Encompass Health
2019 Wells Fargo Healthcare Conference
September 5, 2019
9:35 AM EDT

Peter Costa: Good morning everyone. I'm Peter Costa, I'm Wells Fargo's Healthcare Services Analyst for those of you who don't know me. Welcome to Wells Fargo's 2019 Healthcare Conference; second day, hopefully you'll all getting good meetings and enjoying it. I think there's been a lot of good stuff so far and right now we're very pleased to have with us Encompass Health. And from Encompass Health we have with us Mark Tarr, the President and CEO and Doug Coltharp, EVP and CFO of the company and there in the back is Crissy Carlisle who is the Chief Investor Relations Officer.

We've going to do this as a fireside chat but before we start, I just want to point out, Encompass really has a strong position in the rehab market. They are a leader, by far, and they run some great facilities and I want to talk about sort of where are you positioned today but also some of the near-term pressures that you have on reimbursement and so I'd like to start on some of the pressures on reimbursement and understand sort of what's going on there.

Next year, in your home health business, you talked about the implementation of the patient driven groupings model, PDGM to say it easy, you talked about sort of the estimated negative PDGM impact of 4.1%, partially offset by 1.3% rate increase, market basket rate increase. And then assumed behavioral changes, you know, reduction of about another 8% if those behavioral changes don't happen. But combined, that's really a 10.8% payment cut in home health. It's a very material cut. Can you walk us through your plans to offset that rate pressure?

Mark Tarr: I'm going to ask Doug to go through the map on that. He's done this numerous times now so I'm going to ask him to cover the details on that.

Doug Coltharp: I think it's helpful to separate it into those two pieces. [Impact to the] rule itself is the 2.8%. Step aside for just a moment, the behavioral adjustment is 8%. On that 2.8%, what we said as recently as our second quarter earnings call is that we believe that we can offset a substantial portion of that; some of it on the top line just based on the evolution, you know, patient mix, some of it through additional labor productivity. Regarding the patient mix, the estimate of the net 2.8%, 4.1% less than market basket update, is based on our 2018 patient data, the most recent data available.

Under PDGM there are higher reimbursement rates for patients that flow from certain specific referral sources. What we know based on some proactive measures and based on activities such as clinical collaboration, our patient mix is trending up higher on the (inaudible) and there are other changes within patient mix that are going to receive more

favorable treatment. I think some portion of that 2.8% would be mitigated by the time we move into 2020. There will be some portion of the revenue line that we're not able to offset but as evidenced in the first two quarters of this year, we had been making good progress on a couple of labor productivity and coding activities.

Particularly, in each of the first two quarters of this year, our cost per visit is relatively flat and the number of visits per episode have come down. That is based on some data analytics that we're using, predominantly to make sure that we can have our licensed physicians spending a greater percentage of their time operating at the top of their license and also to make sure that we are taking better measures to align the number of visits per episode to the acuity of the patient.

Currently true for us as well as most other providers, if you look at the dispersion around the mean for visits per episode, it's relatively narrow. But when you look at the acuity of the patients that we treat in home health, it's much broader. There's an opportunity to flatten that curve out a little bit for a more efficient part of our labor. We think those two together, as we carry those initiatives into 2020 will offset a (inaudible).

Behavioral adjustments are more vexing. We have estimated that each 1% of the behavioral adjustments that we aren't able to offset creates a headwind going into 2020, back to $8-9 million dollars on the [guideline]. Three-quarters of the behavioral adjustment function that we will change our [coding] practices, we're still evaluating that. We think there may be some aspects of that that we would find problematic including a clinically appropriate manner to this date. We really don't have an estimate to how much it could offset. April Anthony, who's the CEO of our home health and hospice division on the second quarter call said it felt like the best case scenario was 50 to 60%.

Peter Costa: Okay, I think you actually increased the amount that was tied to coding practices from 4.2% to 5.9%. That's the part that's the hardest to get at and the 50% to 60% is applied to the 5.9%.

Mark Tarr: The full 8%.

Peter Costa: To the full 8%, correct. All right. For the IRF business, there's also some light pressure there. And you cited flat to up 25 basis points for 2020. Others have said the rates are a little bit better for them. Why are the rates worse for you guys than for others?

Doug Coltharp: So, under the new payment model, which is a transition from the FIM, patient assessment tool, to the care patient assessment tool, there's a condensation of certain BRG codes. The area that is most impacted is stroke. Stroke is going from what is currently ten different RIC codes with stratified reimbursement to a fixed payment model. What is happening, we're finding, with the reimbursement is about 18% to 20% of the patients that we [have that are stroke]. We have a higher patient mix oriented toward stroke and neurological and do most of our competitors. That's been by design, it's been something that we've been pursuing over the course of the last decade; thought to move away from in order to [see] the patient mix, the higher acuity stroke [and/or] mix, it happens to be that those diagnostic categories aren't really impacting the lower acuity categories under the new payment.

Mark Tarr: Peter, I think it's important to note that, going back to PDGM, there is a chance for

legislative relief, there are sister [bills] out there; one in the House and one in the Senate Both of these bills have significant support. There are about 20 members of the Senate that have cosigned and there are 60 in the House that cosigned that bill and the bills would force CMS away from the prospective approach of the behavioral adjustments and propose a phase-in of any adjustments going forward based upon actual data and behavior exhibited and then phased that in at no more than 2% per year up through 2025.

So we had been working very hard in Washington with members of our team, our full-time lobbyist, up there to make sure that we're getting the message out to members of Congress. We've been very pleased with the receptivity and the conversations we've had with the members of Congress and (inaudible).

Doug Coltharp: Pete, I think you know, we're cognizant of the fact that investors and markets in general don't like uncertainty. When you look at each of the two payment model systems that are to be put in place for our business segments in 2020, they're extremely large and complex. In spite of their best efforts, CMS is not going to get everything right. There are going to be consequences that are going to mean that 2020 will be a bumpy year for everybody at least in these segments. What it doesn't change is our enthusiasm for these (inaudible). The average age of the patient we treat in our rehabilitation hospitals is 76. The average age of the patient we treat in home health is 77. We treat high acuity patients with largely nondiscretionary illnesses in both of those business segments, which work effectively together with clinical collaboration.

Age cohort in this country between 70 and 80-years old, because of the aging of the baby boomers, has a CAGR over the next five to ten years of nearly 5%. In that same timeframe, the U.S. population has grown 1%. Demand for the services that we provide is only going to continue to increase. Somebody has got to be there to provide the care.

These payment model changes are going to put pressure on volatile, less capitalized players that we think the prospects for our business. Set aside 2020 (inaudible) for the minimum of a decade, beyond 2020 are extremely good.

Peter Costa: Mark, getting back to the legislative [potential fix], it's been hard to get anything passed in healthcare, almost anything passed at all in Congress these days. Is there some vehicle that could carry those, that legislation separately or would it have to go on its own?

Mark Tarr: Yeah, we think that there would be opportunities from now through the end of the year on a number of appropriation bill opportunities that came out of the budget deal earlier. It may come down to December, there may be opportunities before then. We're not sure exactly how the politics will take place, but we do believe that there are opportunities (inaudible).

Peter Costa: MedPAC recommended 5% rate cuts to the IRF business, and this is not nearly that. And CMS seems to have ignored the MedPAC recommendation for now. Do you think that's going to come back and is that something that's going to haunt you going forward?

Mark Tarr: I don't think it's going to haunt us going forward. As you noted, if you go back and you look historically, CMS's willingness to file the recommendations from MedPAC has actually been [rare] over the last ten years. MedPAC focuses in on margins, if you look at the margins, people on the IRF side of the business noted 5% reduction

recommendation came out. There are many more providers in this segment, at single digit margins versus 14% margin for the (inaudible)

-- towards the freestanding hospitals versus units housed within hospitals and very fragmented and a lot more providers that exist in those smaller units with those lower margins. So, I don't think that we would be penalized more than others would, nor do I see this 5% reduction (inaudible).

Doug Coltharp: Pete, if you looked back over the last decade, you'd find a remarkable consistency of MedPAC recommendations for all post-acute sectors around a 5% reduction. And that's in spite of what other changes have occurred within the reimbursement (inaudible) including the rebasing that took place over a four-year period. I think they've kind of lost credibility in that regard. If they would change it up a little bit, people might actually pay attention.

Mark Tarr: I don't think they're going to go in, tweak something where we have so many players with very thin margins so they would penalize a vast majority of providers and not be accomplishing what they're trying to accomplish.

Peter Costa: Doug, you kind of mentioned next year being perhaps bumpy. Will EBITDA grow next year?

Doug Coltharp: Well, certainly we go in with a substantial amount of headwinds from these reimbursement (changes). On the IRF side, even though we're going to get a modest, flat to a modest price increase service, bear in mind as well that on the IRF side, the fiscal year starts October 1. That pricing environment is going to start for us in just another month here and we do believe that by the time we get to the fourth quarter, calendar quarter of 2020, we should see a more normalized service increase in that business. We're still not going to see the kind of price increase that would allow us to get leverage (inaudible)

I think the single biggest line item on the IRF side that we'll de-lever against (inaudible). When you combine what we're anticipating with that zero to 25 basis points with the other payer categories, we estimate that our total pricing for 2020 will be up somewhere between $8-9 million. But [SWB], consumes about 53% of every revenue dollar. [SW] is about 90% of that [53%], which we estimate will increase about 3% which is the rate of inflation that we're seeing in our clinical workforce around the marketplace.

[The smaller piece], the benefits piece, is probably going to go up between (inaudible) that's going to create a $60 million increase in the base [SWB] that is (inaudible) 2019, 2020. That pricing increase means that before you're able to get into any volume increase, you're only going to be able to offset about $25, or about $30 million to $35 million of that pricing. You've got some natural de-levering. That's going to put the pressure back on volume growth. We've got some things to be encouraged about with regard to volume.

You look back over the last eight quarters, our same store discharge growth has been roughly 2% and is probably a real proxy to consider for 2020, versus this year, we will have added between 300 and 310 new beds to our existing hospitals and to new hospitals. Those new beds can add about a point to a point and a half to this. Before we've done

anything differently in 2020, we think we've got 3 to (inaudible) offset (inaudible) It's a bigger hill on home health because you've actually got a pricing decrease but the same pressure is on [SWB] which is about 68% (of every revenue dollar) in that business. So you're going to have to be even more dependent on volume growth in that business. The good news is, that business is growing fast. Organic perspective, we would expect our home health business, once again, to post a high double digit, same store growth, we're going to have the full-year benefit of the Alacare acquisition which closed on July 1, so we would anticipate volume growth in home health in the low double digits. Hospice has been growing pretty steadily at about 20%.

I think the bottom line, Pete, is if you take away the behavioral adjustments for right now, we think that there's a path to EBITDA improvement. When you have to factor in almost any level of the behavioral adjustments, it becomes much steeper.

Peter Costa: I don't think you've disclosed Alacare's EBITDA margin, do you care to talk about what that would be at this point in time?

Doug Coltharp: Lower than our legacy business but, overall, a very well run business.

Peter Costa: Strong business but not quite where you guys want it to be?

Doug Coltharp: And recognize too, it's almost exactly 50% home health and almost exactly 50% hospice. We got asked some questions in Q2 about why after we had closed Alacare, it didn't seem to factor that into it guidance. Two thing to recognize there, remember, our guidance at the beginning of the year included some contribution from home health and hospice acquisition. And so this was larger than that assumption but it also closed mid-year. It's also the case that even with a well-run company like Alacare, and it was already on homecare home-base, there are integration costs that they placed during the first (inaudible) so the integration training costs are offsetting some of the EBITDA contribution, by the end of 2019, we should see those fall away and should expect a more normalized EBITDA contribution from Alacare for the full year of 2020.

Mark Tarr: That's an acquisition we're very excited about. Integration is doing well and that is a family-owned Birmingham-based business. We knew it well. Our home health team knew it well and had been courting them for some time. So we're very excited how that integrated into our company.

Pete Costa: Right.

Peter Costa: We've spent a little bit more than half the time on all of the tough stuff, let's spend some time on the positive stuff because you've got a lot of that going on. Can you talk about your expansion activities and the additional beds in the existing hospitals as well as, you know, the new facilities you've got coming on?

Doug Coltharp: Yeah, so we've announced, in addition to the Alacare acquisition, on home health, we've been asked a number of new IRFs that are coming online. We have four coming online this year, we've already announced some for 2020. We had -- Lubbock is one of the hospitals that came online this year. That is a joint venture facility up in Lubbock, Texas with [University] Health System up there which is really come on and has been very strong. This week we hope to open up a new hospital in Katy, Texas which is a suburb of

Houston where we have a concentration of hospitals there and cover that marketplace. We're excited about some of the new space that we've opened up hospitals in or have announced that we'll be opening hospitals in; South Dakota, Boise, Idaho. We opened up three weeks ago. We have announced CON approvals in the Atlanta market for up and coming Georgia and another one in Stockbridge, so that's in a northern suburb of Atlanta and a southern suburb of Atlanta. We have 150 new beds coming on in the year 2019 and are excited about the potential for 2020.

So not only do we have a lot of momentum going on in home health, but we also have a lot of momentum going on in (inaudible) and new hospital developmental pipeline.

Doug Coltharp: Excuse me, our IRF development pipeline is as robust as it's ever been. In fact, it's relatively evenly weighted between solo De Novo opportunities (inaudible). If you look back over the course of the last decade, in spite of this demographic tailwind that's been building, the supply of licensed IRF beds in the U.S. has been relatively flat. We think that there are a lot of under-bedded markets that lack the capacity, on the IRF side, to address the demands of the aging population. We're got the capital and the resources and corporate infrastructure to be able to step into that gap.

Another exciting opportunity that we're still evaluating is Florida. As you know, Florida dropped its [CON] regulation in June of 2019. We're working with the state to make sure we understand whether or not there are going to be any different licensing requirements or provisions that might temper our enthusiasm but right now it looks like that's going to provide a great opportunity for us to open up new IRFs.

Looking at the State of Florida, we think that there are a substantial number of under-bedded markets. So, an opportunity to add new IRF's, add capacity to our 12 existing IRF's in Florida could [rise] here very soon and that would be additive to our existing development pipeline, not a (inaudible).

Peter Costa: You've already got like seven IRF facilities as you announced that you're starting for development. One of those is in Florida but you're talking about more beyond that.

Doug Coltharp: That's correct.

Peter Costa: Have to -- and how soon could that happen?

Doug Coltharp: So, if we can get clearance from the state, we can actually begin immediately adding beds to existing facilities without going through any kind of process. It would open the doors on new IRF's by July 2020.

Peter Costa: Great, so that could be very incremental for you guys fairly quickly?

Mark Tarr: It's worth noting that whenever we build a new De Novo hospital, we build it with expansion in mind. So when we talk about adding additional beds to our existing portfolio of hospitals, we have enough land in the footprint of the building to add on (inaudible).

Peter Costa: You added Katy, Texas for the fourth quarter. So opening this week, is that a little bit earlier than you thought it would get opened, or is that what you thought?

Mark Tarr: We're expecting it a little bit earlier and then Murrieta, California is one in the fourth quarter that we plan on bringing on later in the quarter.

Peter Costa: The two locations in Georgia seem like they have a lot of overlap with the already strong presence there in Georgia. Was this the primary reason for doing these facilities or was there some other reason that these facilities made sense for you guys.

Mark Tarr: -- The (inaudible) hospitals --

Peter Costa: Yeah.

Mark Tarr: Those are -- these are in the Atlanta metro area where we don't have a strong presence in hospitals. We --

Peter Costa: In home health. You have a strong presence in home health in Georgia.

Mark Tarr: Yeah, we've started to build a presence in Atlanta metro with home health and yes, and having an overlap marketplace where we have an opportunity to integrate the care of our patients, is a priority for us. This would put a nice stake in our present marketplace.

Doug Coltharp: Our presence in the Atlanta market from the home health perspective began with an acquisition that was made two or three years ago; a little bit before that. But we essentially bought a highly under-utilized skilled (inaudible) and the right to operate in the third legacy business (inaudible) that had effectively been building that up on (inaudible) put IRF's into the market, it's going to allow us to scale that business.

Peter Costa: In the presence of your home healthcare, really wasn't a driving factor?

Doug Coltharp: No, it was more -- we identified within -- relatively indifferent between which of the two business segments was going to enter the Atlanta market first, but what we knew just based on the population growth and the demographics in Atlanta is that we wanted a presence with both business segments together, and the Atlanta marketplace now has that.

Mark Tarr: One of the things that we have developed with time, or skills, around just working through the (inaudible) process in various states. Every state is a little bit different. We had two hospitals, actually three hospitals, in the state of Georgia but we had not been able to really tap into that via Atlanta metropolitan area That's why we're so excited about this, it's a very high growth area and (inaudible).

Peter Costa: Can you talk about your partnership with the American Heart and American Stroke Association and its contributions to the number of stroke patients that you have? And, you know, how does that compare to other categories? Is that much further ahead for you guys. I now you were strong in stroke patients.

Doug Coltharp: We're excited about our stroke program and it's a program now that we've really put a priority on for the last eight to ten years. Stroke patients as a whole do very well in a rehabilitation environment in an IRF. American Stroke Association came out, I believe three years ago, with an independent study that noted that if a patient has a stroke and needs inpatient rehabilitation, the quality is superior and the level of rehabilitation

received for IRF's than for SNF's.

Our decision to work on a partnership co-branding with American Stroke Association involves a three-year agreement where we will co-brand with them, have activities, fundraisers, luncheons, opportunities for us to brand our stroke rehabilitation. It gives them a chance to brand their stroke prevention. It was seen as a good opportunity for us for great exposure for our Encompass brand linked to a very credible well-known, nationally known, organization and the timing was good for us because it also tied, as we were trying to get our new Encompass Health name out there. So, we see this as a win/win. It's difficult to tie right back to how many additional strokes we're getting because of this relationship; it's still early on, but we know we're getting exposure in areas that historically we've not been able to (inaudible).

Peter Costa: A key focus of yours has been improving the patient experience through sort of integrated care delivery. We talked about rapid markets a little bit. I think more than 60% of your IRF's are located within overlapped markets and your target is 40% collaboration rates between the home health and the IRF business. I think your collaboration right now is 35%, just to (inaudible). How long do you think it will take you to hit that 40%? Can you help me understand, how important is that to you guys in terms of not just the patient experience but also the cost?

Mark Tarr: Well, we consider an overlap market to be markets where we have both a hospital and a home health agency. Right now, 83 of our marketplaces, there's 132 rehabilitation hospitals, 83 of those markets we also have a Home health agency, it's usually around -- within a 30 mile radius of our hospitals, overlap markets. It is important for us to be able to integrate our care, we think it is a big part of our strategy to go out and have a standardized process which is what we call our clinical collaboration that we have implemented in all of the overlapped markets to make that transition from our IRF home health as smooth as possible, taking into account all of those things that go into play; clinically, socially and from a patient standpoint to make sure our patient gets home in a smooth fashion and has a less likelihood of having an occurrence of readmission back into the hospital.

So we look at it as being extremely important. We think that we can have, actually, 100% of our markets eventually be overlap markets. We are currently as you noted right at that 35% level on our collaboration percentage. 40% is our new term goal. We'd like to think that we can achieve that in the next [year] or so and then continue to climb that, eventually to about 65%, which is about as high as we think clinical collaboration (inaudible). There are reasons why patients may have a preexisting relationship with another home health agency. It could be physician preferences in terms of where they send patients. In some cases we don't have contracts with any company's for the home health portion, have yet to start paying a fair rate in the marketplaces. There are reasons why we wouldn't reach 100% collaboration.

Peter Costa: You didn't mention it, but is one of those that sometimes your hospital referring partners, customers, however you want to refer to them, have the home health and you don't want to compete with them?

Mark Tarr: That's the absolute case. About a third of our hospitals are joint venture partnerships and a number of those acute care hospital systems that we partner with, have their own home

health agency. So, yes, we're certainly considerate of that but it all boils down to patient choice and in some of those markets where we may have a partner that has home health and we have Encompass Home Health in the marketplace too, there could be reasons why the patient (inaudible) partner, but we don't want to be in a competitive situation.

Doug Coltharp: I think it's important to note that clinical collaboration adds an important third leg to the value proposition that you're able to present to the acute care hospital, our referral sources.

Doug Coltharp: The first leg of the stool is that we have this integrated [EMR] that co-developed with Cerner. That has interoperability with all of the systems used by major hospitals and as a result of that, we're able to take referrals out of the acute care hospitals much more quickly and that's a benefit to the acute care hospitals because they're like turning tables in a restaurant. They've got a patient out of their facility, they have an open bed back to fill. The second is that both of our business segments have the ability to create a higher acute (inaudible) and we can take a patient, that might have required a longer length of stay in a hospital, out of that hospital and started on rehabilitation longer.

Third is by having the continuity of care between our IRF's and our home health business. We're reducing, over a long period of time, the hospital readmission that has a financial benefit (inaudible).

Peter Costa: We're about out of time. I just wanted to add one last thing. You talked a lot about having the tailwinds in the -- are there any headwinds or tailwinds that we didn't talk about that we should talk about? Covered them all? Okay, terrific guys. Thank you very much, appreciate it.

Doug Coltharp: Thank you, we appreciate it.