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Encompass Health Corporation

Encompass Health Corporation presentation delivered at the 38th Annual J.P. Morgan Healthcare Conference on Tuesday, January 14, 2020 at 3:00 PM

Gary: Thanks for sticking with us this afternoon on day six of...whatever day this is.

[laughter]

Gary: Day two of the J.P. Morgan conference. Just feels that way. We have plenty of energy left for Encompass Health. Encompass is one of the nation's largest provider of post-acute services, both facility and home-based.

The company is the largest owner and operator of inpatient rehab facilities, fourth-largest provider of home health services, and a top 10 provider in hospice. The company will generate about $4.5 billion of revenue in 2019. The presentation today will be President and CEO Mark Tarr.

Mark Tarr: Thank you, Gary. Gary just did the first four slides of my presentation.

[laughter]

Mark: Good afternoon and thanks for joining us today. It's our pleasure to be back here at the conference and have a chance to tell the Encompass Health story. Start off with the disclosure language around our forward-looking statements. I'm sure you've seen these before.

Many of you may not be familiar with Encompass Health. As Gary said, we're a national leader of integrated post-acute care services. We provide these services in two different settings, one in a facility-based setting with 133 IRFs, inpatient rehabilitation facilities, or hospitals.

We provide it in the home setting, with 245 home health locations, and then also in the home setting with 83 hospice locations. We have a very large geographic footprint, with locations in 37 states and in Puerto Rico.

I would say the common thread that runs across all three of these service lines is that we have the ability to produce industry-leading outcomes but also do that in a very efficient manner.

We report out on two operating segments, from a financial standpoint, the first being inpatient rehabilitation. Accounts for about 75 percent of our revenues.

From a market share standpoint, we are the largest owner and operator. We have 23 percent of the licensed beds, and almost one out of every three Medicare patients receiving care in an IRF facility this year will receive it in an Encompass Health IRF.

You'll see 47 of our hospitals operate as joint ventures with acute care hospital systems. This is a strategy we've used now for almost 30 years. We know how to be a good partner. It remains a big part of our strategy moving forward as we develop new hospitals.

We also have very developed and refined clinical programs. As you can see here, we have 123 hospitals that have one or more disease-specific certifications from our main accrediting agency, the Joint Commission.

The second of our operating segments is home health and hospice, which accounts for the remainder of the 25 percent of the revenues. You can see that we're the fourth-largest provider, with 83 hospice locations. That puts us at the top 11th provider for hospice agencies in the United States.

Similar to the hospitals, we have very refined and detailed clinical programs. Very proud of the quality that we attain on our agencies. You can see here 98 percent achievement on both of these for agencies with three stars or greater for both quality as well as patient satisfaction.

We've had a really strong year in 2019. We're very focused currently on the year 2020, but we bring a lot of momentum from 2019 into 2020. We're able to offer our updated guidance and increased our adjusted EBITDA range to 962 to 967 million dollars.

That contains, as you may have seen yesterday on an 8-K that we released, that 962-967 contains $13 million worth of EBITDA outlined as individual items that may or may not repeat in 2020.

We executed very strongly against our strategic plan last year. We've outlined a number of the areas, starting with growth. We opened up three new hospitals. We expanded our existing hospitals with capacity for 152 additional beds.

Home health and hospice was also a big year. You can see we increased our home health locations. 27 opened up or acquired, 25 hospice.

A big chunk of those came through a major acquisition called Alacare that we closed on in July. That brought in 23 both home health and 23 hospice in the state of Alabama. That also created three additional what we refer to as overlapped markets as part of that.

As part of our growth too, you can see the organic growth that we've had. We had strong same-store growth in both the IRF as well as hospice. We've also made nice traction in terms of increasing our Medicare Advantage exposure, with growth of 18.7 percent on the hospital side of our business.

We also continued on with operational initiatives, including preparation for the two major payment methodology changes that we see in 2020, which I'll discuss further here in just a few minutes.

Clinical collaboration remains a very big part of our overall strategy, as well as use of post-acute solutions taking advantage of the data that we've produced in our IT investments over the last several years.

We also took advantage of favorable conditions relative to issuing $1 billion of senior notes to help us meet our financial obligations in 2020. As part of our guidance for 2020, we can see the adjusted EBITDA range is 935 to 965.

As part of this guidance we offer, the guidance considerations relative to pricing for the IRF segment were flat to 75 basis points for Medicare. You'll see that this is for the first three quarters. Then the fourth quarter of 2020, we estimate and anticipate a 2.5 percent rate increase.

On home health and hospice, we've got an estimated net Medicare two to three percent pricing decrease for 2020. You'll see outlined here too for both segments. You'll see that we have salary increase approximately three percent with benefits increase approximately 8 to 12 percent.

Then down underneath the consolidated, you'll see that we continue a long-term approach to our business. We'll make approximately $5 million investment in our strategic initiatives, including our post-acute innovation and advanced technology.

Relative to 2020 priorities, it looks very similar to our initiatives and our strategic plan that we implemented and executed on in 2019. We'll continue to grow our business, meeting the

increasing need for demand for rehabilitation in both the IRF segments as well as home health and hospice.

We'll do that through a number of different ways. We'll have our new development coming online, de novo growths in hospitals. We'll do mostly grow through acquisitions on home health and hospice, as well as adding new bed capacity to our hospitals.

Operational initiatives. You'll see here too that we'll continue with a major focus on transitioning to the Section GG of the hospital side of our business, the PDGM on the home health and hospice. We'll continue to build market share in stroke.

Clearly, for 2020 our operations teams are focused on the two major regulatory changes. We'll start first with the hospitals. You'll see here listed what we had historically referred to as the CARE Tool or Section GG. That is in effect replacing the FIM tool, which was the primary means of assessing patients. The FIM tool existed for almost 30 years in the industry.

Switching from the CARE tool, which...Literally, we had thousands of our clinicians. That's all they had known, was the FIM tool. Switching to this new GG took a significant amount of education. It took a significant amount of clarification with CMS in terms of how to apply what they were looking for in terms of us rolling this new tool out.

There was also timing perspective that goes along with it. We converted to the new tool on October 1st, but yet ran FIM with the new tool, parallel, up to that point. As we made the switch leading up to October 1st, timing was a big consideration.

Relative to PDGM, we're only two weeks into PDGM, which started on January 1st. Our team seems to be responding well to it. In terms of mitigating opportunities, we're focusing on staff optimization and making sure that our ability to care for the patients is optimized through the greatest efficiencies that we can get.

Part of that involves utilizing information and data from Metalogix, which has helped us to identify the optimum number of visits for a patient to achieve the optimal clinical outcomes.

While we do have two major payment changes in 2020, it doesn't take away from the positive continued outlook we have for the fundamentals of our business. The demographic tailwind is just one example of what is driving the ongoing need and demand for our business.

Our average age patient is 76 in the hospitals, it's 77 in home health. As we all age, the likelihood that we'll need rehabilitative services increases. You'll see here on the chart that there's a three percent CAGR for the Medicare beneficiaries.

If you look over in the table on the right-hand side, you'll see that for our age cohort, that 75 to 79, that CAGR growth goes up to 5 percent for the date range of 2018 through 2022 and then 4.9 on 2022 to 2026.

The ongoing need for our services in both of our segments, all three of our service lines, the hospice, the home health, and IRFs, will be in significant demand as the Baby Boom generation ages out into our age cohort.

We're excited about the continued multifaceted growth strategy we've implemented for this year, 2020. We'll bring on four new additional hospitals. You see here Murrieta, Sioux Falls, Coralville, and Toledo. Two of those hospitals are in brand-new states for us, which we're excited to be a part of.

We'll continue to expand the capacity in our hospitals. We have a minimum of 100 to 120 beds that we'll be adding onto our existing portfolio of our facilities.

Then we're excited about the repeal of the CON process in the state of Florida, where we already have a sizable footprint. We think that the opportunity to go in and add additional beds to our existing facilities or expand new de novos starting in the year 2021 is a real opportunity for us in the state of Florida.

Same with home health and hospice. We have earmarked 50 to 100 million dollars for acquisitions. We certainly think that there is a strong probability that there will be a disruption in the marketplace that will lead to our opportunities.

We're experiencing or have experienced in the past real opportunities to go out and take advantage of a number of different players through acquisitions. We expect that to be the same this year, if not greater.

Then there will continue to be, as you see here on the last bullet point, opportunistic to find those larger-scale acquisitions similar to what we did with Alacare this year. There may not be as many in 2020 as 2019 or 2018, but we do believe that those exist and will continue to pursue those opportunistically.

One of the key points of our strategy over the past several years, you can see here. Since 2015, we have instituted what we call our focus on our clinical collaboration, where we standardized the process of the transition of patients from our rehab hospitals at the time of discharge, those that had been identified or referred for home health.

All the task that goes involved with that relative to patient education, drug reconciliation, working with the families, making sure that the transition process goes smooth. You can see that we've increased the clinical collaboration rate now consistently.

Starting out in the first year of 2015, when we first started tracking it, at18.5 percent and then 2019 finishing up at 35.6 percent. We still think that 40 percent near-term goal is a good number for us with that. Longer-term, we could see this getting as high as 60 percent. You can see the real progress that we've made in increasing this clinical collaboration.

We're also very encouraged by what we see in terms of the clinical quality indicators in our overlap marketplaces. Where we've been able to coordinate this care, we're seeing an increased number of patients going home at the time of discharge with home health versus some of these patients being discharged to a skilled nursing facility.

We're also seeing an increase in the patient satisfaction scores in these overlap markets. We're very encouraged and excited about what we're seeing from the clinical outcomes of this clinical collaboration.

Over the past years, we've talked a lot about stroke and how we see it as being an opportunity. The bottom line is we have done a really good job. Our clinicians have done a really good job treating stroke patients. Our outcomes have proven as such.

Matter of fact, a number of recent independent studies, most recently with the JAMA and the VA, have talked about how if a patient has a stroke and needs inpatient care, that inpatient care should be provided in an IRF setting versus a skilled nursing facility.

We've seen that as we've gone along. Matter of fact, we have a partnership with the American Stroke Association that we started this year and will continue on for the next two years. It's a co-branding initiative where we work collectively with them in our various marketplaces.

It gives us an opportunity to go out and educate others on our brand and our clinical expertise

with stroke patients, reaching a population that we would not otherwise reach but have the capabilities of doing that through our co-branding with the American Stroke Association.

We anticipate continuing to take market share, continuing to grow this program. You can see that our three-year stroke CAGR is six percent. That continues to be an opportunity for us going forward.

It's also an area that we've seen continued traction on with the Medicare Advantage plans as they have been able to look at our value proposition and our clinical outcomes that we're able to achieve with their patients.

Versus historically, they would send those to a skilled nursing facility. We continue to see growth opportunities with our stroke programs and benefits of this partnership moving forward.

Post-acute innovation is an area we've also talked a lot about. We've made significant investments in our IT platforms on both the operating segments over the years.

Those investments are now creating a significant amount of data that we can use to our advantage to create clinical tools, whether that is identifying patients that are at risk of an acute readmission from our hospitals or identify patients that may be having an onset of sepsis.

All this data is helping us to put tools in place, whether that is using internal data or whether that is utilizing data that's been generated by Metalogix or Cerner, another organization that we have a partnership with. We think longer-term this is creating a clear competitive advantage for us.

It is giving us an opportunity to do some of the navigating and helping acute care hospital systems to identify the best post-acute setting for their patients at the time of discharge and do that with data-driven analysis from, once again, some of this data that I've mentioned that we're generating either internally or externally.

We've been piloting it now in a number of our different marketplaces, particularly in Texas with a large presence in Houston. We're really starting to see some progress on this initiative.

With that being said, we are very optimistic on the fundamentals of our business when you look at our growth trends, our quality indicators that we have been able to produce out there.

If you think about our track record and facing historical times when there's been regulatory

changes, we've been able to mitigate the negative impacts of those changes, embrace change, and then come out on the other side of this time in a really strong fashion when other providers in the industry continue to struggle.

We look forward to 2020 and the future year's progress that we have ahead of us. With that, I invite you all to join us for the Q&A in the Sussex room. Thank you.

[applause]

Q & A immediately following presentation



Encompass Health Corporation Q&A

Encompass Health Corporation presentation delivered at the 38th Annual J.P. Morgan Healthcare Conference on Tuesday, January 14, 2020 at 3:30 PM

Man 1: Great. Thanks so much for joining the Encompass Breakout Session. I have a few questions I'm going to start with, and then I'll turn it over to the audience because I'm sure you guys don't want to hear me go through my whole list of things.

A couple of things jumped out at me from the presentation I thought were interesting. One was just on the inpatient rehab, seeing discharges up about 1.8, but MA discharges were up like 19. I'm not sure that's the same sort of number, but it's a huge number regardless.

Can you talk a little about what's driving that and why are these MA plans finally perhaps seeing so much incremental value in that setting?

Man 2: That wasn't an overnight phenomenon. We've been working now for years in terms of what we refer to as our value proposition, taking our outcome data to the MA plans and showing them that, describing how well we do at eliminating acute care transfers or getting patients back home at the time of discharge.

What we've seen now, for the past three or four years running, is an increase in the MA plans that are approving patients that historically would have been referred to us. They would not have pre-

certed the patient and, historically, would have sent them to a skilled nursing facility.

We're now starting to see a lot more progress and traction in getting the pre-cert process where they've been able to identify that we do a better job with certain types of patients than skilled nursing facilities.

One of those particular clinical areas is with the stroke patients. Matter of fact, one of every three of those patients from the MA plan now is a stroke patient. It's an area that we've been able to differentiate ourselves. We believe that, too, will have a halo effect in terms of the same types of phenomenon that we'll work with, other neurological categories that go hand in hand with stroke and those types of acute conditions.

We would expect that to continue, going forward. We certainly tried to exploit the relationships with the MA plans and show our quality. It's starting to pay off.

Man 1: Another thing that jumped out at me just a little bit was you're laying out some of the labor cost growth, home health and hospice heading into 2020, 3 percent on salaries, but 8 to 12 percent on benefits. Is that picking up, accelerating as we head into '20? It seems higher than what some of the other providers have talked about. Is that a larger market phenomenon or what are you thinking on that?

Man 2: I'll ask April to weigh in on what she's seeing on home health, and then I'll ask Doug to talk about what we put in the guidance.

April: Our 8 to 12 percent for next year is really a result of a particularly strong year this year. We just feel like we've probably got a mean-reverting situation, where we had a really good year, very few very large claims in our self-insured base in the home health sector. It's not so much about a real rise as it is just getting over the anomaly of 2019 on the home health side.

Doug: It's really the same story for the expected benefits increase in both of our business segments. We headed into the fourth quarter, which is the start of our budgeting season for the ensuing year, anticipating the benefits increase in 2020 would be in the same range it has been for the last couple of years, which is really in that six to eight percent inflationary range, with most of that being on the group medical side.

The very favorable performance we had it both segments -- not only in group medical, but in some of the other categories of benefits, as well -- meant that 2019 came in with a lower base

than we anticipated. Yet, because so many of the things related to medical inflation are really mean reverting, we just kept the same nominal dollar level of increase on a lower base. That resulted in a higher percentage for 2020.

Man 1: The three percent on wages, is that consistent? Is that picking up a little bit?

Man 2: I would say the three percent of wages is consistent. Both of our operating segments do quite well in the retention. When we look at it and we measure, retention is primarily on nurses, and then therapists are both categories. We have single-digit turnover on therapists in both of our segments. We're right at the industry standard, just a little bit less on the hospitals and right at it for nursing and home health.

Man 1: One more for me and I'll turn it over. You're the second company today that mentioned Medalogix. You also mentioned Cerner. You talked a little bit in the presentation about predictive analytics, and AI stuff. Can you just describe that a little more?

I guess my perception is, the post-acute and discharge planning process, whatever, clinicians are assessing these patients, have a pretty good idea from their experience what they need and where they'll do best. What is the data giving you that's beyond that that's proving to be helpful?

Man 2: I'll take first on the hospital side. One of the things we've talked about is what we call our ReACT program. That is, where working with Cerner, we've been able to go in and establish criteria and a set of alerts on our electronic medical records.

Our clinicians can see this, our physicians can see it, and identify or be made aware of certain alerts that would indicate that a patient may be having certain areas of risk that could lead towards a need to transfer the patient back to the acute care hospital. Having this alert allows them to go and take a preemptive clinical intervention with the patient.

Sometimes, it's something very simple. Sometimes, it's more involved, but it does tie our physicians and nurses together. We've really seen nice progress. As we've taken a higher acuity patient, we've actually seen our acute care transfers reduced with time.

Doug: April, do you want to comment on Medalogix now?

April: Yeah, the Medalogix's equation, what we're really utilizing that tool for is for care planning and for utilization management. I think there's a perception that really the tool is designed to cut

visits, but the reality is that's not actually the case.

The reality is, what it's designed to do is come up with that truly just right care plan for every patient. In some situations, we're clearly saying that it's recommending more visits than we have historically done. In other situations, it's recommending less.

We're really encouraged by the early data. We've got about 67 percent of our total locations utilizing the Medalogix's Care tool at this point in time. We'll reach full deployment by the end of the second quarter.

What we're seeing in our early deployment results is that we're seeing not only a decline in the visits, but we're actually seeing an improvement in the outcomes. I have to tell you that we were positively surprised by that. The reality is, when you start looking at the details of why we are realizing that improvement, it is clearly because the system is using a very independent objective standard for determination of care.

When the human was making that decision, there was a tendency to become habitual and have a similar process for every patient for how care was delivered. Now that the system is discerning the best level of care, we're seeing that certain patients are getting well more care than they used to, as a result, better outcomes from that care.

Others, who are getting less care, aren't seeing any degrade of their outcomes because, frankly, they were receiving care that was not necessary in the old world. It's really helping us control both the volume issue, but driving better outcomes in the process.

We're very excited about the progress. We think it has nowhere to go but up from here. As we complete the deployment phases in the first half of this year, really encouraged by the early news from that.

Man 1: Thank you.

Man 3: Building off that Medalogix, is that also providing improvement and maybe labor utilization, as well? Maybe talk about where you are in that process.

April: Yes. When we think about labor utilization relative to Medalogix, it actually has the potential to go the other way. We're a bit unique in that about 80 percent of our visit volume is performed by full-time staff members.

We have a really high proportion of full-time team members. What Medalogix is doing currently is bringing visit volume down, but if we don't right-size our staffing almost immediately along with it, then we actually don't realize the savings because our staff are still being paid their salaries and full wages.

We've really got to be cautious to make sure that as volume is decreasing overall with patient care volume, that we're getting our staffing right-sized as well. It's a little bit of a lagging indicator to get that staffing right sized.

In some instances, we don't want to cut those people. We want to instead grow into that new capacity because, as you know, staffing is a big issue in the home health world. In other instances, if we're seeing real significant declines in volumes, we may have to actually change our mix of full-time to PRN staff.

It's not necessarily making it better, but it is certainly highlighting the opportunities to readdress our capacity.

Man 1: Other questions from the audience?

Man 4: A couple of the other home health companies who have presented today and yesterday seem to have indicated that as they've gotten more work on PDGM -- whether it's in small centers before it really kicked off in January -- the ability to make up some of that gap. It's improved slightly. Now, again, we'll see.

Do you feel like you've iterated at all? From where you're reviewing that, in two, three, four months, generally, the amount of the gap you think you can cover is still roughly the same?

April: I think we've been very consistent. When we've looked at the impact of PDGM, I think we've been very consistent since the third quarter when we got the final rule coming out, and our perception of what was there. We've done a lot of work to assess the proportion of the behavior assumptions that we can realize.

That has remained pretty consistent to date. Obviously, we're only two weeks into PDGM, so it's impossible to know if our assumptions are going to prove right about that. Ask me in another three or four months and I'll give you a better answer there.

What we have been encouraged about is, even though we are a leading provider from a margin perspective in the home health segment, we continue to find opportunities to add incremental cost controls, and think we can mitigate some of the revenue impacts through continued improvement in productivity and optimization of our lower cost disciplines with LPNs and PTAs.

We're encouraged that even though we lead the industry in margins, we still believe there's opportunity to continue to fine-tune and hone our behaviors in order to drive greater efficiency to offset and mitigate some of the rate challenges that we're going to experience this year.

Man 5: [inaudible] they say that there's value to having IRF in outpatient. You guys got rid of the outpatient business a while back, actually. Do they own it now?

Man 2: Yes, they bought it from us, several years ago.

Man 5: Now that the balance sheet is in a much better place than it was when you had [inaudible] , is there value to having outpatient? There are a bunch of assets out there that were for sale or might be for sale -- probably expensive prices, but is there are reason to have IRF and outpatient together?

Man 2: We don't see that at this point. When our patient mix changed -- actually 10 or more years ago now -- you saw the orthopedic component of our patients drop significantly. That was replaced by a neurological component. We saw a pretty drastic reduction in our outpatient business.

These patients, if they're orthopedic they can go home, drive back to your outpatient center and get care. When they're 77, 76, they've had a stroke or some other neurological condition, or they've had an acute circumstance, they're much more likely to get home health at the time of discharge.

Matter of fact, over 60 percent of the discharges we have from our IRFs go home with home health. If anything, we've been rationalizing our freestanding outpatient clinics over the years. We've also been rationalizing the hospital-based outpatient service line over the years. It has been an area that we don't see a need for, going forward, given our patient population.

Doug: I think that less than 10 percent of the patients discharged from one of our IRFs go on to receive outpatient therapy. It's largely a commoditized business.

Woman 1: Just remember, if you could, restate the question for the people on the webcast. Thank you.

Man 6: Yeah, can you talk a little bit about reimbursement rates in home health business from private insurance versus Medicare? Are you seeing any change as insurance companies see the benefits of that?

April: The question was in regard to the rate comparison between Medicare home health and the other Medicare Advantage payers, as well as the commercial insurance payers.

Fortunately, what you've heard Mark speak of earlier, as it relates to the IRF and how they're beginning to find those non-Medicare payers getting closer and closer to the Medicare rates, we're not yet seeing that much traction in the home health space.

We, like the IRF division, are trying to tell our story effectively about lowering costs and lowering readmissions. We continue, because of the fact that there are 12,000 home care providers out there nationwide, to be commoditized as a rate-driven segment.

We're working to really create a distinctive story in the marketplace, as are some of our other market-leading peers. We're really all being cannibalized a bit by those small mom-and-pop agencies that'll take substandard rates.

That being said, we have seen a little bit of improvement. Over the last three years, we've seen the rates in the home health sector for our business specifically go up by about 20 percent, from a $98, $99 effective per-visit rate up to about $118 per visit.

We are now setting a minimal threshold of $120 for any new contracts, and that's before we'll even talk to anyone. We hope that, over time, we can begin to move that up into the $125, $130 rate, but that still is a pretty significant discount to the about $175 that we see being the effective per-visit rate for Medicare. We're not quite where the IRF division is yet, but continuing to try to tell our story distinctively to get there.

Man 7: What percentage of the stroke patients are you seeing nationally and is there a natural ceiling to your ability to continue to grow that due to a geographic limitation to an IRF? Do you know?

Doug: The question was what percentage of the overall stroke population in the US are we

currently treating in our facilities? Is there any natural ceiling on our ability to continue to grow that at a level commensurate with the recent growth level, just based on the location of our facilities or anything else geographically?

Our current market share for stroke in the US is a little over five percent. Not all of the patients who have a stroke in the US are going to qualify for care in an IRF. There's a portion of those who unfortunately pass away from the stroke. There are others who the stroke is not severe enough to meet the medical necessity criteria for admission to an IRF.

We can tell you that there is a substantial portion of the 800,000-plus strokes in the US where patients would meet the medical necessity criteria for an IRF and instead they're receiving that care in a SNF.

We made very good inroads in that over the last several years which is why our organization has had a six percent, three-year CAGR in IRF discharge. Mark referenced that during his comments. We think it can accelerate from here and we don't see any barriers or limitations that would say it's going to cap out anytime soon.

The incidence of stroke and survivability of stroke are likely to be relatively constant in the aging population for much of the next decade. Mark cited three very credible external sources that had done independent studies that highly recommended utilizing IRF services instead of SNF services to recover from a stroke. That's certainly a part of our value proposition.

As Mark mentioned, you take that 18-plus percent discharge growth that we have in Medicare Advantage in 2019, a full third of our Medicare Advantage volume is stroke. Clearly, that payer class also sees the value proposition that we bring to the table and the efficacy of our treatment for stroke patients.

Man 8: There was a comment of CONs phasing away in Florida. You sounded like you were pleased or interested. Doesn't that go against how we've all grown up that CONs are a good thing, and keeping more of a stable, competitive environment? Could you comment on that?

Man 2: Whether or not CONs provide a stable environment or somewhat protect you once you have the CON, there is some side of that that that's true. It also limits your growth in a marketplace. We have a very nice platform of IRFs in the state of Florida. We think with the repeal to CON, we'll be able to go in and add additional capacity to hospitals that are already running at high capacities.

We think, longer term, as early as 2021, we'll be able to start adding de novo hospitals in marketplaces that we had evaluated over the years. We are still waiting for some clarifications from the state on how this repeal process will work, and what the dates will be. We've been very proactive in setting our plan going forward, so once we get the green light, we'll be able to be hopefully first to market in many of these markets.

Doug: Not all IRFs are created equal, so we believe we have a superior competitive product. We build more freestanding IRFs than anybody that's out there. We've got a 30 percent market share. The next largest market share in any single competitor is four percent, which means we've ascended a learning curve that many of our peers have not.

We've got the clinical protocols. In Mark's presentation, he mentioned 123 disease-specific certifications. We've got more stroke certifications than any other player that's out there. We've made the investments in technology, both clinical technologies and the electronic medical record. We compete very well in non-CON states.

The greatest example is our largest concentration of IRFs is 24 in the state of Texas, and there's no CON requirement there. Given the demographic characteristics and the under-bedded nature of a market like Florida, we would much rather take our chances in a non-CON market and be able to deploy capital to add new IRFs to meet that demand, regardless of whether or not somebody else is going to try to compete with us.

Man 8: Small follow-up on that, would you need any more hospital partnerships or alliances or anything in Florida, or do you feel like you're aligned with who you need to get that build up?

Man 2: We look at that market by market, project by projects. In some markets, we think it's strategically advantageous to have a partner. Other markets, we feel that we're comfortable going in an owning the facility 100 percent.

Doug: It has been a subtle change in our strategy, but an important one, and that is we continue to value the JV relationships. There are a number of markets that we look at where we think it's preferable to enter into that market with a JV relationship.

Whereas previously, we might have waited until the joint venture was agreed upon and formed before we would proceed with the development activity. Now, we're inviting potential joint venture partners to the table, but we make it pretty clear to them that we're going to go ahead and enter

that market whether or not they choose to partner with us or not.

Man 1: A question in the back, could you speak up, please?

Man 9: Do you think PDGM was too far overreaching? Let's say it's not budget neutral in certain states, how long would it take CMS to come back and Medicare if that's the case?

April: The question was if PDGM has overreached and made too much of a cut, how long will it take Medicare to come back? My guess is that it will take, at the earliest, 2022. That's a two-prong answer.

On the one hand, I think that means that in 2021, they will not have enough evidence to provide any additional cuts. I also think it means they will not have enough evidence to provide any relief. 2022 is the earliest that we might see a course correction if, in fact, they have overreached.

I don't know that I would suggest that I think they've overreached globally. They have overreached in particular areas. For example, if you look at the cuts to the therapy service line, I think they've overreached in that area. I've been consistent in my statements on that. They may neutralize that. They can do it simply by moving the case weights associated with those episode types.

We could very well see a little bit of shift in that just based on the early results. I really wouldn't expect a material correction either way until 2022 at the earliest.

Man 1: Just on home health in general, do you see, anticipate really massive disruption of the smaller players, both with the RAP payment being phased out, and also with PDGM? Is this going to be just absolute chaos for the smaller players?

April: I'm probably not going to say that it's going to be absolute chaos for the small players. I do think that what we are going to see is that those small players are going to be particularly disrupted by the cash flow changes.

If we go back to the last time there was a major reform in home healthcare, it was the '97 to 2000 period, at which time 30 percent of the agencies were disintermediated and consolidated. We went from 10,000 to right at 7,000 as an industry. We may see something along that similar magnitude coming from this.

If you look at what caused that, it wasn't so much the reimbursement change. It was the cash flow change that was the big driver to that 30 percent attrition that happened in that period.

It's going to be the RAP payments cutting from 60 percent to 20, and in turn, going away altogether next year, that are going to be the drivers that will particularly affect those small agencies, agencies with 100 or fewer patients. Roughly call it $1.5 million, those folks are really going to feel the pinch.

Even those who go up to $3 million of annualized revenue could also be impacted, but particularly look to that particular small end. You may think, how many are there? The reality is about 10,000 of the 12,000 home care providers have $3 million or less of annualized revenue. The average home health provider is $1.5 million of revenue, the average. That will give you a sense of just how many are on the small end.

We think there could be pretty good fallout, but it's going to happen at the very lowest end of the market would be my anticipation.

Man 1: With that, we'll wrap. Thank you very much.

April: Thank you.

Man 2: Thank you, all.

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