $100 million to $125 million of fixed costs that I referenced in the slide.

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Yes, that's a great point.

Gary Taylor, Cowen and Company
And do those folks -- are those folks going to reside at the centers or they're going to reside in a different setting where they're primarily accessing these data analytics?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Yes, so they're -- both models are what we will use. We've tried to paint a -- simplify what is a very complicated picture here, and there are some contracts that are local, driven around a nephrologist and a clinic, others that are national contracts. So we have nurse practitioners who could be local working in the clinics when we've got a high density, and then we've got a more centralized model for patients that are spread out across the country.

Operator
We have an additional question from Kevin Fischbeck at Bank of America.

Kevin Fischbeck, BofA Securities
So yes, a few more questions here. I just wanted to confirm: I think, Joel, you said that the 3% to 7% OI growth number is not really skewed by COVID. I mean, I guess the trajectory from year to year within a couple of years are going to be skewed by COVID, but should we think about DaVita's growth over the next five years, it's not that COVID tailwinds get you to 3% to 7%; it's 3% to 7% core, and that's the way to think about DaVita kind of even longer-term? Is that the right way to think about it?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
I don't -- that's not the way I would put it. The way I would say is, COVID is a complicated dynamic through this four-year period. It will be a significant headwind in 2022 over '21. It will be a tailwind, we would expect -- assuming COVID lapses into the background during 2022 -- we would expect it to be a tailwind from there going forward. If you were to peel back the numbers, I would say overall, the net impact from COVID on OI growth through this four-year period built into our numbers -- and again, there's a big range, but at the middle of the range, the net positive impact from COVID is 1% a year. So that 3% to 7% would be 2% to 6% without COVID. That said, I think there's a real possibility that the tailwind from COVID would last past this four-year range, so there'd be a continued tailwind post-2025 as well.

Kevin Fischbeck, BofA Securities
Okay. That's helpful. I guess when you guys talked about IKC, you talked a little bit about how CKD isn't going to be a big economic driver to that value proposition. I guess, why are you doing it? Is it something you have to do to serve the other side of the population? And I guess, is it harder to -- what exactly is the gating factor to making that side of the business more profitable?

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Yes. Before the economics, I would just start off by saying it's good for the patient. It's good for the system. And so any time you get an opportunity to do something that is going to enhance the quality of life for the patients, we want to do it. And then of course, it's all about having sustainable economics. And so we think that overall, when we do get to scale, the economics can have a low margin contribution, but it is a contribution, and doing good work for our patients and doing good work for the system. So we view it as our responsibility to do it, and then we think that it can have a nice contribution over time for shareholders.

Kevin Fischbeck, BofA Securities
Okay. And I guess, what is the difficulty? Why is that not necessarily going to be as profitable?

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Well, it's just difficult because people assume that grabbing the risk is easy, and then you can just eliminate all these extra costs. The reality is, it's not as easy, and then of course, once you do get the savings, you have to split it up between the nephrologist, you have to do something with the payor, in this instance in CKCC, the government takes a cut out of it from the top, and then of course you have your model of care.

And so when it's all put into equation, we think we can do a good job. We think we're best prepared for it. Because we talked about what you need as, number one, access to the patient. So many models don't have access to the patient. We have 500 hours with a patient in a year, or connectivity to a home on a daily basis. Then you talk about technology and analytics; we've talked about it a lot. We have 30 million treatments a year and we have it for over a decade, so we have a lot of data that can get us smart, and then we have the flows. Our nephrologists have, literally, access to the flows already. And so many models of care have a degree of difficulty in that if a physician needs to look at several EHRs, that it's just not something that they want to do, and they get distracted. They have too many things going on. And so the good thing is, they're already engaged in our workflows, and so we think all those things put us in a right to win from an overall perspective.

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Kevin, I'd add one thing. I wouldn't want you taking away from this that we think CKD risk is a bad business or there's no opportunity there. I think the key to the message is, for DaVita, ESKD -- the economics of ESKD risk are more attractive.

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Oh, I'm sorry, Kevin. So I thought you said CKCC, and you said CKD. So thanks for clarifying it. So that makes a lot more sense. So take my speech for ESKD.

Kevin Fischbeck, BofA Securities
All right, will do.

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Thanks.

Kevin Fischbeck, BofA Securities
I guess maybe, though, that helps with the -- me transition to the accounting of this. In the chart where you show kind of DaVita's share of net savings, you have it after the model of care costs, and so when you talked about the revenue recognition being that $700 million, the model of care investments that you're making, is that going to show up separately in G&A or is that actually going to be a net number, so that it's in the -- the $700 million already reflects those costs?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
No, that would -- the model of care cost would be after the -- that $700-million number. So it would be an expense on the P&L.

Kevin Fischbeck, BofA Securities
Okay. So if I was looking at that chart where you have that -- maybe the model of care cost should be on the right side? You get your share, and then you have to have the model of care cost, and you're funding yourself, and then net of that is your -- the economics to you, but the revenue number is actually going to be the $2,000 to $4,000 you save plus the model of care cost?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Right. Let me just back up and, just for clarity, walk you through how this could work for that model contract on that slide you're referring to. So the, call it $10,000 at the middle of range, would be the gross savings. Some of that would be shared if we have an 80-20 contract with an MA player, for example, or a 50-50 deal. We would get some of that and then the MA plan would get some of that. That could be before model of care costs or after, so that would affect the percent that would go to the MA plan, but that number, call it somewhere between 50% and 80% of that $10,000, would represent our GAAP revenue. From that you'd subtract the model of care costs, and then you'd subtract the G&A, and that would get you to an overall profit number. Just to be clear, that $2,000 to $4,000 on the slide, though, is before G&A.

Kevin Fischbeck, BofA Securities
Okay. Because when I heard $700 million, and that was going to be your percentage of the contribution of the earnings, it kind of sounded like it was $700 million of income, actually, that you would be generating, but we have to think about that as $700 million minus G&A and minus model of care costs?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Correct.

Kevin Fischbeck, BofA Securities
Okay, that's helpful. And then I guess my last question: You've talked a lot about the shift to home, and then you've talked a lot about value-based care. One of the main things that you've outlined as far as being important to be successful in value-based care is that access. Do you feel like, when the patient is home, you have the same access and the same ability to influence costs downstream? So any color there?

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Yes. And we're working really hard, in essence, to say that the patient is supported by all of our care teams even though they're home. And so yes is the short answer. While we get to see them less, the connectivity is literally going to be on a daily basis, and the care team literally now -- you press a button and you can get your care team. And so it's a different experience, but highly connected to our patients. And again, we talked about the interconnectedness and the fluidity between going from one modality to

the other, and so we do get to see the patient a fair amount, either virtually and then they come to our center roughly once a month to be seen live. So yes, a lot of connection to the patient at home.

Kevin Fischbeck, BofA Securities
Okay, great. And actually, one last question, sorry. When you talk about the savings and the economics of IKC, how much of the savings do you have line of sight into right now? Things that you've done and you've proven out? A lot of the companies who get into value-based care say, well, as our model iterates, we'll continue to find savings and continue to identify things. Are these economics you kind of outlined in broad strokes, are these things you have line of sight into or is there some amount of known versus go get, in there?

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
There's a little of both because when you get into these models you're going to discover a lot of things. But the experience in the ESCOs and the SNFs really have us honed in, into a zip code, if you will, and then there's some that are going to play out, and of course, some technology that needs to be rolled out at scale. I don't know if you want to add anything to that, Joel.

Joel Ackerman, DaVita Inc. – CFO & Treasurer
No, I think that's right. I think we've got line of sight on most of it. It's proving that we can do this at scale, that I think is the -- more of the operational challenge.

Operator
We have an additional question from Justin Lake at Wolfe Research.

Justin Lake, Wolfe Research
Wanted to kind of move over to the '21-to-'23 bridge that you provided on OI.

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Uh-huh.

Justin Lake, Wolfe Research
And specifically, I'm looking at this, and for '22, your core performance looks like a slight growth, right? So I'm sitting here doing some just rough math for my x, saying okay, 4% to 5% is normal core; that's -- pick a number. Say it's $80 million -- positive. The -- it looks like you're $20 million positive here. So you would have, give or take, you'd have $60 million of headwind.

Now, we know the IT is going to be $30 million of that, right? Because I think it's three quarters of the total headwind, right? Because you're starting in the second quarter, I think, there, Joel, but correct me if I'm wrong. So then it looks like you have maybe $20 million or $30 million of headwind net in labor and COVID, which, given to your point, Joel, you already know you have some annualization of the mortality here. Doesn't -- it looks like it's almost kind of neutral, right? Next year, doesn't look super conservative in my mind. So can you -- am I missing something there, or can you walk through the puts and takes in terms of what might offset the labor and COVID?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Yes. So I think you're underclubbing the headwinds from labor and COVID in your numbers. The -- we called labor headwind out as $50 million to $75 million on the Q3 call, so it's bigger than the number you have there. And then COVID has, really, two headwinds. One is sequestration, which we put in the other bucket, and then there's the mortality that's in -- that would be in the numbers you're calling out, and that's really two things. One is the annualization of the excess mortality that we saw in 2021, right? It didn't all

happen in the first quarter. And the second is the potential for continued excess mortality; in particular, a winter surge that appears to be looking more and more likely.

So if you add together the labor headwind of $50 million to $75 million, call it $40 million for the IT depreciation, and then another big slug for COVID mortality, you're looking at a pretty big headwind, well above $100 million. And the question is, how do we offset that over and above the normal core growth? And I'd point out three things. One is MA; the penetration continues to grow. There'll be an annualization of that, plus we could pick up some more in open enrollment. Second, we are looking, at the clinic level, at our operating model and looking for opportunities to create a time for our teammates there to spend more time with their patients, working on IKC things and potentially improving productivity. And the third are just other operating costs, mostly in the clinic, that we've been quite successful at managing over many, many years. So I think your characterization of the core delivering some growth next year is a reasonable characterization; I think the headwinds are significant, and I think our opportunity to offset those are also pretty significant.

Justin Lake, Wolfe Research
Okay. That's helpful. I wasn't taking into account -- it looks -- so it sounds like you think the core is going to be helped a lot by a bunch of cost-cutting offsets that you're going to -- your core would be above and beyond the normal if it wasn't for this other stuff, and that's fine. Can you give us a --

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Well, I think the MA penetration will be the biggest of those, so I wouldn't say it's all cost-cutting.

Justin Lake, Wolfe Research
Okay. And is MA penetration -- so I think you said you're in the low 40s now. What do you expect that to go to in 2022?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Hard to tell, but I think we're expecting higher than normal growth. If you go back prior to this year, we were growing, say, 2 percentage points a year. I think for next year, we'd expect another year of higher growth, although nowhere nearly as high as we saw this year.

Justin Lake, Wolfe Research
Okay. And remind me what you saw this year?

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Well, we started in the low -- in the high 20s and we're now running in the low 40s, so we've seen well more than 10% already.

Justin Lake, Wolfe Research
Okay. So not as low as 2% and not as high as 10%, and that'll be a big tailwind. Got it.

Joel Ackerman, DaVita Inc. – CFO & Treasurer
I think that's a good range.

Justin Lake, Wolfe Research
Do you -- can you -- since you gave us the labor number and the depreciation number, can you help us with the COVID -- with a COVID estimate, even if it's a range? That'd be really helpful.

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Yes. So COVID for next year is hard to predict. We -- and I'd point out three things. So sequestration, we're assuming, is going away, and that's a $70-million headwind. There have been historical offsets, the -- to the benefits of sequestration and PPE pricing in particular -- gloves has been a big one. I would say we expect that to get a little bit better next year, but there'll be more tailwind in '23, probably, than '22, although that's really driven by external factors, so it's hard for us to predict.

In terms of the negative impact of mortality next year, there's a lot about how COVID plays out over the next few months and then through all of '22 that is hard to say. I would say, if I had to give you a number -- I don't know, probably $40 million to $80 million, somewhere -- I know that's a big range, but maybe somewhere in that range. Could be a little higher.

Justin Lake, Wolfe Research
That's really helpful, okay. And then last question on the -- back on integrated care. The breakeven number is interesting relative to your significant success at ESCOs, and you've probably got some decent history on the Medicare Advantage side in terms of what costs you could take out. And so I guess that number's a little bit lower than what I would have thought it would be given your success on the ESCOs and what you've talked about in MA. Are -- is it -- one of the things I've been thinking about is just like you said, on the Medicare Advantage side, some of the contracts might be 50-50 sharing. I know you've got to share with the nephrologist. So when you talk about the net number to the company and that margin maybe being in the 2%-to-4% range, what are you assuming for kind of a gross margin before sharing?

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Grab it, and then I'll add a little color on the ESCOs.

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Yes. So we tend not to think in terms of margins because the revenue number is so complex here. I think in terms of the savings dollars that -- the saving percent relative to the value-based-care dollar that we think we can achieve, we think there'll be a lot of variability in that number, and it'll be contract by contract, and it'll vary over the timing of that contract. Where we think we can get is probably somewhere in the teens.

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
And Justin, let me grab another piece of it. And the reason why you might think that that number's lower than what you see on the ESCOs is, remember, the ESCOs, we only had three markets. In those three markets, there was one in particular that had a very high benchmark. And we're very explicit about writing all about this, as to how it would play out, meaning the benchmark was one of the most levered starting points economically. And so when you go nationally and you do it at scale, those benchmarks actually kind of even out. And so you've got to go back and earn it with a lower benchmark. Does that make sense?

Justin Lake, Wolfe Research
Absolutely. Maybe I can ask that --

Joel Ackerman, DaVita Inc. – CFO & Treasurer
Hey, Justin, I'm sorry -- before you dive into your next question, let me clean up my own misstatement. So when I say it's somewhere in the teens, that is not apples to apples with that 10% number that we showed on the ESCO slide. My teens number is a savings on the non-dialysis costs. I would say, if you were to think about the savings on the total number, something more high single digit, low double digit would be the right number.

Justin Lake, Wolfe Research
Okay. And just last question in terms of the -- kind of more directly, if we think about Medicare Advantage versus the CKCC, can you tell us, on average -- I know every contract's different, but what percentage of the savings do you get to keep in the -- in Medicare Advantage versus the plan, just rough numbers? And then same thing on CKCC. I know you're sharing some of it with the nephrologist. What percentage do you get to keep in CKCC, so we can think about that in terms of the economics to yourself?

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
I think it's a great question, but I think it's better, Justin, if we stayed at that simple math that basically we said out of the roughly $10,000 that we get in savings, we share $5,000 or so with the nephrologist and the payor, roughly evenly split. You do get into very customized contracts with complicated math, but I think for averages, it's a good number to use.

Operator
We have an additional question from Pito Chickering at Deutsche Bank.

Pito Chickering, Deutsche Bank
I'll keep this one simple and just one question, and no follow-ups. As you think about Medicare Advantage plans for -- that are in non-large dialysis organizations, will the small and mid-sized dialysis groups also take full risk on these MA patients, or are there discussions around you guys or the other large dialysis chain managing those patients? Or does Medicare Advantage start steering those patients into yours or the other large dialysis centers? Just trying to figure out what happens to other third of the market that is not controlled by you guys and the other large person here.

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
Yes, it's a great question, and of course, the payors want to have a robust and competitive marketplace. And so right now, best we can tell is they're contracting across the board. What we hope and have aspirations to do is to show that we have the best platform and the best model of care, and that over time, we have the greatest savings, and so that hopefully, over time, the plans start to favor us. But as it starts now, it's a competitive landscape, and one that everybody's got to perform in.

Operator
And at this time, I am showing no additional questions in the queue.

Javier Rodriguez, DaVita Inc. – CEO & Executive Director
All right. Well, we spent an hour and a half or so together; I really appreciate your interest in our company. As you can see, we have an ambitious goal. We are very excited to deliver more value to our patients and to the system. We want to thank you for your interest in DaVita and I want to wish you and your family a great holiday season, and we'll talk again in 2022. Be well.