UBS Global Healthcare Conference
HealthSouth Presentation

May 23, 2016
02:00 PM EDT

A.J. Rice: Well, I think we'll go ahead and get started on our next presentation. Next up in this room is HealthSouth. We're very happy to have them as part of our conference this year. Jay Grinney, President and CEO, is with us, as is Doug Coltharp, EVP and CFO, and Mark Tarr, EVP and Chief Operating Officer. Crissy Carlisle is also with us as the Director of Investor Relations.

HealthSouth's the leading player in the inpatient rehab and home health area. Been a stellar performer in the post-acute space and we're very happy to have them with us to tell us about some of the changing reimbursement models and how they're dealing with it and what their exposure is.

We're going to do this as sort of a semi-fireside chat where Jay has specifically got some input on some of the new payment programs. And so to start off with, I'm just going to ask him to frame his current exposure to BPCI and CJR and some of these other bundle payment programs. And I think you're going to just give us some sense of how you view that relative to HealthSouth and relative to the broad industry.

So with that broad opening, I'm going to pass it on to Jay and let him give us some (inaudible).

Jay Grinney: Thank you, A.J. Obviously, we were prepared for that question, hence the slides. But the main reason that we wanted to provide an overview is because there seems to be a lot of misinformation out there about the CJR model -- what does it mean, how does it work -- and the potential impact to us. So, what we thought we'd do is just take a couple minutes and -- we're not going to go through all the slides in a lot of detail. All of these are in our updated investor reference book, which we updated this morning. It's out there for you to see. And you can see the bottom left portion of the slide, the page numbers if you want to go back and review it afterwards.

First thing that you need to understand is -- and investors need to understand -- is that this is for MS-DRG 469 and 470, but there's not a perfect crosswalk to the Rehabilitation Impairment Codes that are the basis of our billing and the basis for us categorizing our patient. So in the past, people looked at the information that we would provide on lower extremity joint replacements and so on and take those numbers and start extrapolating, you know, the potential impact that CJR might have for us. And so I wanted to first start off by saying you can't do that because in the Rehabilitation Impairment Codes -- it's the RICs -- we have RICs, as you can see here, 07 and 08; 07 is lower extremity fractures; 08 is lower extremity joint replacement.

And within each of those RICs, there are multiple DRGs that get coded into that or that are the discharge codes from the acute-care hospital. As you can see in the middle of the slide, for RIC 07, about 30%. When we show hip fractures, about 30% of those are either

coming from 469 or 470. Similarly, if you look at RIC 08, that number is about 75%. So a lot of the knees and hips are coming from 469/470. That's point number one on this slide.

Point number 2 is we've been dealing with the shift in lower extremity joint replacements -- the simple knees and hips -- you know, for probably 12 years. I mean, it started in 2004 with the 60% rule. And so this isn't anything new for us as a Company. And I think -- I would certainly argue that we've managed in the last 12 years very well in terms of replacing lost simple knees with higher acuity strokes, neurological conditions and even going and expanding our focus on hip fracture.

So the second thing this -- I'm not going to -- you all should know this; I'm assuming you do, how it works. If we're in the CJR market, we're going to continue to get paid exactly the same amount as if we were in a non-CJR market. The acute-care hospitals are going to get paid exactly the same amount. Now, the acute-care hospitals have a target price, and at the end of the performance year CMS is going to come in and they're going to evaluate the performance of that hospital, acute-care hospital, based on that target price, and you can see how the target price is determined. And either the acute-care hospital receives additional payments or they have to make a payment back, depending on whether or not they're over or under that target. So the point here is that the post-acute providers, as well as acute-care hospitals, continue to get paid just like they always have based on the severity of the patient.

You then look at a unique aspect, and we're going to talk about this in just a minute. The CJR model allows for risk sharing among the providers. So we, as a post-acute provider, can go to the acute-care hospital and seek to become a collaborator with that acute-care hospital in providing care for the knees and hips in that market. If you see on the bottom right, where those payments are starting, in 2016 there's really no downside for the acute-care hospitals. So this year, it's really sort of rolling it out, getting comfortable, trying to figure out what the data means, trying to figure out who the right players are that they may want to partner up with. And the real penalties then start kicking in in 2017 and going to 2020. And there's some limitations as to how much we as a collaborator can receive in terms of reconciliation payments, which is really a payment for better behavior, or repayments. So again, this is just background just to kind of help set the stage for how CJR is expected to work.

Now let's talk about, you know, HealthSouth. All right? So you go to the far left and you can see that we have in the fractures and the replacements about 2,000 of our patients are in CJR markets today where, of those 2,000 patients, some of them are hip fractures, some of them are simple knees and hips. And it represents about 2% of our Medicare discharges and about 1.5% of our total discharges. So it's not a huge headwind for the Company by any stretch of the imagination.

If you then look at the next column, the 90-day episode spend, and that's an important metric because that's what the acute-care hospitals are going to look at. They're going to look at, all right, I've sent this knee out. It went to a skilled or a rehab or home health depending on the severity of that patient, and then there's a 90-day additional spend. If the first stop -- that might be us as a rehabilitation hospital; it might be a skilled nursing facility -- if that first stop is a lower quality and that patient then gets readmitted back into the acute-care hospital, the acute-care hospitals are going to take notice. They're going to look at what is that 90-day spend.

So we've gone in and we've looked at all of those patients, and we have data that we have from CMS that looks at our cost -- and when I say cost, it's how much we got paid by the Medicare program for that 90 -- for our stop, and then how much was spent for that 90 days for us, all the other rehab providers in that market, all the other nursing homes in that market, all the other home health providers in that market. And what we saw in that middle area is that when it comes to hip fractures, a stay in an inpatient rehabilitation hospital is overwhelmingly less expensive in that 90 days than it is for a patient going into a nursing home. And that's something that we have certainly known intuitively because our readmission rates are so much lower, and we get the patient rehabilitated and home much, much faster.

Now on the replacement side, it's a little different story. And we've know that for a long time that the simple knees and hips, you know, it's pretty hard to compete because these are lower acuity patients and they don't require the same level of intensive services that we would typically provide for the vast majority of our patients. However, there are certain patients where there are comorbidities -- additional illnesses, conditions -- that require that patient to be in an acute care facility or licensed as an acute-care hospital. So they come in; they get 24-hour nursing care, physician coverage, constant team clinical collaboration in the facility. And so if you get down then to those areas where either where we're more expensive, the number is a much, much smaller number.

And so you're looking at the far right, you can see that in terms of fractures, there may be 130 cases that we might be at risk to potentially lose, and another 750 on the knees and hips. Okay? So, again, just putting it in perspective, and we're not saying that those are patients that we will lose because, especially on the hip side and to some degree on the knee side, to the extent that we could help reduce readmission rates for patients who are leaving our facility and reduce that 90-day spend, the more attractive I think we are going to be for the acute-care hospital as the post-acute provider, especially in those markets where we have a high quality home health provider, which we have with our partnership with Encompass Home Health and Hospice. Okay?

So, all of this noise that this is going to be, you know, the death knell for the Company and this is such a significant headwind we believe is significantly, significantly overblown. Okay? So, how are we going to mitigate that? Well, as you saw, there are a lot of markets where our hip fracture 90-day spend is less expensive than the spend going into a nursing home. So we're obviously going to be exploiting that. We're going to be taking that information, going to the acute-care hospitals, going to the CEOs and the Medical Directors and showing that data to help them think through how they're going to respond to CJR.

And again, 2016, everybody's just trying to figure it out. There's no downside. Maybe there's a little upside. So we're not seeing this just huge massive shifts in our markets, but we do see that the acute-care hospitals are starting to pay attention to this. And so we think there's an opportunity to exploit our cost advantage. And again, when I say cost it's the payment from Medicare, how much we get -- Medicare has to spend, Medicare's cost. We think we can exploit that.

Additionally, we think that Encompass has a unique opportunity to capture patients that historically went maybe from the acute-care hospital right into SNF and then into a home health environment. We think that by providing the quality of care that they can, and they focus on the higher intensity patients, that they'll be able to bypass procedures that otherwise -- or patients that would otherwise go into a skilled nursing to go right into an

Encompass agency. Or that stay in the nursing home might be shortened because the Encompass providers there could be able to take that patient sooner.

The third thing, the third strategy is what I touched on a minute ago. We're putting plans in place today to be a collaborator. So we're going to go out, and we're going to be taking and pursuing risk opportunities, risk-sharing opportunities, in our markets or that we believe is going to be advantageous for us because we can tout the cost advantage; we can tout the quality advantage. And by doing that, we believe that we will be able to attract more patients into our facility.

And then the final thing I touched on a minute ago, we'll be able to get in there and where our costs are maybe higher, the cost of Medicare a little bit higher because our readmission rates aren't as good in those few markets where we have that, we're going to continue to focus on that. We're using our electronic medical records system to facilitate that. We're already putting in place a predictive modeling algorithm to help physicians see where the clinical variables of their patients may be deteriorating. And the predictive model would suggest that if unchecked, that patient may have to be admitted back into an acute-care hospital. We can jump in, identify that patient before they get to the point where they need to be transferred.

And then the last thing, and this isn't really CJR-related, but we decided that we would talk about it at this conference because we think it is a very, very significant development in the world of inpatient rehabilitative medicine, and that is the recent guidelines that came out by the American Heart Association and the American Stroke Association categorically saying you have a stroke and if you survive that stroke, so you're not dead. You're alive and you're suffering from the consequences of a stroke. We, the American Heart Association/American Stroke Association, recommend that you be treated in a rehabilitation hospital.

We think this is huge for, number one, for patients, but for us we think that this is going to be something that will really benefit us. If you go back to this slide, you can see 100 of our hospitals are already stroke-certified as a center of excellence by the Joint Commission. So, we've built that up over the last several years. We have known that our outcomes are superior. Now there's this objective, very credible report, clinical guidelines telling physicians you need to really think about sending those patients to an ERF instead of a SNF.

So you think, well, what difference is that going to make? I mean, you can imagine the first time a physician admits to a SNF that should have gone to an ERF, the patient has a bad outcome, they're sued. Or maybe it's the managed care company; maybe it's a Medicare Advantage Plan. And they've got the Medicare Advantage Plan Medical Director sitting in the -- being cross examined, and the plaintiff lawyer holds this up and says: Are you aware of the American Heart Association/American Stroke Association guidelines that patients suffering from strokes should be going to rehabilitation hospitals? If he doesn't know, he's screwed. If he does know, he's screwed. Because in either case, either he's negligent and doesn't know the information or he completely ignored those guidelines and inevitably, you know, there's going to be some additional cross examination that's going to get down to, well, it was cheaper. We thought it was cheaper. Well, you know, in our world that is not the compelling argument for bringing patients in. We bring them in because of the quality and now we have that quality essentially validated through these guidelines.

So if we look at, you know, the future, CJR, we think it's very, very manageable. We think there's a lot -- actually some upside there with being a collaborator, exploiting the cost advantage that we have with the fractures, reducing readmission rates where those might be a little bit higher than what we want. And then the icing on the cake is that we're going to be able to continue to push the clinical advantage of what we do in treating stroke patients.

A.J. Rice: That's great. And I'm sure we probably have some questions from the audience but I'll ask a few. So, just before I go back to CJR on this stroke, is there anyway to size the opportunity? What does it mean?

Jay Grinney: We're trying to do that now. We have -- use an outside consultant that actually helps us in every single one of our markets on an annual basis size the yield in that market. How many inpatient rehabilitation discharges are coming out of that market? Where are they going? Who are the physicians? And what do we need to do to bring our value proposition to those physicians?

So we're in the process of doing that right now, A.J., and I think it's going to be pretty significant. I don't think it's going to happen overnight.

A.J. Rice: Right.

Jay Grinney: But these are very important guidelines. And our belief is that the 90+% of the physicians who really are interested in doing what is right for their patients will look at these guidelines and if they had any sort of question in their mind -- well, you know, SNF, ERF, I guess it really doesn't matter -- I think they're going to be directing those to the ERFs. Now, you know, the guy who's getting $2,500 a month because he's got nursing home, you know, stipend, you know, being a Program Director or a Medical Director, he's making decisions based on his pocketbook, it may take, you know, a couple lawsuits before he decides that he needs to get onboard. But I think the opportunity is pretty significant

A.J. Rice: The discharge pattern today, is that tend to be split evenly, mostly to SNFs or is it --?

Jay Grinney: No, I wouldn't say that it's mostly SNFs, but there are -- I mean, even MedPAC two-three years ago said: Well, we need to start looking at, you know, it's all within the context of site neutral. Well, we need to start looking at maybe strokes. We could have some kind of site-neutral payment (ph). I think this is a huge roadblock to them going down that path.

A.J. Rice: Okay.

Jay Grinney: And so, you know, right now we just know that there are patients who are going into a skilled nursing that shouldn't be there. I mean, we deal with that every day in our markets.

A.J. Rice: Right.

Jay Grinney: And so, I think that this really creates a very, very nice long-term tailwind for the Company.

A.J. Rice: So going back to CJR, I know that the Company's made the case to policymakers in Washington for some time about if you look at total cost, we're better in many instances

than going to a skilled nursing facility. My sense is when it comes to the hospital discharge, up until very recently it's been all about where can I offload this patient as quick as possible? And that really hasn't been the nature of the dialogue you're talking about. How hard will that be to change that discussion, educate them, about what you're saying?

Jay Grinney: You mean the acute-care hospital?

A.J. Rice: Yeah, acute care.

Jay Grinney: Harder than we envisioned. In part because of all the other initiatives that the acute-care hospitals are having to deal with in terns of the readmission penalties and value-based purchasing. The acute care -- I've talked (ph) to Bill -- I mean, they've got a lot on their plate just coming at them and, frankly, with CJR as I showed, there's no downside in 2016.

A.J. Rice: Right.

Jay Grinney: So, you know, it's just a matter of prioritization. In many instances, if not most, we bring the data to the acute-care hospitals and it's the first time they're seeing the data. I mean, this is information that's coming from CMS, you know, from 11 different files. And, you know, we're focused on this and so what we're doing is we're taking all that information from the 11 different files and we're using an outside firm to help us then put this into meaningful information that we can then send and sit down and share with the acute-care hospitals.

So I do think that that's now, you know, they're starting to realize, okay, we need to really think about this from a 90-day episode perspective.

A.J. Rice: It seems like -- I was at a bundled payments conference last week actually -- and it seems like there is a lot of excitement and interest. People that have really engaged on this in trying to sort of shorten that skilled nursing stay, maybe eliminating go-to-home health as quickly as possible. It may be still early, but are you having discussions? I mean, we talk about being a collaborator, that seems to me like you're angled to get in there is more from the home-health angle. What kind of --

Jay Grinney: Actually both. We want to be a collaborator for the full continuum (ph). We'll go in and say we'll take -- and especially in those markets where we have Encompass -- we'll go in and say, listen, we'll take that risk. We'll take it even on the knees where we may be slightly more expensive but, you know, if we're able to facilitate a smooth transition into the home health and bypass what patients who are today going into a nursing home, and bypass that altogether and, together with our home health partner, have a lower cost. And even if it's slightly more and we have to pay back, we're willing to do that.

A.J. Rice: Okay. Okay. Who is the -- I mean, the Discharge Planner is often the person that handles the Medicare discharge and finds the location, but I would think when you start talking about CJR and shared risk, it may not be Discharge Planner that you're having that discussion with. Do you know who will be the point person? Is it settled out in the facility at this point?

Jay Grinney: I don't know that it has settled out. I don't know that it's consistent across the board. Mark may have --

Mark Tarr: The first people we try to get to is the CFO of the acute-care hospital -- CEO or CFO. And then, to the extent that they have a development person that's involved at the hospital on a larger scope in the market, that would be a third individual we'd want to get in front of with our pack of information.

A.J. Rice: And I guess one other question and then I'll ask if anybody in the audience has a question about any of this and then I'll ask just some specific HealthSouth questions if we have time. But one of the things that struck me at the conference I was at is they had commercial payers coming in and they're looking at this and saying how can we apply this in our different product lines. To the extent you're having discussions with commercial payers, are you seeing interest in this, movement toward any of this kind of stuff?

Jay Grinney: Not a lot, in part -- now on the Encompass side, we definitely are.

A.J. Rice: Okay.

Jay Grinney: But it's more limited on the inpatient side.

A.J. Rice: Okay. Okay. Before we just move to a couple things on the HealthSouth story, does anybody else want to ask a question about the bundled payments discussion we've had?

A.J. Rice: So one thing on the HealthSouth specifically, you guys have last quarter had good volumes.

Jay Grinney: Very good (inaudible).

A.J. Rice: Sort of worked through all the things you're talking about up there in the last few years. And I guess you've put out today that you're still seeing pretty good volumes.

Jay Grinney: Yep. Yep. Feel pretty good.

A.J. Rice: What do you think's behind that? Give us some flavor for what is driving that.

Jay Grinney: You know, I think there's a couple things. Number one, the nondiscretionary nature of the conditions that we treat, coupled with number two, the fact that demographically most of the patients are elderly. The average age is 73/74. Average Medicare age is, you know, closer to 78. So it's really a function on nondiscretionary conditions that the elderly are afflicted with that need inpatient rehabilitative care.

The other aspect -- and it's really unlike, you know, you heard from LifePoint -- is there's not a lot of what we do in our hospitals that can be done on an outpatient basis. And so, whereas you've seen in the acute care world a shift, the volume is still there but more of it is going to the outpatient and less is going inpatient. That same phenomenon does not apply to us.

A.J. Rice: Okay. When you think about the Reliant acquisition, I think you said that that came on with them treating lower acuity patients. Would you hope over time to move that up? Where are you at in the process and how long will that take do you think?

Mark Farr: That process is moving well. There were a number of the Reliant hospitals that had a higher percentage of their patients in the orthopedic mix than what we typically see in our hospitals. So over time, we are adding the neuro components to those hospitals. They

may still treat those orthopedic patients, but we're trying to add the capabilities of treating this higher severity, higher acuity patient. So we're making nice progress on that. I think that will take, you know, another six/eight months to fully have that vetted in, but we've moved the Reliant hospitals over to our operating structure. We're in the process of moving EMR, electronic medical record, to all those hospitals. That will be done this year. And then we have backfilled in some staff where we felt that they were a little bit understaffed in terms of therapists, in terms of the quality reporting role in each one of those hospitals. So we're just about done with that staffing component.

A.J. Rice: Okay. And when I think about the home health business. Is the nature of the patient coming your way changing in any way because of any of these things we've been talking about? I know the perception of growth is very strong to begin with anyway.

Jay Grinney: Yeah. Encompass has always positioned itself to take the higher acuity patient.

A.J. Rice: Okay.

Jay Grinney: So, unlike many of the public company peers where they're taking the lower, this is really --

Unidentified Participant: Took the light out.

Jay Grinney: They're always treated higher acuity patients. But I think all of us treating Medicare patients are just seeing that acuity increase just generically throughout all of our markets.

A.J. Rice: And as patients -- oh, go ahead.

Jay Grinney: Yeah. Therapy mix is going on.

Doug Coltharp: (inaudible) The Company has been focused on the clinical collaboration with (inaudible) nurse. Again, that's a very deliberate strategy. They are seeing an increase in the number of therapy patients (inaudible) in that kind of a role.

Jay Grinney: You've shed some light on that topic.

Unidentified Audience Participant: Would you repeat that? We couldn't hear what you said (inaudible).

Doug Coltharp: Sorry. I said that the therapy mix of the Encompass home health patients has increased as a result of their clinical collaboration with our inpatient hospitals.

A.J. Rice: And as more types of patients are coming your way in the home health, do you have to -- I don't know what kind of screening mechanism there is or is that even an issue at all that you have to be aware of what it may require? Is that --

Jay Grinney: No. I mean, there's -- it's not as if there are differences in the types of patients that we're seeing. I think that, with the exception of what Doug just said that, you know, many of the agencies are now seeing more therapy-related patients. But --

A.J. Rice: Right. But you're not at risk for those? You still getting fee-for-service payments (inaudible)?

Jay Grinney: Yeah. And I think that the -- you know, of all of the services out there, I think that home health is probably going to be the most advantaged going forward --

A.J. Rice: Right. Right.

Jay Grinney: And I think we can capitalize on that because, as you saw, we're the low-cost facility provider for many of these conditions. And coupling that with Encompass, I think gives us a very strong competitive position in those markets.

A.J. Rice: Our time is running down here but I'm going to squeeze one last question in.

Jay Grinney: Okay.

A.J. Rice: I know you guys have expressed a little frustration with your stock and with maybe there being some misunderstandings in the investment community. You have the financial wherewithal on the balance sheet. How do you -- give us a quick comment about stock repurchase. You've got certainly some development activity. You had acquisition.

Jay Grinney: Well, the good news is, and Doug has said this on the last call, we're in the fortunate position that we're generating so much free cash flow it's not an either/or. I mean, we're looking at share repurchase. We're looking at continuing the dividends. We're looking at being able to continue the development activity. We've got a very healthy pipeline in terms of inpatient rehabilitation opportunities, a lot of joint ventures in that pipeline. And then on the home health side, a very compelling pipeline as well.

What we're trying to do is to identify those markets where we have an ERF but we don't have home health, and then Encompass is zeroing in on those to pursue acquisition opportunities that will round out those markets.

A.J. Rice: Okay. Great. Well, there's a lot to chew on there and certainly the breakout session, some of this can be explored in more detail. We really appreciate the management from HealthSouth being part of the conference this year. They'll going to do a breakout one floor down in the Alvin Carnegie room. And next up in here will be -- actually, there's a break in this room. So, thanks.