HealthSouth Fireside Chat
UBS Global Healthcare Conference

May 23, 2017
08:00 AM EDT

A.J. Rice: I'm A.J. Rice, the healthcare service analyst here at UBS. Welcome you to the second day of our conference. And we're very pleased to kick off with a leading post-acute provider, a leader in inpatient rehab and home health, HealthSouth. And we're very pleased to have the President and CEO of HealthSouth, Mark Tarr, as well as Doug Coltharp, EVP and CFO. Travis Wilson's with us, too; investor relations.

We're going to do this as a fireside chat. There'll be time if you'd like to ask questions so think about that. We'll give you the option to ask some questions. But if we could get started, maybe I'll throw out a few.

Thanks again for participating.

Mark Tarr: Sure. My pleasure.

A.J. Rice: If we look at the last few years or so, I think HealthSouth has compounded adjusted EBITDA at about 12% and adjusted earnings at about 13% to 14%. When you think about going forward are those metrics that you think could be achievable in the next three to five years? Do you think-- and what would be maybe some of the components of growth around that?

Mark Tarr: Yeah. So A.J., in our business outlook slides we have 5% and 9% growth on EBITDA going forward and we would achieve that through consistent volume growth in both our IRF segment as well as home health. We would expect after 2018 a more normalized pricing environment for home health. And then a big part of our overall management focus, as always, is efficiency in managing our labor about that 3%. So combined we would expect that 5% to 9% EBITDA growth.

A.J. Rice: Okay. That's great. And that would be before any kind of inorganic growth, I guess. You're not really including acquisitions in that?

Mark Tarr: That's correct. Right.

Doug Coltharp: Well that's inclusive of our baseline assumption for home health and agency-- home health and hospice agency acquisitions.

A.J. Rice: Okay.

Doug Coltharp: So the recent historical CAGR around those earnings metrics that you referenced earlier did include a couple of good-sized acquisitions--

A.J. Rice: Right.

Doug Coltharp: Both Reliant and CareSouth. Last year we did $50 million in home health and hospice agency acquisitions. This year our base assumption is $50 million to $100 million, and it's probably a reasonable assumption on a going forward basis and that would be included in that 5% to 9% that Mark mentioned.

A.J. Rice: Okay, great. And what do you think from a big picture standpoint, headwinds, tailwinds? Mark, you mentioned after 2018 home health. Maybe expand on that, to the extent that there are some people that are a little new, what happens post-2018. But what would you characterize as some of the things that could create upside and the things that might be challenges?

Mark Tarr: Sure. So let me start first with the tailwinds. And we believe there are substantial tailwinds when it comes particularly to demographics. If you look at the Medicare beneficiary CAGR it's 3%. Our average-age patient in our facility-based is 76. Home based it's 77. So if you look at the CAGR in those age ranges it's more 4.5% to 5%. So we think that the demographic, just the aging of the population, as the population ages out they're more likely to have conditions and increasing needs for rehabilitation, whether that's in a facility-based or a home setting. So we think there's continuing strong demand for our services.

When you think about any potential headwinds that might be out there, certainly the pricing environment particularly in home health has been a bit of a challenge through the rebasing environment the last couple of years. This year we're expecting to take a 3.6% pricing hit on home health, primarily due in part to the types of patients we treat and acuity. But after 2018 we expect to get back to a more normalized market basket rate of close to 3% and have somewhat of a more normalized environment out there from a pricing structure.

A.J. Rice: And when I think about your two business lines, the rehab-hospital business has-- among the different subsegments that we would broadly categorize as post-acute has enjoyed sort of a very stable reimbursement environment. The volumes have been pretty steady. It's probably been sort of the safe haven area in all of post-acute care. Do you see that continuing? Do you-- and why has it sort of avoided some of the pitfalls of other areas in your mind?

Mark Tarr: Yeah. We don't see anything in the near term that would impact that in a negative way. We-- the IRF industry itself is a very fragmented industry. There are many more units located within acute care hospitals operating at a single-digit margin, a low percent margin. And so therefore, when you look at a HealthSouth versus the industry as a whole, we stand out to the positive but a lot of that comes with our scale. It is an area of clear focus for us in terms of our ability to implement the management operating systems, focus on our efficiencies. So there are some things that make the overall industry very stable going forward, particularly from the volume and the regulatory front.

A.J. Rice: Okay. You've talked in some of the recent periods about taking on some newer or higher-- getting a better-- bigger share in things like stroke and neuro-- some neuro categories and that those are higher-acuity patients, which presumably give higher revenue to some degree. Is that just because the market's moved in that direction or is this some marketing that you've done? What-- how would you describe what you're doing in terms of targeting in the rehab area? And does that translate, those types of patients, if they're higher acuity, it's-- what is the effect on margins of taking on that kind of mix?

Mark Tarr: So I think there's really two areas that are driving that. One, the need for these services

has always been there. There's always been stroke patients in the acute care hospitals, or neurological patients suffering from those maladies that are neurologic in nature other than stroke. Our ability to take those patients historically, say 10 years ago, would have been limited by this acuity. But we made a concerted effort to go in and meet the services-- meet the needs of those patients by increasing the competency of our critical care nurses in our hospitals; we have increased the clinical education of our therapists; we've supplied our hospitals with additional equipment, all to better position ourselves in order to take this higher-acuity patient. So we're essentially meeting the need of an increasing segment that's out there in the marketplaces.

If you compare these patients to an orthopedic patient back say 10 or 12 years ago, the margin is slightly lower than the orthopedic patient, but the growth of these neuro patients meet the regulatory requirements from a medical necessity standpoint. So we see this as an area of continued growth. There is continued demand from acute care hospitals who would like to have patients discharged from their ICUs and neuro floors to post-acute and our ability to take this higher-acuity patient has played a favor to us.

Doug Coltharp: And I'd just elaborate on that, A.J.--

A.J. Rice: Yeah.

Doug Coltharp: That the-- those patients will carry a lower margin than the ortho, but they're going to create more margin dollars. And just as an example, for-- under the Medicare fee-for-service schedule an average stroke patient is going to have revenue per discharge of roughly $23,000. If you compare that to an LEJR without a lot of comorbidities it's going to be like $14,500.

A.J. Rice: Okay.

Doug Coltharp: So even with the margin differential you're going to generate more dollars with the stroke patient.

Mark Tarr: It's been increasing our case mix index or our acuity factor, therefore we get paid more for those patients.

A.J. Rice: Right. Are you-- is that something where the whole industry has moved in that direction or is that sort of unique to HealthSouth? A lot-- we don't have great visibility on a lot of the one-off rehab hospitals out there. Would you say that they've moved in that direction?

Mark Tarr: Well I think the industry as a whole has had to move away from such a focus on lower-extremity joint replacement--

A.J. Rice: Right.

Mark Tarr: Orthopedics, and that came with medical necessity. It also came with-- and with the 60% rule guidelines, is those patients typically do not meet the 60% rule guidelines. But I think we've been able to take it to a higher degree than the rest of the industry. And not only do our discharge status metrics indicate that in terms of we're up now to over 18% of our total discharges were stroke patients in the first quarter, but we've shown it also on our quality outcomes and our ability to get those patients back home, back to their community and not be readmitted back to the acute care hospitals. That's where we're really standing out as we compare HealthSouth hospitals to the industry.

A.J. Rice: And we hear a lot about your home health operation, Encompass, that it has a superior model in home care. In what ways do you think Encompass differentiates themselves?

And it's again something that's hard for us as outside observers to tangibly completely understand, but it's something we hear consistently. What is it about the Encompass model that differentiates itself from the other home health providers?

Mark Tarr: So first of all, they too, similar to our facility-based, they have excellent outcomes. They have very well-defined clinical programs. They are extremely flexible in terms of their overall staffing and ability to make sure that they put the right level skill mix with the right patient to maximize efficiency and productivity, particularly on the staffing. And they're also what we consider to be the super users of home care, home-based, which is the industry-leading IET system that allows for this additional documentation in a more efficient way, as well as help put the correct staff level at the right time, at the right place with the patient. So logistics comes into play, too. So they minimize the amount of time that a therapist is in their car driving to the next visit.

A.J. Rice: Interesting. I know sometimes when we've seen companies make an acquisition in an area and have-- by someone that has a sort of unique model, they've been challenged in trying to replicate that and take that into other markets. You guys have owned Encompass for a while now. How has the experience been in trying to expand that model into other markets?

Mark Tarr: They've really done a nice job, A.J.. And their ability to go in and implement their systems and their culture, their standardized processes and build those clinical programs I alluded to earlier, that's how Encompass has grown over the years, primarily through acquisition and so they really have that fine tuned. CareSouth was a prime example when they-- as a multi-site acquisition and they fully have those facilities implemented now and are up and running on their standards.

A.J. Rice: And you talked about IT investment in the home health business. I know a few years ago when the push for acute care hospitals to adopt meaningful use came in there were subsidies for them, but there weren't subsidies for the post-acute player so most post-acute players didn't make that investment. But you guys did go ahead and put in a lot of those capabilities. Now that hospitals have it or they're trying to take advantage of it is that-- how is that making a difference in your competitive--?

Mark Tarr: We're very glad we made that decision. This is our fifth year and final year of the rollout of the Cerner platform across all of our inpatient rehabilitation hospitals. This is a system that we worked to develop with Cerner, so it's customized to how we operate in an inpatient rehabilitation hospital. It is able to interface with our referring acute care hospitals. It allows us to begin to extract data now. We have some predictive modeling efforts onboard based upon the data that we're able to extract from our historical uses so that we can begin to predict those types of patients that may be at high risk for acute care transfers back to the acute care hospital.

So we're very glad we made that decision back then to invest. It will be over a $200 million investment for the Company all in. And we think it's going to play out very strong in our favor going forward, particularly as we look at the ability to collaborate with the acute care hospitals, start to think about episodic management and the alternative payment models. So we think this all plays in our favor.

Doug Coltharp: And I would just add, A.J., it's a strong point of differentiation in our discussions with new potential JV partners. When we're in an RFP process, which happens in some of those JV opportunities, again, it is a clear advantage that we bring to the table.

A.J. Rice: Okay.

Mark Tarr: And then a final comment on that. Therapists, nurses and physicians don't want to work

in hospitals nowadays where they have to document by paper. And it also works against you when you're trying-- in a world where documentation plays a very strong part from a regulatory environment. So we're seeing benefits on that, too, relative to recruitment and retention of nurses, physicians interested in practicing in our hospitals, and we think it's tightened up our documentation requirements as we submit to Medicare.

A.J. Rice: Okay. When you think about recruiting labor, so in your case I guess it's not just nurses but it's therapists as well, there's been some discussions early the second half of last year about a sort of tightening labor market. What are you guys seeing in terms of the basic metrics, year-to-year updates in wages, turnover rates, vacancy rates? Any update on that?

Mark Tarr: So we have not seen an across-board increase in terms of labor pressures, particularly for nursing, but we do have pockets that we've-- that have our attention. We've paid a great deal of attention to our ability to retain staff over the last four or five years and so what we've seen is our turnover has dropped below the industry standard. For example, in Q1 we ran less than 20% turnover in our nursing ranks when you look at an industry standard of almost 25%. On the therapy side in terms of licensed therapists, physical therapists, occupational therapists and speech therapists, we're well below the industry standard. We're at single digits. Somewhere around a 7% or 8% turnover rate when the industry's north of 10%. So if you're not turning over your staff you're not having to hire new staff but higher wages.

So I would say that the market is still tight. We-- it's got a lot of our focus from our human resource department, but we've been able to offset any of the real struggles and be very competitive in these marketplaces.

A.J. Rice: Okay. I'm going to ask about free cash flow, but we'll also see if anyone has a question they want to ask in the audience. Feel free if somebody has a question they'd like to ask.

Okay.

Unidentified Audience Member: Thanks. I was wondering if you could talk about the cardiac and CJR bundling demonstration projects that are scheduled for 2018 and how that might affect your business going forward?

Mark Tarr: So we had-- first of all, we had very little exposure. About-- less than 5% of our total discharges are lower extremity joint replacements. So from an exposure standpoint, negative exposure standpoint, there is very little impact from a CJR. We saw it just the opposite. We saw it as an opportunity for us to go out and carry our value proposition in terms of meeting with these hospitals, acute care hospitals in the CJR marketplaces, and start to talk to them about our willingness to collaborate with them in these bundles and even our willingness to begin to accept a portion of risk in working directly with them. CJR, the language in that, there is the ability to establish yourself as what's called a collaborator and actually sign up with acute care hospitals to accept some of that risk.

As we've seen more of these markets and these bundle initiatives under the new administration start to be-- like to the voluntary reverses mandatory, the tendency of the acute care hospital systems seem to be more that they would just like to work with us in a preferred provider type of arrangement than signing a formal collaborator agreement. But it's really opened doors for us, I think, in terms of going out and meeting-- we prioritized 38 different marketplaces where we have hospitals that are in CJR markets and we are going out and meeting with every one of those acute care hospital CEOs and CFOs to discuss this value-based proposition to them and, once again, our willingness to start putting in our toe in there to take on risk.

A.J. Rice: It does seem like-- and I don't know whether it's they're just in transition and they're trying to get their sea legs or whether they are consciously sort of slowing the process down and slowing the momentum behind some of these bundled payment initiatives, but do you guys have a perspective on that?

Mark Tarr: We've spent a lot of time in Washington and last week we met with some of the new folks at CMS. And all indications are is that they-- and if you look at Dr. Price's history, I think that what you will see, that they'll be voluntary, not mandatory. Of course we've not seen anything come out long term that actually states that, but it does seem like they would prefer to see these as being voluntary. I think that they continue to see bundles as an aspect of an alternative payment model that will have some legs in the future. I think they're looking at how to structure those that would be-- both accomplish what they're trying to do in terms of overall reduced spending for Medicare, but also be provider friendly where there would be more providers that voluntarily participate in these bundles.

A.J. Rice: Okay.

Doug Coltharp: I think two themes that we have seen out of the new administration is, one, an awareness that there have been a large number of new initiatives that have been imposed upon the provider community in a relatively short period of time, and that there needs to be more time for the providers to adjust and to digest the existing initiatives before new ones are tossed on top. And also, specific to CJR, the belief that not enough provider input was included in the development of those programs, and that the efficacy of any go-forward programs will be greater if there is more provider input on the front end and they're going to allow time for that to happen. You can see some of that language creeping itself into the proposed rules that are coming out.

A.J. Rice: Right, right. I did want to at least spend a minute on your cash flow. I think the target I have is $305 million to $395 million in adjusted free cash flow this year.

Mark Tarr: That's correct.

A.J. Rice: When you think about that, maybe talk a little bit about your priorities and how you see that directed and maybe how that might-- will that grow commensurate with earnings over the next few years? Is there anything that we should think of as an adjustment on the free cash flow?

Mark Tarr: Well as you can see on the slide, you can see the way we prioritize. The first priority is to fund our growth. Whether that's through bed expansions-- this year I think we're-- should have somewhere around 155 beds we'll add to our existing hospitals this year. Also finding growth through our de novo IRFs or acquisitions. We have two major replacement hospital projects that are currently in the works so funding would be used for those. Also to continue to look at our opportunities on our balance sheet and debt reduction. We ended the first quarter at 3.7 times. We'd look at continuing to work that down in the year somewhere between 3.5 and 3.7. And then continue with our shareholder distributions, whether that's through our dividends or the opportunities for a share repurchase.

Doug Coltharp: I think in terms of growth, A.J., one thing to note is that we exhausted our remaining NOL. It had been augmented in the first quarter of this year by a favorable IRS ruling, but we exhausted the NOL at the end of the first quarter. So the assumptions that we have out for this year include three quarters as a full cash tax payer. On a go forward basis we'll see that for the entire year, but otherwise we would anticipate that adjusted free cash flow would grow highly correlated to EBITDA. We may start to get to leverage against the maintenance CapEx number in outer years, particularly because the

installation of our clinical information system has been running through maintenance CapEx. Having said that, as we've identified previously, we have some other initiatives underway with regard to a number of large hospital remodels.

A.J. Rice: What is-- what would be the Company's leverage target or range for leverage?

Doug Coltharp: I think anything at 3.5 or below. We feel like we've got a lot of extra capacity in the balance sheet. When we did the Reliant and CareSouth acquisitions - and it was a bit of a unique opportunity that they both arose within a relatively short window - we took the leverage immediately up to 4.5 times. We expressed a willingness to do that only with clear visibility to be able to bring it down under 4 times in the near term and we did that in less than a year.

A.J. Rice: Okay.

Doug Coltharp: We would consider those types of things if the right opportunities presented themselves on a go-forward basis.

A.J. Rice: One very specific question I'll go ahead and ask in here is there is this pre-claim review demonstration for home health in Illinois and Florida. Considering any update on that?

Mark Tarr: It's been postponed for right now. They-- originally for at least 30 days with 30-days notice once they-- if they put it back in place, but that's a-- that was a favorable ruling and I'd credit the new administration with helping to make that happen.

A.J. Rice: Okay. And maybe I'll just close with-- I think, Mark, it's been about six months since Jay stepped down and you've taken over as CEO. The Company was doing very well when Jay transitioned out, but I was wondering if there would be any new initiatives or priorities that you've brought to bear once you assumed the reins?

Mark Tarr: Yeah. Well our strategy remains the same. We feel like we're in a good position to continue to grow and grow out our IRF segment, continue to grow out the home health segment. Focus on the overlapping markets that will create the marketplace, or we could work collaboratively between our IRFs and our home health. We've put in a TeamWorks initiative this year to help standardize that whole process. So we feel good about the existing strategy and the ability to grow the Company going forward.

A.J. Rice: Great. Well with that we're going to wrap up here. The Company's going to do a breakout down in the Broadway Room, one floor down. And I really appreciate HealthSouth participating in the conference this year and thanks, everyone, for turning out.

Mark Tarr: Thank you.