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Encompass Health Corp.

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Unidentified Participant: All right. I want to thank everyone for joining us today. It's my pleasure to introduce Encompass Health. Encompass is the largest provider of inpatient rehabilitation services in the country. They also are one of the largest providers of home health services in the U.S.

Presenting today, we have Doug Coltharp, who's the CFO of the company. We also have Crissy Carlisle, who's the chief Investor Relations officer, as well as Barb Jacobsmeyer, who is the president of the inpatient hospital business, in the audience.

Doug was nice enough or foolish enough to go right into Q&A. So, appreciate that. And I encourage anybody if they have any questions to just raise your hand and you can ask. We'll call on you to ask questions, but I'll kick off the Q&A.

Could you talk a little bit about –? I guess both sides of your business are seeing some reimbursement changes for 2020. So, could you talk a little bit about how you guys are quantifying the impact and how you guys are looking to potentially mitigate the impact?

Doug Coltharp: Absolutely. So, the payment changes for 2020 are on two slightly different cycles. The fiscal year for the IRF business, our largest business segment, runs on a government fiscal year. So, those changes will go into effect on October 1 of this year. Home Health is on a calendar year. And so, a little less visibility to what ultimately the final rule will look like on that particular basis.

So, for the IRF rule, the proposed rule came out in April of this year, and embedded in that is the anticipated transition from the current basis of reimbursement, which is something that's called the FIM assessment. And FIM is an acronym for Functional Independent Measurement. That is a tool that is used by all IRF providers to measure a patient's current status and level of impairment on an array of physical and cognitive impairments upon coming into our facility, and it's used to judge the acuity of the patient and, therefore, factors into the reimbursement we get for treating those patients.

As part of the IMPACT Act which came out in 2014, which was aimed by Congress at trying to reduce regional disparities in post-acute spending across the country, both of these payment model changes represent a move towards what's called a common patient assessment tool, which will be off in the future and is designed eventually to move towards some form of site neutrality.

So, FIM, beginning in 2016, began to run concurrent with a second patient assessment tool, called the CARE tool, C-A-R-E. And for 2017 and 2018, we ran both of those assessment vehicles, but only the FIM assessment was used to determine our reimbursement, and the CARE tool was used for information gathering only. Beginning on October 1 of this year when we transition to the Fiscal Year 2020, all IRF providers will drop the utilization of the FIM tool and will adopt solely for the purpose of reimbursement the CARE tool.

And although they were intended to be essentially highly correlated together, based on the way the rule has been designed there are some highly uncorrelated outcomes that result. For example, one of the things that was done – about 18% of the patients that we treat in our IRFs are stroke patients, and those patients tend to have a very high acuity and, consequently, a higher level of reimbursement. For reasons that are not very clear to us but that were at least couched in terms of trying to simplifying documentation for providers, the CARE tool actually condenses the number of CMGs that are applicable to stroke patients and eliminate one of the higher reimbursement codes for stroke patients.

And so, when you flush all of this through, although the adoption of the CARE tool is intended to be budget-neutral for the full industry, there are winners and losers. There are certain parties who based on their patient mix are going to see a decrease in reimbursement and certain parties who will see an increase, netting to what is expected to be, again, an even outcome for the whole industry.

Unfortunately, because we're skewed towards higher-acuity patients, we're on the negative end of that change. And based on the specifics that were included in the proposed rule applied to our most recent historical and LTM patient mix through the end of the first quarter, we would assess that translating into a Medicare reimbursement change for Fiscal 2020 of flat to down 25 basis points. Now, it doesn't sound like a lot, but it's against our previous assumption for Fiscal Year 2020 that had been a net market basket update of positive 2.4%. So, the delta for us is down 2.4% to 2.65% against what we were otherwise anticipating.

And that's a price cut, which means there really isn't anything we can do with regard to offsetting cost of input or any expense savings that you might see if this were coming out of volume versus a price cut.

Again, the rule is in its proposed form. There's a comment period that will extend through July. We're engaging both as an individual company and also as part of various industry groups to provide additional comments on how we think the CARE tool can be improved to CMS during this period. But whether or not there will be any changes from the proposed rule to the final rule is yet to be seen. And therefore, that's our anticipated impact.

We don't have quite the same visibility with regard to Home Health.

Unidentified Participant: So, maybe before we jump to Home Health, on the IRF side oftentimes when there's, like, a redistribution like this then it makes certain other categories maybe more profitable than they were in the past. Do you see any opportunity to maybe shift or take in new patients as a result of this, that maybe something was not appropriately paid for but now is more appropriately paid for?

Doug Coltharp: We've never pursued patient mix based on the relative profitability of each class. We've done it to try to go where the demand for services is highest and also where we can create the most competitive differentiation. And so, you see us skew towards the high end of acuity. I mentioned stroke is about 18% of what we treat. Neurological disorders, which are also associated with a highly complex patient, are almost another 20%. So, almost 40% of our patient mix is skewed towards those two categories.

And the fact is that the incidence of those two maladies in the aging population is only going to continue to increase with the demographic tailwind. So, even if there is a lower margin assigned to those patients, the demand is great, the volume is there, those patients are in need of our services, and we have the clinical programs in place at our hospitals to effectively treat them and create good outcomes. We'll continue to pursue that strategy.

Unidentified Participant: Okay. So, that was going to be my follow-up, was that then stroke, because you've been doing a shift to stroke over the last several years, that strategy has not changed at all.

Doug Coltharp: And we're really just at the tip of the iceberg in terms of being able to provide our services to stroke patients, and I think the increasing awareness in the medical community of the benefits of inpatient rehabilitation for patients recovering from a stroke is only increasing, as well. We assess our nationwide market share across all payers of stroke to only be in the 5% to 6% range, and it's been growing nicely at about a 6% CAGR over the last three years. But there is tremendous upside in terms of, again, being able to bring the right level of services to patients who are recovering from a stroke.

And you mentioned that there's no obvious kind of cost offset on the IRF side from this. I guess, historically, we usually kind of think that whenever there's a rate cut we just kind of say, "Well, they'll be able to offset one-third of it." I don't know how, but you guys always seem to figure out a way to offset some portion of it. I don't know. Is it less obvious now? Or you are going to find some way but there's just no direct offset, is what you're saying.

Doug Coltharp: If you look at our overall cost structure, we are by far the most efficient provider in the industry. And about 50% of every revenue dollar on the IRF side is consumed by salaries, wages, and benefits. This is a competitive market for skilled clinical resources. We employ predominantly nurses and therapists. And right now we have penciled in for kind of our long-range assumption that salaries and wages will increase about 3% per annum, and the benefits portion, which is almost solely comprised of group medical expense, will be up in the 6% to 8% range. And it's really hard for us to do anything to get more efficiencies around that.

We also look at labor productivity, and we measure that with something called EPOB, employees per occupied bed. And we tend to run in the 3.4 to 3.5 times, which given the complexity of the patients that we're addressing we really just don't think it makes sense from our operating model to produce the kind of patient outcomes we want to, to try to drive that down any further with efficiencies.

We'll turn to Home Health in a minute, and I think there are some incremental opportunities there.

There are opportunities elsewhere on our P&L to get leverage in certain categories just based on continuing economies of scale. We'll continue to look for ways in supplies. We've done a pretty good job with that, and we saw some further evidence of that in the first quarter. And then things like occupancy expense and corporate G&A can get levered with incremental revenue growth.

Unidentified Participant: Okay. Great. So, now let's move on to Home Health.

Doug Coltharp: So, continue to throw acronyms at all of you. There's a payment model change that is happening in Home Health, as well. Again, it's going to take effect when it becomes operational on January 1 of 2020. It has the same core objective as the movement to the CARE tool, which is eventually to move all post-acute sectors towards a more common patient assessment vehicle.

This is a model called PDGM, which stands for Patient-Driven Groupings Model. It will do a number of things to revise the basis of reimbursement for home health providers. One of the things it does is it reduces the days in an episode, which is the method for payment, from a 60-day episode to a 30-day episode. That may not sound like it's doing

much, but there tends to be – based on the type of patient you're treating, there can be a heavy skewing of visits during the first part of a 60-day episode. So, it may be that all of your visits occur during the first 30 days. And if you don't have this basis of a 60-day payment model, you can wind up with your reimbursement for that particular patient getting cut in half without having reduced your workload, at all. So, there's some anomalies that kind of flow through on that basis.

It is – we are awaiting the proposed rule for Home Health because it starts on a different calendar year. We won't get that until the end of June. Based on the dialogue that was included in the rule-making cycle for last year and applying how the rule was scripted then towards our recent historical patient mix, we think it would translate into a net pricing decrease for our Medicare patients of about 3.8%, just based on the composition of the rule.

Now, there's a second and more insidious feature built into the rule from last year, and it's a called an assumed behavioral adjustment. And so, historically, what the Medicare administrator, CMS, has been able to do is if they institute some rule changes and they ultimately look back and see that as the rule is adopted providers changed the way that they operate – they made a behavioral adjustment – then they will, based on that observed behavior, make a change to the base rate so that the implementation of that rule had proven to be budget-neutral.

What's unusual about the current PDGM is that it makes an assumed behavioral adjustment. So, CMS hasn't actually observed that this will happen, but they're anticipating when all of these changes go through that providers are going to make certain changes to how they operate and that, left untouched, that would have had the unintended consequence of raising reimbursements rates by 6.4%. So, in the wisdom of CMS, what did they do? They said, "Well, we'll just cut the base rates 6.4%, and then you'll be back to neutral."

Now, again, the magnitude of that behavioral adjustment is unprecedented. The fact that it's being done on an assumed versus an observed basis is unprecedented. In the rule-making cycle last year, CMS was kind enough to lay out a path for us to say "this is how we anticipate providers will get to that 6.4% benefit," and fully two-thirds of it was based on one assumed behavior change, and that is that all providers when they have a secondary diagnostic code for a patient that would result in a higher reimbursement level than the primary diagnostic code will choose to flip them and go with the secondary code.

From a programming perspective, we could flip a switch tomorrow and make that happen 100% of the time. There's just one small problem with that: we believe it constitutes Medicare fraud.

And so, we've gone to CMS and said here's our position, not just us but as part of the industry group: we think this is fraud. And they said, "We'll look the other way. You're good to go on that." We said, "That's great." We said, "What about DOJ and OIG?" And they said, "We can't speak for them." So, that's a problem.

The good news is this behavioral adjustment is getting a lot of attention in Congress, where we've been lobbying as a company and where the industry has been lobbying. Home health has a lot of bipartisan support in Congress. There is a Senate bill that has already gone through that would limit CMS' ability to make behavioral adjustments of this nature, and there is now support in the House from Congresswoman Terri Sewell, who we're proud to say is from Alabama.

And so, we believe one of two things will happen once the proposed rule comes out. First, we think when the proposed rule comes out in the late June time frame, it's unlikely to have any significant changes from the prior version. It's going to look and smell like it did before.

But in the comment period that goes between the proposed rule and the final rule, there will be two streams of action: continued comments from the industry regarding the composition of the rule and then working now with Congress to try to get something legislatively done to remove that behavioral adjustment if in fact CMS chooses not to do it proactively.

Unidentified Participant: And it is a little strange, to your point, because my assumption was that if CMS is putting in a behavioral adjustment, whether they mean to or not they're essentially encouraging the industry to make the behavior that they're saying the industry will make anyway.

Doug Coltharp: That's right.

Unidentified Participant: It's kind of like a self-reenforcing dynamic.

Doug Coltharp: Exactly.

Unidentified Participant: In order to mitigate it you have to do what they say you're going to do. So, to your point here about there's a little bit of gray area about CMS is fine with it but we don't have the sign-off from the other agencies, would you feel comfortable going ahead and making this if CMS does this?

Doug Coltharp: No.

Unidentified Participant: Because it would be strange for CMS to say, "We assume that the industry will commit fraud and we're going to make a rule where we assume that they're committing fraud." It seems like you have some cover from CMS as a defense from that. But you're saying you wouldn't pursue that.

Doug Coltharp: Absent something affirmative from all three of those agencies, we would not make the change.

Unidentified Participant: And is there any precedent for that? I've never heard of that before.

Doug Coltharp: We could not find any, no.

Unidentified Participant: Okay. And when do you think –? So, you mentioned a lot of bipartisan support, and we're hearing the exact same thing for this. Is there a thought about the timing exactly of when that bill would be...?

Doug Coltharp: I think that Congress is unlikely to take any action before they actually see that CMS was not responsive in the proposed rule. And then I think the heat will get turned up, both in terms of Congressional pressure on CMS to do something without it having to be legislated and, if they don't see progress there, to purse legislation. So, I think there's going to be a lot that happens between the July and October time frame on this.

Unidentified Participant: And then, what about the other one-third? You said that two-thirds is kind of the one dynamic. The other one-third, are those behaviors that you could adopt relatively easily to mitigate this?

Doug Coltharp: They're complex. So, there are a couple of assumptions in there. One of them has to do with LUPA coding. I won't bore you with another acronym. But the problem with that in terms of choosing a LUPA code is there are 400 different codes that are applicable to LUPA patients right now. So, it would have to be very nuanced. There's probably an algorithm we could build into our systems around that that would help there, but probably not ready to go into effect on Day One.

There's a second assumption that also is a little bit problematic that says with low-cost outliers if you're there because you're not getting enough visits per episode, that providers will manage, but it's just plus or minus one visit, that you'll manage to that optimal visit level in order to get a higher reimbursement. And again, we're not sure that that's consistent with executing the appropriate plan of care on a patient-by-patient basis.

Unidentified Participant: Okay. And so, then you mentioned that when we were going through the IRF side of things that there might be some offsets here. Are you talking about this? Or is there additional offsets that you might think about (inaudible)?

Doug Coltharp: Yes. And I think it's a very different type of labor management that you have in Home Health versus in an IRF, where you have more of a fixed-cost basis on that. And our Home Health, under the leadership of April Anthony, is just really good about using metrics and getting very sophisticated in terms of how you get additional productivity. And we already started to see some evidence of the gains that they're able to make in the first quarter of this year. And in the first quarter of this year what we reported is we had a very small year-over-year reduction in the cost per visit, which is good when you're seeing labor costs and so forth increase. And we also had a small reduction in the number of visits per episode. And in spite of the fact that each of these were small adjustments, when you apply those together across all of the visits we have in a quarter it made a significant difference in our margin.

And the way that we're getting there, with regard to the cost per visit one of the things that we've spoken about before that we're continually refining is being able to match the license of the caregiver to the needs of the patients. Now, that sounds fairly simple, but it means that you've got to be able to look at a patient's condition and say, "What level of clinician do I need to really be able to administer the appropriate level of services to that patient?", and then to be able to do route planning – and this requires some market density – so that you have a clinician operating at what we call the highest level of their license as frequently as possible.

On the visits per episode, it's really two things. One is we're using a third-party tool. It's with a company called Metalogix, that some of the other home healthcare providers use. And that helps in our care planning in terms of, historically, even though within our Home Health patient base we have a pretty wide dispersion of patient acuity, we tend to be very clustered – and this is just kind of something that is a bias within clinicians – we tend to be very clustered in terms of our plan of care around the number of visits per episode that each one of those patients gets.

And in fact, there ought to be more of a dispersion which matches the distinction in the patient acuity. A Metalogix tool helps us assess the patient and determine the optimal number of visits. That then stands as a guide for the clinician. They still have to use their clinical judgment to try to establish the right number of visits per episode. And that's allowing us to reduce some of the visits.

As part of that plan, as well, we've looked at what each one of our caregivers is actually doing during the course of a visit and tried to optimize their activity there. And in a number of instances, what we've determined is if we lengthened the duration of a visit by,

say, five or 10 minutes, it may allow us to accomplish more and to ultimately decrease the number of visits in an episode, and that results in a positive trade.

So, all of these things are on the margin, but we think we're very effective at identifying these opportunities and executing to them. And again, we had empirical evidence of that progress in the first quarter.

I want to say, too, with regard to these payment changes, they'll be administratively cumbersome to move through. They'll have some temporary effect on our ability to grow EBITDA. None of these change our strategy and none of these things change the enthusiasm we have for the businesses that we operate, which benefit for the next decade-plus based on the aging demographics in this country. I think all of you are aware – many of us in this room fall into this category – but the vanguard of the baby boomers were born in 1946. So, they turn 73 this year. The age cohort for the next five years, or so, between 75 and 85, has a CAGR of 5%, whereas the U.S. population over that time frame has a CAGR of less than 1%. The average age of the patient that we treat in both of our segments is 76.

So, that demographic tailwind is still in front of us, although it's getting awfully close, and it just means that the demand for the services that we provide is only going to continue to increase. And what's been happening to supply over the last decade? Well, over the last decade the supply of licensed IRF beds in this country has been flat. We've been adding capacity, but it's been coming out of other providers; most notably, the not-for-profit providers, in many instances driven by the Affordable Care Act, because when that included a broader insurance coverage many of those acute care hospitals that had operated an IRF unit within their hospital chose to repurpose that space for general medical and surgical utilization. And so, the supply has not increased with the demand, and that demand is only going to increase.

And you've got somewhat of a similar phenomena that's happened on Home Health. Home Health is benefiting not only from the growing demographic, but also disintermediation, predominantly out of SNFs, as providers and payers look to reduce as much as possible post-acute inpatient stays and move those directly into the home. And if you've got a highly clinically oriented home health business like we do, you can take a more acute patient and potentially bypass a SNF stay altogether.

So, all of these – and from a supply side on the Home Health, you've gone from 14,500 licensed agencies in the U.S. five years ago to I think the most recent number is 11,800.

Unidentified Participant: And I guess, structurally, when you think about the rate growth, obviously 2020 is kind of an unusual year. But even when we get kind of past that, you had said that, like, 2.4% or 2.5% was kind of what you thought the rate should generally be. And you talk about wage growth of 3%, I guess, in both of your businesses.

Doug Coltharp: Right.

Unidentified Participant: So, when you think about that just setup, how do you think about your ability to maintain or even improve margins from here? What's the building blocks that you (inaudible)?

Doug Coltharp: I think if you can get into a more normalized rate environment, which would be, say, in the 2% to 2.5% for Medicare fee for service, and because most of the Medicare Advantage business is correlated to that it would tick up at about the same level. That if wage growth is at 3% and let's say your healthcare inflation – so, your benefits cost – stays in that 6% to 8%, for the IRF business that's about 50% of the revenue dollars. It's a little bit more for Home Health. That gives you an opportunity to basically have offset the

SWB increase with your pricing increase, and then you still have the ability to lever some of the other expense categories based, predominantly, on economies of scale. So, you can see increases in margin once you pass through this base year readjustment.

Unidentified Participant: So, that economies of scale, I guess, is driven by volume growth, you're saying. So, what kind of volume growth then do you need before you can kind of get that leverage that you need on the cost side?

Doug Coltharp: I think if you're getting anything north of about 3% in volume growth you're in a category where you should be hoping to realize some of those benefits. Really, any incremental volume is going to help you there because you've offset the labor cost increase with your pricing increases.

Unidentified Participant: And can you talk a little bit about capital deployment? You guys spend a decent amount of money on CapEx building out new IRFs. How do you think about the returns on that? You spend – from an acquisition perspective, you spend a lot more money on Home Health and Hospice than you have on IRFs. That might just be opportunity. But can you talk about those buckets and where you see the most opportunity?

Doug Coltharp: Yes. So, there is really kind of a paucity of acquisition opportunities on the IRF side. And so, we have grown our capacity there by building de novo hospitals, many of them in joint venture relationships with acute care hospitals, which has been a central part of our strategy for the last 20-plus years, and then by doing bed expansions on existing facilities.

We have a stated target of opening four to six new IRFs per year. We've got four coming on this year and feel confident that we'll hit that target again next year. On average, these are 50-bed facilities. So, it costs anywhere between $25 million and $30 million – unless you go to California, and then it's twice that – to build and open one of those.

And then, in addition to the four new units that are coming on board this year, we'll be adding 150 beds to existing hospitals. If I had to pick one spot to invest capital, I would always choose bed expansions. You're tacking onto an existing facility. You're leveraging referral relationships that are already in the market. You're leveraging the existing physical plant. You're leveraging the staff. And you're building into an established demand curve.

While on the de novos, we target an IRR of north of 13%, it is not infrequent that on bed expansions we'll see an IRR in the mid-30s. So, very nice returns on capital.

A little bit of the opposite story in Home Health, which in many states in the union there continue to be either very strict CON and licensor agreements and/or overt moratoriums on opening new agencies. Because even though 11,800 licensed agencies is down from 14,500, that's still a boatload of agencies to try to regulate. So, CMS would like to see that number come down.

And so, the primary vehicle for expansion is by making acquisitions. Sometimes we make very small acquisitions that simply give us the license to operate in a new geography, focused priority on trying to create more overlap with our IRF business because of the clinical collaboration that takes place between them or making some of these regional acquisitions that you alluded to.

And we've been fortunate in the four years that we've been partners with Encompass Home Health and Hospice we've been able to consummate on three of those. We did CareSouth in 2015, Camellia in 2017, and we've got Alacare pending right now with an anticipated close date of June 1 of this year. And those last two, Camellia and Alacare,

have the added benefit of being roughly evenly split in their revenues between home health and hospice. Hospice is another business line that we're in that we're attempting to build more scale.

Below that then we're able to augment the investments that we're making in these operating assets with shareholder distributions. Our board initiated a common dividend in 2013, and that has been increased on an annual basis every year since then. And that's a committed outgoing cash flow of about $110 million per annum right now.

And then we have shown that we will opportunistically utilize our excess free cash flow and also some of the balance sheet capacity to buy back our own stock when we think it's unfairly valued. And we bought back some in the first quarter. We're really just getting our toe in the water. And we will constantly be evaluating the appropriateness of deploying more capital to repurchase our own shares. That's buying a business that we think pretty highly of.

Unidentified Participant: And can you talk a little bit about hospice, how that kind of fits in? Is that going to be a bigger part of the business, going forward?

Doug Coltharp: Yes, we hope so. Our rationale for getting into home health was that there was a very strong clinical collaboration that could take place between the IRFs and the home health. And that is that about 60% of the patients who get discharged from an IRF require follow-on home health services, and we wanted to be able to administer care to the patients for the full continuum of their episode in order to create better outcomes and a higher degree of patient satisfaction. So, it really made sense to put those two businesses together.

Although you hear home health and hospice uttered in the same breath a lot – and there are some benefits to having them in the same market and with the same company – the same opportunity for clinical collaboration between those two business segments doesn't really exist.

But the rationale for being in that business is, one, that it serves the Medicare beneficiary population, which is what our key focus is. And two, it is also benefiting from the strong demographic tailwind that I described before. And it's got an additional tailwind or two, one of them being a shift in societal desires to have end-of-life care provided in the home setting and not filled with tubes in an acute care hospital under heroic measures for a 95-year-old patient.

And also, when you look at trying to meaningfully change the cost curve from Medicare expenditures in this country – many of you have heard the statistic – somewhere between 25% and 30% of the total Medicare annual budget – now, that's an annual budget of $800 billion – somewhere between 25% and 30% of that is spent in the beneficiaries' last 30 days of life. And so, we can't really talk in this country about reigning in Medicare expenditures unless there's more of an acceptance of the hospice benefit.

And you're seeing that in the tremendous growth that the hospice industry is undergoing right now. We've got a relatively small footprint in hospice. We're approaching a run rate of almost $150 million in revenues, though. But we think there are really good opportunities based on the demand and based on our operating efficiency to continue to grow that service line.

Unidentified Participant: In your slide deck you have this slide that says, like, in 2020 you could evaluate new businesses to get into. Are you talking about hospice? Or are there other things that you're looking at kind of beyond that?

Doug Coltharp: There really isn't anything else we're looking at right now. We think that there are such good growth opportunities based on this favorable demand characteristic that I've talked about that IRF, home health, and hospice give us all the avenues we need to successfully deploy capital with high rates of return.

Unidentified Participant: And actually I asked the question about the IRF side, where rearranging the payment rates it doesn't sound like it changes your view about where you should be focusing your business. On the Home Health side, does that do anything? I hear a lot from the managed care side saying, "Taking someone out of a nursing home and putting them into home health is great, but 60% of my costs are in chronic care." So, it kind of feels like there might be an opportunity there if you take money out of rehab and put it into something that might be more chronic care-related to service a new population. I don't know.

Doug Coltharp: Yes, and you're seeing the rise of personal care services and so forth, all of which are things that society will need and benefit from. We've got enough white space in front of us focused where we are, which is on nursing patients and therapy patients. About 55% of our book of business is in-home therapy patients, and we'll continue to be focused there.

Unidentified Participant: All right. I think that's all we have time for. Thank you very much.

Doug Coltharp: Great. Thank you.