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Encompass Health

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Unidentified Participant: Okay, thanks. Good morning everyone. I'm (inaudible). I'm Senior Healthcare Facilities and Care Analyst at UBS. It's my pleasure to have the leadership team from Encompass representing the compass -- the company, we have Mark Tarr, our President and CEO, Doug Coltharp, Vice President and Chief Financial Officer and Crissy Carlisle that runs the investor relations effort for the organization. So with that, we might just get right into some questions.

I thought I would go ahead and address one of the major inbound questions, concerns, that we've been receiving over the last week, two weeks, three weeks, it's just around the setup into 2020 given some of the cross-currents that you face with both the rehab business and the home health business. So I just wanted to start with maybe the IRF changes that you're facing, transitioning, with the FIM tool. When you've characterized the headwind, I think you've stated that you believe that the net of the market basket that the rate update should be about flat to down maybe 25 basis points for the first three quarters of 2020 and then you'll receive, you know, whatever the normal market basket increase will be in the fourth quarter, we call it 2%, 2.5% something in that range. So when I think about all the rate factors, I don't really think about the rate headwind being much of a dollar headwind in 2020. Is that a fair characterization Doug?

Doug Colthrap: It is. Actually, if you take that dynamic with regard to the first three quarters and the fourth quarter on fee for service and, of course, most of Medicare Advantage is tied to the same rate structure and then factor in the normalized increases for the entire year for our managed care book of business. It will get you to a slightly positive price increase for the full year.

Unidentified Participant: Okay, perfect. And then when I look at the core growth of the business over the last three to five years and even isolate the pricing dynamics, we've generally observed the core business sort of growing maybe in the 1% to 2% range easily over the last three or four years, would that still be your expectation that underlying growth of the business could still be up?

Doug Colthrap: I think there's some reason to believe that volume growth will be even a little bit better in 2020 and a lot of that has to do with the past editions that we're making this year. We're bring four new De Novo's online during the course of this year. One of them is going to open later this week in Lubbock, Texas. The other three are in the back half of the year so they'll be hitting their stride as we enter calendar year 2020.

And then importantly, we're adding 150 beds to our existing hospitals as well. Most of

that is skewed towards the back end of this year but that will be a contributor to volume growth as well.

Unidentified Participant: Got it.

Doug Colthrap: And then just for good measure, I'll remind you that next year is a leap year, so we get an extra day.

Unidentified Participant: Got it. And you'll anniversary a number of the rebranding initiatives that you've been making and I don't think there's probably that much of a tailwind but nonetheless probably one other factor or consideration, think about in terms of the intangible opportunities going into 2020.

Doug Colthrap: Yeah, the rebranding cost that spilled into this year, because we completed the field asset rebranding in January was relatively nominal. We had been investing some resources in the preparation for the rule changes that were faced in both of our business segments and given that the rules will still be new to us, as we enter 2020, that investment may stay in place but there may be a little bit of opportunity in the G&A line as pull back on some of those early efforts.

Mark Tarr: But to your point, the rebranding initiative has gone extremely well for us and, as Doug pointed out, this is a process we announced in July of 2017, rule it out in the field in 2018 and finish in the last marketplace in January of 2019 and it's gone exceptionally well, is exceptionally smooth. There was no confusion in the marketplace and people tend to really recognize the Encompass name and how it, in fact, captures our strategic initiative.

Unidentified Participant: Got it, okay. So, to sort of summarize, 2020 net of all the rate changes, commercial, MA, fee for service, the net pricing update should actually probably be slightly positive than flat to down. Okay, and then on the core business, isolating just the core performance of the underlying assets, the De Novo's, the rebranding initiatives. My numbers, not your numbers, but it's easily conceivable to see $15 million to $20 million of growth just from those variables alone.

Doug Colthrap: We anticipate IRF segment, volume growth and pricing growth for next year.

Unidentified Participant: My numbers, not yours, of course. Okay. And then maybe shifting to the home health business. There's a couple of different maybe comments or points, the narratives coming out of different organizations right now and their view of the behavioral adjustment but just to maybe set the facts here, I think the way you've characterized PDGM just to transition away from a therapy driven model in and of itself, not [payroll] adjustments, but just the PDGM transition as maybe a net 3.5% -- 3.8% headwind when you adjust for the market basket and the inflationary update. Is that fair?

Doug Colthrap: That's correct.

Unidentified Participant: Okay. So, that, to me, is about a $25 million headwind alone. So let's just put that into the corner. So you've got a negative $25 million headwind but then I think you've said that you believe you can manage that down to being flat to down, maybe 150 basis points -- 100 to 150 basis points; something in that ballpark. So that would imply that you're starting off point would only be maybe $10 million lower year-over-year.

Doug Colthrap: And, again, just to -- because I know there's been a lot of confusion about the potential impact.

Unidentified Participant: Yeah, I want to take these in buckets so that we make sure that we're crystal clear.

Doug Colthrap: And I think you've done a great job there because within the change to PDGM, each company is impacted by two elements within the rule. There is an element that is specific -- that is company specific, that is based predominantly on your historical patient mix and the referral sources for your patients and so forth and that is the element that results in the initial estimate of the 3.8% price reduction for us and then I know you're going to go to the behavioral adjustment in a moment, but that's common across all providers. So you've characterized the ability to mitigate a substantial portion of that 3.8% appropriately. Some of that is due solely to the fact that we made that 3.8% estimate based on the most recent historical patient data that's available to us and we know that our patient mix has been evolving since then amongst other reasons for the increase in clinical collaboration which qualifies as an institutional referral source. And we believe in terms of mitigating that, and another place that I want to be clear, some of that will be a direct mitigation to pricing impact on the revenue line and it's where we do things like change the balance in our referral sources.

Some of the rest of it will be improvements in productivity that don't offset it in the revenue line but offset the impact on the EBITDA line and you saw great evidence of that in the first quarter where we were able to post a year-over-year decrease in cost per visit and in visits per episode. We would expect those elements to perpetuate into 2020.

Unidentified Participant: So just aligning the clinical staffing model to the new payment model is maybe a good way to look at it?

Doug Colthrap: And just getting more efficient overall. It's not necessarily just related to the implementation of the new payment model, it's our constant striving to be the most efficient and most effective provider --

Unidentified Participant: Field level adjustment I think is the most important way to look at it.

Doug Colthrap: Yes.

Unidentified Participant: Okay, okay. So that will get us to being down 100 to 150 basis points so that starts off, you know, down maybe $10 million in the hole then we shift to the behavioral adjustments. Now, of course that's a 6.4% behavioral adjustment headwind for everyone within the industry, some people have characterized it a little bit differently. So that, on paper, would be about a $40 million reduction so maybe give us your latest updated view on what you can do or what you plan to do or maybe just the dialogue that you're having with CMS and policymakers.

Doug Colthrap: Yeah, so within that 6.4%, I know this is another element that has created some confusion, CMS pointed in the final rule last year to the fact that about two-thirds of that behavioral adjustment was an assumed changing and coding practices. And specifically they cited that in about one-third of the cases they reviewed, there was a secondary diagnostic code that if had been made the primary diagnostic code would have resulted in

a higher reimbursement level. So they were specific about that, about a third of the cases they reviewed.

Then they got very nonspecific and said we believe that for a portion of those, it would be clinically appropriate to switch the two codes. With the difficulty for us in trying to actually implement a behavior change that would correspond to that is that we believe that we have been coding in a clinically appropriate way all along. There weren't any changes for us to make on that.

If it goes in, as stated, we will continue to look for productivity adjustments, we'll continue to look for ways to offset a pricing impact with volume increases but there's not a lot that I can point to that would be directly an offset to that 6.4% behavioral adjustment.

Unidentified Participant: Okay. I mean, is there maybe a number in mind that you have to say, just given some of the field level changes, some of the efficiencies, some of the staffing redesign that we can do, we -- we can -- feel like we could -- we could maybe mitigate a quarter of that, 50% of that, you're not at a place where you want to make a commitment?

Doug Colthrap: You know, we never say never and I think as we've demonstrated through our track record is we are as good as anybody out there in both business segments at adapting to a changing environment but we thought we were doing pretty well to say that we were going to almost fully mitigate to 3.8%. This is -- it's just a straight out price cut.

Now, we're optimistic and I think we've expressed this as well that either through changes that are likely to occur in the rule between the proposed rule and that has dropped in late June or early July in the final rule or outside of the rulemaking process through legislative action and congress, that there will be some relief around the behavioral adjustment.

I think the two most likely forms of that relief are either in mandate that it will not be done on assumed behavior but actually been retroactively based on observed behavior which has been the historical precedent utilized by CMS and/or that there will be a cap on the amount of cut that could be made in a particular year so that it would be phased in over time if, in fact, that change in behavior is observed.

Unidentified Participant: Got it. So maybe two other factors to think about before we move on from home health just bridging into 2020. So if we have a $10 million headwind from the therapy changes in PDGM, you have another $40 million worse case, so we're down maybe $50 million before any other tailwinds. Clinical collaboration you continue to execute extraordinarily well relative to our internal expectations. That historically has been anywhere from a $10 million to $15 million annual tailwind and then M&A of course, we haven't even talked about that, what's been announced and hasn't been announced that easily could be another $10 million or so, in my mind. So, you know, I sort of like add these two together and it seems to, I think reduce maybe about half of that potential headwind that you're facing. So maybe just some other considerations.

Doug Colthrap: Yeah, I think the point that you're making is when you're facing a pricing cut, obviously, your path to growth is through volume and on the home health side we've been growing our organic business in the high single digits, pretty regularly, with about 20% of that

growth into increases in clinical collaboration and then in these last two years we've had a good sized acquisition in addition to some smaller bolt-on ones. We anticipate that we'll close on the Alacare transaction on June 1 of this year. The 2018 revenues for Alacare were just under $120 million. We'll get a half year benefit from that this year and then a full year benefit including additional growth in 2020 and we will, again, seek other acquisition opportunities.

All right, shifting gears a little bit to the inpatient rehab segment. Over the last three to five, even further than this, health -- Encompass has really focused on trying to grow stroke, neurology, brain injury, a lot of the more inelastic, nondiscretionary types of services, can you talk about some of the latest, you know, operational initiatives that you have; service line development, anything that makes you optimistic as you look out over the next two to three years?

Mark Tarr: Sure, so almost a decade ago now, we made a commitment that we were going to shift away from a lower acuity patient which was typically associated with orthopedic patients back then; more toward a higher acuity patient, stroke and other neurological cases of which those two categories right now make about 40% of our overall discharges.

We have shown a real ability to come in and have significant results on outcomes and growth attributable to stroke cases. If you look at the overall stroke population in the United States, it will be about 800,000 cases this year. Of which 142,000 or so of those won't survive, so that leaves a substantial portion, a little bit over 600,000 cases of what we would look at as opportunity.

Last year we had 32,000 stroke discharges. So we have about a 5% market share in stroke currently, which has been growing each year so we've really tried to brand our stroke program where you have used it in terms of our opportunities to go out and negotiate with innate plans on the value proposition. So it's an area that we see as significant growth opportunities go -- going forward. These are non-discretionary patients. To your point with --that they aren't deciding where they go home or go to the hospital, they're going to be in an inpatient facility and we think we're the best option for those patients.

Unidentified Participant: Can you spend a minute talking about the collaboration, the partnership, with the American Heart, American Stroke Association? You know, how you think about a national branding campaign, you know, just where that partnership evolves over the next --

Mark Tarr: So we have a long history in our marketplaces, individual marketplaces dealing with the American Stroke Association, American Heart Association and there are very positive relationships. So this year we made the jump towards a national effort with our organization as well as American Stroke Association on a national front. We saw this as an opportunity not only to continue our campaign of marketing our outstanding stroke program but it was also a good time to pair it up with our name and brand change to Encompass Health.

So we have started rolling that out. It involves everything from sponsoring Go Red for Women luncheons across the United States and our various marketplaces. It involves a social media aspect where we have videos of stroke patients. We have established a

brochure with additional resources in terms of caring for patients that have suffered a stroke, the American Stroke Association, of course, is focused on the prevention side. So it's been a nice branding effort for us. We're still early on but it's a three-year initiative. We're about halfway through the first year of which we think is a real positive result in terms of recognition within the community marketplace. I think it will just continue to help our ability to grow our market share and being linked with stroke.

Unidentified Participant: Many years ago, three, four, five years ago, you made some staffing model redesigns, I think, to sort of position Encompass for your mix and where you aspire to take your business and I think there was a year maybe 2015, 2016, where you had a noticeable amount of pressure on some of your premium pay costs and maybe some of your contract labor and since then it feels like we've seen a leveling out for two years now, not seeing any outsized inflationary pressure on some of your wage.

Maybe just an update, Mark and Doug, on how you look at your nurse staff costs today, how you think about your clinical staffing model within rehab, whether or not you need to make any additional changes or if you feel like you're really well positioned for -- to grow your volume over the next two, three years?

Mark Tarr: Well, I think we are well positioned going over the next two to three years. And we think about staffing, we -- and turnover, we -- we're really focused on retention and if we can retain the staff, not have the turnover then you're not put in a position where you have to take on the extra cost of recruitment and potentially bringing in a replacement staff that are higher salaried then the ones that you turned over. So, whether it's clinical education, whether it is ongoing professional opportunities for our nurses and therapists to develop their specialty programs and clinical programs that we have in our hospitals, we've done a really nice job in being an industry leader and retaining our therapists with a single digital turnover rate which is well below the industry.

When you look at nursing, of course nursing is more difficult than what we've seen in terms of therapy marketplace but we are below the industry standard on that as well. So our initiatives on both of our operating segments to retain the employees and not have the turnover and look at everything form education to our benefits, to having a marketable salary has allowed us to continue to retain our staff, position ourselves well for growth going forward and really having, once again, it's that brand recognition within the industry and those that are looking for jobs in either therapy or nursing, they want to be in rehabilitation, they're going to think about Encompass Health.

Doug Colthrap: And with -- specific to the hospital staffing model changes in that 2015 and 2016 timeframe that you referenced, it was really the convergence of three things. One is, as Mark alluded to earlier, that was really during the timeframe when we were accentuating our ability to implement the more complex clinical programs across the mix and so we did have to change our staffing in order to meet that higher percentage of stroke and neurological patients.

The second thing was, that was the advent of new quality reporting requirements for the IRF segment and we didn't want to pull people away from administering care to administration and so we added some resources to augment that. And the third significant piece was Reliant. We acquired the 15 Reliant Hospitals and they had a very different staffing model, focused much more on the lower acuity ortho patients.

Unidentified Participant: In that same timeframe you guys also made a major investment over a three or four year period in to some clinical IT software with Cerner and I think that's had some maybe additional benefits in terms of recruiting and retention. Maybe just in the quick update on the return that you've seen on that investment to-date?

Doug Colthrap: It's very difficult to isolate a return on that. We can tell you that it is a huge competitive advantage in many of the ways that Mark just alluded to. First of all, the workforce, the clinical workforce that is now sought after in a very competitive way wants to work in an automated paperless environment.

When you start thinking about the movement towards increasing episodic payment models, your ability to have information flow seamlessly on a real time basis from provider to provider is essential. A small example of how that worked for us, is one of the components of our value proposition to acute care hospitals is that we can help you reduce the length of stay in your hospital, which obviously increases their margin. And we can do that because we can respond to an electronic referral submission so much more quickly than our peers and make a decision on the appropriateness of that patient coming into our facility. So that's one tangible example.

And then I think just always where we will start to see it show up is eventually our ability to resolve all audits including ADR's on a more real-time basis. In order for that to actually show up into the numbers, we've got to start getting past the 2011 backlog but we're already seeing a positive impact and you see that on our most recent bad debt numbers.

So all of those are elements of the return. We feel very positive about the system-wide implementation of -- as we refer to it internally as [ACIP], and now we're in kind of a continuous upgrade mode.

Unidentified Participant: That's a good segue to the recent changes with your Medicare audit contract. You guys continue to sort of underwrite an expectation this year that your denial rate and your denial and bad debt will remain higher than, I guess, the recent experience. You'd rather get a little bit more actuarial experience before you adjust your actuarial assumptions. So, maybe just give us an update kind of like where you are in some of the assumptions that you've made that you're really evaluating today that you may, in the future, look to revise?

Doug Colthrap: Yeah, absolutely. And there are really three components to how we're estimating our bad debt experience. One is we said initially that we had transitioned from Cahaba as the [math] presiding over about 80% of our IRF revenues to Palmetto. And not having had any historical experience with Palmetto and that was a transition that was made in February of 2018. We just wanted to have some time pass to see how they were interacting with us and to determine whether or not it was going to be similar to distinct from Cahaba. It has been very distained, it's been a positive experience and we feel like that is going to continue into the future.

The second is that CMS issued some new guidelines to all [MAC's], with the acronym TPE, that changed the way that they would audit and the audit cycle and we needed to gain some experience on that. We're still gaining that experience, thus far, we've had

very good experience where TPE has been initiated. We've been able to successfully resolve the [denied] claims through that process without any kind of extrapolation. So hopefully with a little bit experience, that will factor into our assumption. But, the third thing that's going to limit our ability to adjust that assumption for bad debt down in the near-term, is it's aging based and we have such a significant portion of claims awaiting adjudication in the backlog, I mean, we're up to $185 million in AR sitting in on the balance sheet that dates back as far as 2011 where we have historically prevailed at a very high rate but until we actually see those move through the pipeline, we can't adjust the bad debt number down.

Unidentified Participant: -- what you're success rate is when you [yield to the LJ]?

Doug Colthrap: A little over 70%.

Unidentified Participant: Yeah, okay. We've only got like a minute left. Doug, maybe just spend a minute talking about the clinical collaboration model, what your long-term targets are, what the experience has been, what you're hearing in the field in terms of patients and their level of satisfaction wit the continuity of care that's being delivered in that strategy.

Doug Colthrap: Mark do you want to take that one?

Mark Tarr: Yeah, so the clinical collaboration has gone extremely well for us. Our near-term goal now is 40%. We ended last quarter at 36%. As you said, one of the nice things we're starting to see on this is not only the collaboration percentage but our ability to coordinate at the time of discharge from one [standing] to the next leads to increased patient satisfaction with the overall experience. So we think that there will not only be this collaboration percent increase in benefits from that which tie to growth and financials, but you're also going to have a qualitative aspect of this too that just the fact that we are clinically collaborating and coordinating the care just is yet one more opportunity for us to show our superiority in the post acute setting.

Unidentified Participant: Well, great. Well, with that we are just out of time. We can take it downstairs for some more Q&A. Guys, thank you so much.

Mark Tarr: Thank you.