Encompass Health Q3 2018 Earnings Call

Transcript

PARTICIPANTS

Corporate Participants

Crissy Buchanan Carlisle – Chief Investor Relations Officer, Encompass Health Corp.
Mark J. Tarr – President, Chief Executive Officer & Director, Encompass Health Corp.
Douglas E. Coltharp – Executive Vice President & Chief Financial Officer, Encompass Health Corp.
Barbara A. Jacobsmeyer – President-Inpatient Hospitals, Encompass Health Corp.
April K. Anthony – Chief Executive Officer, Home Health and Hospice, Encompass Health Corp.

Other Participants

Matt Larew – Analyst, William Blair & Co. LLC
Matthew D. Gillmor – Analyst, Robert W. Baird & Co., Inc.
Frank George Morgan – Analyst, RBC Capital Markets LLC
Sarah E. James – Analyst, Piper Jaffray & Co.
Kevin Mark Fischbeck – Analyst, Bank of America Merrill Lynch
Kevin Ellich – Analyst, Craig-Hallum Capital Group LLC
A.J. Rice – Analyst, Credit Suisse Securities (USA) LLC

MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone, and welcome to Encompass Health's Third Quarter 2018 Earnings Conference Call. At this time, I would like to inform all participants that their lines will be in a listen-only mode. After the speakers' remarks, there will be a question-and-answer period. [Operator Instructions] Today's conference call is being recorded. If you have any objections, you may disconnect at this time.

I will now turn the call over to Crissy Carlisle, Encompass Health's Chief Investor Relations Officer.

Crissy Buchanan Carlisle, Chief Investor Relations Officer, Encompass Health Corp.

Thank you, operator, and good morning, everyone. Thank you for joining Encompass Health's third quarter 2018 earnings call. With me on the call in Birmingham today are: Mark Tarr, President and Chief Executive Officer; Doug Coltharp, Chief Financial Officer; Barb Jacobsmeyer, President, Inpatient Rehabilitation Hospitals; Patrick Darby, General Counsel and Corporate Secretary; Andy Price, Chief Accounting Officer; Ed Fay, Treasurer; and Julie Duck, Senior Vice President of Financial Operations. April Anthony, Chief Executive Officer of our Home Health and Hospice segment also is participating in today's call via phone.

Before we begin, if you do not already have a copy, the third quarter earnings release, supplemental information and related Form 8-K filed with the SEC are available on our website at encompasshealth.com. On page 2 of the supplemental information, you will find the safe harbor statements which are also set forth in greater detail on the last page of the earnings release.

During the call, we will make forward-looking statements which are subject to risk and uncertainties, many of which are beyond our control. Certain risk and uncertainties that could cause actual result to differ materially from our projections, estimates and expectations are discussed in the company's SEC filings, including the earnings release and related form 8-K, the Form 10-K for the year ended December 31st, 2017 and the Form 10-Q for the quarter ended March 31st, 2018, June 30, 2018 and September 30, 2018 when filed. We encourage you to read them.

You are cautioned not to place undue reliance on the estimates, projections, guidance and other forward-looking information presented which are based on current estimates of future events and speak only as of today.

We do not undertake a duty to update these forward-looking statements. Our supplemental information and discussion on this call will include certain non-GAAP financial measures. For such measures, reconciliation to the most directly comparable GAAP measure is available at the end of the supplemental information, at the end of the related press release and as part of the Form 8-K filed yesterday with the SEC, all of which are available on our website.

Before I turn it over to Mark, I would like to remind everyone that we will adhere to the one question and one follow-up question rule to allow everyone to submit a question. If you have additional questions, please feel free to put yourself back in the queue.

With that, I'll turn the call over to Mark.

Mark J. Tarr, President, Chief Executive Officer & Director, Encompass Health Corp.

Thank you, Crissy. And good morning to everyone joining today's call. The third quarter was another strong quarter for Encompass Health. The operational and financial trends we experienced in the first half of the year continued in the third quarter with consolidated revenue increasing 8.8%, consolidated adjusted EBITDA increasing 9.6% to $224.3 million, and adjusted earnings per share increasing 37.9% to $0.91 per diluted share.

Revenue and adjusted EBITDA for the third quarter of 2018 included $4.5 million of business interruption insurance recoveries related to the 2017 hurricanes. And adjusted EPS included an additional $2.9 million in property insurance recoveries also related to the 2017 hurricanes.

Our company is extremely fortunate to employ industry-leading clinicians and professionals who provide the highest level of care to our patients with the support of the service-oriented professionals in our home offices.

Our employees, again, demonstrated their commitment to the care and safety of our patients when Hurricane Florence impacted the Carolinas and Hurricane Michael impacted the Florida Panhandle. Our employees stepped up in this time of need, working around the clock to care for patients and each other.

The accounts of selfless compassion and leadership exhibited by these employees are numerous. And we can't begin to express our appreciation to and admiration for those who put the care of their patients ahead of themselves.

Within our Inpatient Rehabilitation segment, seven of our hospitals were in the path of Hurricane Florence, with our hospital in Murrells Inlet, South Carolina, being the most impacted by this storm.

That hospital, which opened just days before the storm and had not received its accreditation from The Joint Commission or its Medicare certification at the time of the hurricane, was evacuated under mandatory orders from the Governor of South Carolina on September 12th, 2018, and began accepting patients again on September 17, 2018. There was no significant impact to property or operations at the six other hospitals.

Our Home Health and Hospice segments operate eight home health locations in the areas impacted by Hurricane Florence. While caregivers were unable to conduct patient visits in the impacted areas for a short time, there was no significant impact on the segment's operations as a result of this storm.

Three of our hospitals were in the path of Hurricane Michael when it made landfall on October 10th. Our hospitals in Dothan, Alabama and Tallahassee, Florida endured the storm with their buildings suffering minimal damage. However, as you've all seen in the news, Panama City, Florida took a direct hit. And our hospital in this city incurred substantial damage.

On October 12th, our teams worked with local officials to evacuate 42 patients in this hospital to our hospitals in Tallahassee and Dothan. At this time, our hospital in Panama City is not operable. We are hopeful our building will have its most critical repairs completed and be operational at a reduced capacity by the end of November. However, repairs could be ongoing to this hospital for months.

Our Home Health and Hospice segments operate three home health locations in the Florida Panhandle that were directly impacted by Hurricane Michael with the greatest impact toward Panama City location. In addition, there were 11 home health and 2 hospice locations that were impacted to a lesser extent in other states.

Caregivers in the Florida locations were unable to conduct patient visits due to road closures, power outages, and/or the displacement of patients from their homes. Our home health staff worked through the storms and continued to make home health visits in the affected areas when conditions were safe.

In some instances, patients evacuated to other areas within the company's home health coverage and continued to receive care in those alternative locations. The communities impacted by Hurricane Michael have faced, and will continue to face, tremendous hardships.

Given the catastrophic devastation to these communities, we have no way of knowing when residents or physicians whose homes were destroyed will be able to return to the area or when the local acute care hospitals will be able to resume normal operation given the destructions to their building.

During this period, we will incur expenses and we'll forego the expected profit contribution from this market. Based on what we know today, we estimate our fourth quarter adjusted EBITDA will be negatively impacted by $4 million to $5 million. The power of this storm left more than a 100 of our employees and their families in the Panama City area with uninhabitable homes, extensive loss and damage to their property; many losing everything.

During this time of financial loss and hardship for so many, our employees across the country contributed to the Encompass Health Care Fund. This fund was created to help Encompass Health employees during a covered disaster.

Last year, many of our employees in Puerto Rico received monies from this fund when Hurricanes Maria and Irma hit the island. It was touching to see the number of our Puerto Rico employees who gave back to this fund when Hurricane Michael devastated the Florida Panhandle. It's just another example of the caring and compassionate employees we have. I thank you all for your compassion, professionalism and perseverance.

I'd like to turn now to providing an update on our strategic initiatives around growth and operations. Thus far, in 2018, we've opened four new inpatient rehabilitation hospitals, including our joint venture hospital in Winston-Salem, North Carolina, our first in that state, that opened in October.

We've also added 16 beds to our existing portfolio. Our Home Health and Hospice segment has added 16 net home health locations and 20 new hospice locations to its portfolio, the majority of which came through the acquisition of Camellia Healthcare in May of this year.

In addition to growth, we continue making great progress in terms of clinical collaborations between our segments. Our clinical collaboration rate for the third quarter was 34.3%, an increase of 560 basis points over the prior year and consistent with the increase we've experienced in the first half of 2018. This provides further proof of the efficacy of our teamwork's clinical collaboration initiative.

Our rebranding and name change continues to go well. On October 1st, we completed the third wave of transitioning our assets to our new brand. At this time, approximately 60% of our hospitals and agencies had transitioned to the new brand, with their next wave scheduled for January 1st.

We also continued our work with the post-acute innovation centers to develop advanced analytics and predictive models to enhance clinical outcomes and reduced cost of care across a broader episode of care.

We are actively using care management tools at our hospital in Tyler, Texas as part of the hip fracture pilot with CHRISTUS Trinity Mother Frances. We have completed the onboarding of our patients' data from our partners, Epic system, our IRF data from our rehabilitation specific electronic medical records system, and our home health data from Homecare Homebase.

Combined, these datasets serve as a patient's longitudinal record across the continuum of care and across diverse healthcare institutions.

We are also in production of our 90-day post-acute readmission prediction model. The model was developed with advanced machine learning and comparative statistical analysis to identify patients at risk for readmission across all post-acute settings.

We have instituted multiple algorithms to provide advanced awareness of high-risk patients that are likely to need further monitoring and/or potential interventions to reduce the risk of acute care readmission. We will continue the piloting of care management tools and our readmission risk model at more Encompass Health hospitals by the end of the year.

Turning now to the regulatory front. In July, CMS released its 2019 final rule for inpatient rehabilitation facilities. We estimate the rule will increase our Medicare reimbursement rates by approximately 1.2% in fiscal year 2019. The 2019 final rule also will implement changes to the patient assessment and case mix system for rehabilitation hospitals in fiscal year 2020. A system that will be based on data collected over a two-year period from the new care patient assessment tool which has been running concurrently with the established Functional Independent Measure or FIM tool.

When CMS proposed this change, one of the key concerns we expressed was that the change was being based on one year of assessment data. So we're pleased to see it will be based on two years assessment data.

The proposed Case Mix Groups or CMGs, payment weights and length of stay values for fiscal year 2020 that were issued in the fiscal year 2019 proposed and final rules will be subject to additional refinement with additional year of the assessment data being added.

On July 2nd of this year, CMS published the 2019 proposed rule for home health. As part of this rule, we were pleased to see our first Medicare reimbursement rate increase in nearly a decade, coming our way in 2019. The 2019 proposed rule includes a net market basket update of 2.1%.

But, as in prior years, it incorporates case mix reweightings that are redistributing payments based upon the most recent changes in resources by payment group. Based on our current patient mix, we estimate

2019 proposed rule would result in a 1.6% increase in our reimbursement rates for our home health business.

In addition to the payment update for 2019 and as required by the Bipartisan Budget Act of 2018, CMS is proposing to replace the current home health prospective payment system with a new system called the Patient-Driven Groupings Model or PDGM. Consistent with the directive of the Bipartisan Budget Act, PDGM includes 30-day payment periods and is intended to be budget neutral. However, budget neutrality will only be achieved if providers make the anticipated 6.4% behavioral changes that have been assumed in the current provisions.

We continue to support the movement away from volume-based payment mechanisms to those based on patients' needs and acuity. However, PDGM is very similar to HHGM in all respects with one exception. And we remain concerned that elements of it such as not fully accounting for the relative intensity of care between initial and subsequent 30-day periods could result in unintended consequences related to Medicare beneficiaries' access to care.

As we've done in the past, we will continue to work individually and via our trade associations to provide constructive feedback to CMS and we are hopeful CMS will seek additional industry input, perhaps by reconvening the Technical Expert Panel or TEP which met only once in the process.

It remains too early to assess the potential impact of PDGM on our business in 2020. Much is likely to change in the details of the rule, our approach to the business and our patient mix between now and then.

CMS has proposed behavioral assumptions totaling approximately 6.4% related to coding specificity and [ph] LUPA (17:41) classifications, which would be implemented as a reduction in payment in order to achieve budget-neutral implementation of the PDGM. We will prepare ourselves for these assumed behavioral changes.

In addition, and based on our 2016 data, assuming no changes to the rule, our approach to the business and our patient mix, which are all very big assumptions and all unlikely to transpire, the estimated impact to our home health business is an incremental 5.4% reduction.

We have approximately 14 months in both the current and subsequent rulemaking processes to prepare for any resulting changes to the payment system. And we have demonstrated repeatedly in the past, we are still at adapting. We expect the final rule to be issued soon.

Now, moving to guidance. As a result of our strong performance in the first nine months of 2018, we are raising our full-year guidance ranges as follows.

Net operating revenues from a range of $4.2 billion to $4.275 billion to a range of $4.25 billion to $4.3 billion; adjusted EBITDA from a range of $865 million to $880 million, to a range of $880 million to $890 million; and adjusted earnings per share from a range of $3.45 to $3.58 per share to a range of $3.55 to $3.63 per share.

With that, I'll turn it over to Doug.

Douglas E. Coltharp, Executive Vice President & Chief Financial Officer, Encompass Health Corp.

Thanks, Mark, and good morning, everyone. As Mark highlighted, Q3 was another strong quarter for our company as both business segments exhibited solid revenue and earnings growth and we leveraged our corporate G&A expenses.

Let me begin by reiterating Mark's summary of our financial results. Our Q3 consolidated revenues increased 8.8%. Adjusted EBITDA of $224.3 million increased 9.6% and adjusted EPS increased by 37.9% to $0.91 per diluted share. Revenue and adjusted EBITDA for Q3 included $4.5 million of business interruption insurance recoveries related to the 2017 hurricanes and adjusted EPS included an additional $2.9 million in property insurance recoveries also related to those hurricanes.

Cash flow generation remains strong in Q3, driven by adjusted EBITDA growth and favorable working capital changes primarily related to improved collections of accounts receivable. Adjusted free cash flow for the first nine months of 2018 was $424.8 million, an increase of 12.6% over the prior year. Our balance sheet remains well-positioned. Our leverage ratio at quarter-end was 2.9 times and the balance on our $700 million revolving credit facility was $65 million. We faced no significant debt maturities until 2022.

Moving on to segment results, IRF segment revenue increased 5.4%, driven by volume and pricing growth. The aforementioned $4.5 million in business interruption recoveries is included in the outpatient and other line of IRF segment revenues.

Our revenue reserve related to bad debt for Q3 was 1.3% as compared to 1.4% in the prior year. I'll remind you that Q3 of last year was when we first began to see a significant reduction in pre-payment claims denials which we attributed to the implementation of TPE and the re-letting of the MAC contract from Cahaba to Palmetto.

As can be seen on page 21 of the supplemental slides, new claims denials remained at a low level in Q3. As we have said on our prior calls, we are pleased with our year-to-date experience on pre-payment claims denial, but we still do not have enough experience with Palmetto or TPE to assess the sustainability of the bad debt levels realized over the past several quarters.

Additionally, in September, CMS approved RAC audits for IRF patients based on medically reasonable and necessary criteria. We do not know to what extent we will be subject to these RAC audits, but this activity may also impact our revenue reserve for bad debt. This caution is reflected in our revised 2018 guidance and will likely continue to prevail into 2019.

As a final note on bad debt, little-to-no progress has been made on resolving the substantial backlog of claims, many now in excess of five years old awaiting adjudication at the ALJ level.

Discharges grew 3% in Q3 with 2% coming from same-store growth. Revenue per discharge for Q3 increased by 2.2% primarily due to increased reimbursement rates from all payers and patient mix within our non-Medicare business.

IRF segment adjusted EBITDA for Q3 increased 6.3% to $212.9 million. Q3 of this year included the previously discussed $4.5 million in business interruption insurance recoveries. And Q3 of last year included approximately $2.5 million in hurricane-related expenses.

Adjusted EBITDA is net of the non-controlling interest or NCI related to our joint venture partnerships. NCI increased by $2.3 million in Q3 due to increased adjusted EBITDA associated with our JV hospitals including the conversion of one wholly-owned hospital to a JV, and a bed addition and another JV hospital both of which occurred in Q3 of 2017.

Removing the impact of hurricanes from both years, SWB for Q3 was essentially flat with last year. Improvements in labor productivity were offset by group medical expenses as well as the ramping up of new stores. Labor productivity as measured by Employees Per Occupied Bed or EPOB improved to 3.49 from 3.52 last year.

Group medical expenses for Q3 increased 6.3% on a per employee basis. We did see an increase in claims activity within our group medical program in Q3 and the expectation of this trend continuing into Q4 is included in our revised guidance.

Our preliminary estimate is for group medical expenses to increase approximately 6% to 8% per [ph] FTE (25:27) in 2019, which we believe is generally consistent with estimates of healthcare cost inflation.

Moving now to our Home Health and Hospice segment, Q3 revenue increased 22.2%, driven by volume growth including the impact of Camellia, which closed on May 1st. Home health revenue increased 16% as admissions rose 9.2%, 3.8% on a same-store basis, episodes increased 14.9%, 6.9% on a same-store basis, and revenue per episode declined 0.4%.

As Mark mentioned, the clinical collaboration rate between our IRFs and Home Health agencies increased by 560 basis points over Q3 last year to 34.3%. Hospice revenue increased 84.3%, driven by acquisitions and including a same-store increase of 21.1%.

Home Health and Hospice segment adjusted EBITDA for Q3 increased 24.1% to $43.2 million. Cost of services as a percent of revenue increased 90 basis points, primarily due to merit increases de-levering against the reimbursement decline and the impact of Camellia on patient mix. Conversely, support and overhead cost as a percent of revenue improved by 80 basis points, primarily due to operating leverage resulting from our revenue growth.

We remain pleased with the development pipelines for both of our business segments. Within the IRF segment, we will be within our target range with four new hospitals opening in 2018 and at least another four anticipated for 2019.

Our de novo pipeline remains balanced between wholly-owned and joint venture opportunities and between CON and non-CON states.

Based largely on project timing issues, we expect to add approximately 30 beds to our portfolio in 2018, below our target of approximately a 100 per year. As a reminder, we added a 166 beds via bed expansions in 2017 and we expect to add more than a 100 in 2019.

For Home Health and Hospice, we exceeded our annual bogey of $50 million to $100 million in annual acquisitions with the closing of Camellia on May 1st and continue to augment our portfolio of Home Health and Hospice locations with smaller bolt-on acquisitions.

We are a disciplined acquirer and this results in a number of what appeared to be initially attractive opportunities not standing up to our due diligence. Our development pipeline remains populated with opportunities to create additional IRF overlap markets and includes a number of regional operators which may be actionable in the near to intermediate term.

Strong and consistent free cash flow generated by our companies, together with our relatively low financial leverage and the unfunded commitment of our revolving credit facility provides substantial capacity to pursue growth opportunities in both business segments.

And now, we’ll open the line for questions.

QUESTION AND ANSWER SECTION

Operator: [Operator Instructions] And your first question comes from Matt Larew with William Blair.

<A – Mark Tarr – Encompass Health Corp.>: Hey. Good morning, Matt.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning.

<Q – Matt Larew – William Blair & Co. LLC>: Hi. Good morning, guys, and thanks for the question. I first wanted to ask about the dynamics in the same-store IRF growth. Obviously, nice growth here at 2% and now coming off sort of a four-quarter run, some of the strongest growth you've had in years. Could you just walk through some of the dynamics of our same-store growth in this quarter and maybe relative to the last several quarters to give us a sense of what might be sustainable moving forward?

<A – Mark Tarr – Encompass Health Corp.>: Yeah, Matt. So, this is Mark. And we have 3% in our business outlook for total discharge growth and we're very pleased with what we saw in the vast majority of our markets relative to a same-store in terms of taking market share, continuing to develop programs specifically around the growth of stroke and other neuro which, we continue to believe, will help sustain this growth moving forward.

<A – Doug Coltharp – Encompass Health Corp.>: Matt, one piece of additional color that we'd throw on top of that relates to timing. What we experienced in the month of September is that the build-back in our ADC, following the Labor Day weekend, occurred a little more slowly this year than it did last year. But then, it built back very substantially in the second half of the month.

And then, that was compounded by the fact that September and the quarter-end was on a Sunday, which is our lowest discharge day of the week. And so, we carried a higher balance of in-house patients over into the month of October than we had in the previous years.

So, that had some impact on third quarter volume. It may be a little harder to see that show up in the fourth quarter numbers, A, because of the comp that we're up against, and, B, because of the impact of the hurricane.

<Q – Matt Larew – William Blair & Co. LLC>: Okay. Thanks. And then, just as a follow-up about longer term de novo and expansion activities in IRF. You mentioned that the bed expansion may be behind the 100 target for this year, but will be above that in 2019.

Obviously, your free cash flow generation, very strong year-to-date. Can you just help us think about the targets of 4 to 6 neuro, so 100 new beds per year in the context of the strong growth environment and the free cash flow generation? Is there a chance we see any upside revisions or different targets at some point here in the future?

<A – Doug Coltharp – Encompass Health Corp.>: That is definitely something we're evaluating. We speak a lot to the investment community internally. The demographic tailwind that is favoring both of our business segments reminds you that the average age of the patients that we treat in our inpatient facility is a 76, and the Vanguard or the baby boomers turned 72 this year.

That age cohort between 75 and 85 and [ph] has an anticipated favor (32:10) over the next 5 to 10 years between 4% to 5%, and yet over the last decade, the static of IRF beds in the – or the supply of IRF beds in the U.S. has been relatively static. All of that speaks to us about the opportunity to potentially add capacity more quickly. I think the targets are unlikely to change for 2019. But it is something that we're evaluating beginning in 2020.

Operator: And your next question comes from Matthew Gillmor with Baird.

<A – Doug Coltharp – Encompass Health Corp.>: Hello, Matt.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Hey. Good morning, everyone. Let me start with the guidance. You're implying a lower sort of growth rate in the fourth quarter versus the year-to-date. And another hurricane explains some of that. But I just wanted to confirm, are you maintaining the bad debt assumption and medical costs assumption for the fourth quarter? Or are there other things you'd call out to kind of to help us understand that difference in the growth rate?

<A – Doug Coltharp – Encompass Health Corp.>: Those are the two primary drivers, Matt. We carried those assumptions that they would both be mean-reverting into the fourth quarter, and then also on top of that, we should expect that the increase that we saw in NCI related to the composition of our joint venture hospitals is likely to perpetuate not only into Q4 but beyond that as well.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: And then as a follow-up, I want to ask about the Medicare Advantage mix on the IRF segment, the revenues from MA keeps climbing. It seems like you made a lot more progress this year than in prior years. So, can you tell us what some of the internal drivers are that's attributing – contributing to that or is that more sort of external factors in terms of just MA penetration?

<A – Mark Tarr – Encompass Health Corp.>: Yeah. It's Mark. I'll tell you that the – one of the primary drivers is we believe that the value proposition has really started to unfold for the payers, Medicare Advantage particularly when it comes to stroke patients. Almost 30% of the volume we get from Medicare Advantage is tied with stroke patients and that is a program that they have seen the benefits of having patients and the strong outcomes we get in an IRF setting versus sending them to a skilled nursing facility particularly.

<A – Doug Coltharp – Encompass Health Corp.>: And, Matt the combination of getting more stroke patients and more higher acuity patients, out in the Medicare Advantage plans together with an increasing percentage of our contracts being on a case rate basis on a per diem continues to close the gap between our average payment for discharge under fee-for-service and Medicare Advantage.

A specific example in Q3 of last year, Medicare Advantage on average paid us 82% of what we received from fee-for-service on a revenue per discharge and that was up to 88% in Q3 of this year.

The other thing that I would throw out there that may seem a little bit contrary to some of the Medicare Advantage trend is we track on a quarterly basis the enrollment in all of the counties in the U.S. in which we operate an IRF, the new enrollment in Medicare Advantage and the new enrollment in fee-for-service. In the counties in which we operated the third quarter, enrollment in fee-for-service was higher than it was in Medicare Advantage.

<A – Mark Tarr – Encompass Health Corp.>: Matt, one more thing on the – just in terms of our efforts and building our stroke program is that we're excited that next year, we'll be doing co-marketing program with American Stroke Association, which I'm going to ask Barb Jacobsmeyer to elaborate on.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: Yes. So, we'll be taking off in January of next year a three-year commitment with the American Heart, American Stroke Association to co-brand on educating both the consumers, as well as the professionals, the physicians and other clinicians, on stroke and where should stroke patients receive their rehabilitation care. So, we think that's just going to continue to give us the information we need out to the referral sources and the clinicians to support IRF-level care for stroke patients.

Operator: And your next question comes from Frank Morgan with RBC Capital Markets.

<A – Mark Tarr – Encompass Health Corp.>: Hello, Frank.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, Frank.

<Q – Frank Morgan – RBC Capital Markets LLC>: Good morning. Hey, I wanted to go back to one of the earlier questions about your capital deployment strategy. And I mean, I guess I would have asked the question the opposite direction which is just with the uncertainty around the IRF proposed rule and maybe even the home healthcare, does that – it doesn't sound like that's giving you any pause with regard to maybe even slowing down capital deployment until you really get this thing resolved.

And it sounds like your capital deployment through 2019 will be unchanged, but I guess that's a sign of confidence, your previous answer that you're not that worried about these new proposed IRF rules with the new case mix system or the patient-driven group remodel?

<A – Doug Coltharp – Encompass Health Corp.>: Well, we would never say that we're not worried about those new rules because they're going to be very substantial and we anticipate that both business segments, in spite of our best efforts to prepare for them, they're going to be bumpy on implementation. But nothing changes our view about the long-term growth in demand for each of the few business segments and each of the three service lines that we operate in.

I mean, the population in the U.S. is getting older. There isn't anything on the horizon that points to any kind of technical obsolescence for the types of conditions that we treat through our business segments. And somebody has got to be there on the provider side to add capacity increase and address that increase in demand, and we think that we should be one of those parties.

So, we remain very optimistic about the demographic tailwind. And, yes, it is our anticipation that we'll continue to add capacity. We also believe that to the extent there is any bumpiness in either one of the two business segments as we progress to these new payment model revisions in 2020. But that could create additional acquisition opportunities for us and, therefore, we may find it prudent to move into 2020 with a little extra slack in the balance sheet.

<A – Mark Tarr – Encompass Health Corp.>: Frank, just a reminder, the patients in our IRFs are non-discretionary in nature. They're very medically complex. They need this intense level of care. And in spite of what the reimbursement scenario lays out, these patients need to be treated in an inpatient rehabilitation setting and, therefore, as Doug said, we're very positive on the outlook going forward.

<Q – Frank Morgan – RBC Capital Markets LLC>: Got you. And that's a good answer. And maybe on the – in the interim, yeah, absolutely I get it that demand is not changing and that maybe there are bumps just with the change in the system, but the demand is still there. In terms of just through the bumpiness, could you maybe give us a couple of examples of what you could do from a mitigation standpoint, kind of what would be the normal levers that you would pull to kind of offset this until you kind of comp your way through it and rebase off of it. Thanks.

<A – Mark Tarr – Encompass Health Corp.>: Frank, at least on the IRF side, the first thing we're doing is just making sure that our staff is educated on the CARE tool. I'm going to ask Barb Jacobsmeyer to go a little bit further in depth on that.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: Right. So, when we thought there would be initial set of data, what we did see is there was a lot of variability not just within our company, within the industry on how things are being scored on that new CARE tool. And so, the biggest focus for us right now is really educating our clinicians on some clarification that we've received from CMS on some of the ways that this CARE tool is scored. And so, our focus right now is just making sure we have the consistency among our clinicians on how that's being done so that we're prepared for that come next October.

<A – Mark Tarr – Encompass Health Corp.>: Back in August, CMS had came out with some Q&A that provides some information to us at least in terms of clarifying how to apply the CARE tool itself, and we had some questions on application, and that led to some of the differences from one side to another. So, some of those questions have been clarified, and we feel better about it going forward. April, do you want to comment on the PDGM and the focus?

<A – April Anthony – Encompass Health Corp.>: Sure. On the mitigation side for home health, I mean obviously so much of our cost is tied up into the direct personnel cost. We always have to keep a close eye on our cost per visit, make sure that we're doing a good job of balancing our utilization of RNs versus LPNs, PTAs versus physical therapist. And so that certainly will be a continued focus in the PDGM era.

I think the other thing that we'll have to look at is utilization control and really we are working on a number of tools that we can implement to use more of a data science-based approach to make sure that we're actually providing really a best practice set of utilization for visits during these episodes. So, I think we'll look at our utilization controls and how we can do a better job there.

And then, the third thing, I would say, is given the high level of expected behavior change at 6.4%, we're going to have to understand exactly what Medicare's expectations are on that. And then, we're going to have to successfully execute and implement strategies around those expectations so that we don't come in on the wrong side of what they expected us to do.

So, those would be three major efforts and there'll be others that will evolve as we get closer and have more clarity on PDGM with the final rule, but those would be the three big ones for now.

Operator: And your next question comes from A.J. Rice with Credit Suisse.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, A.J.

<A – Mark Tarr – Encompass Health Corp.>: Good morning, A.J.

Operator: A.J., your line's open. You may be on mute.

<A – Doug Coltharp – Encompass Health Corp.>: Maybe we can come back to A.J.

Operator: And your next question comes from Sarah James with Piper Jaffray.

<Q – Sarah James – Piper Jaffray & Co.>: Thanks. Thank you.

<A – Mark Tarr – Encompass Health Corp.>: Good morning, Sarah.

<Q – Sarah James – Piper Jaffray & Co.>: Good morning. I just wanted to clarify some of these comments that you've made on the call today. So, when you talk about utilization control, is that the timing of treatment between the first and second 30 days or total treatment over the course of care? And could you be more specific about some of the aspects that you got further clarification on from CMS that made you feel more comfortable with the rates?

<A – Doug Coltharp – Encompass Health Corp.>: We'll start first with April.

<A – April Anthony – Encompass Health Corp.>: So, on the home health side, the utilization control, I would be referencing, would be more over the total episode. I think there may be some opportunities to look at the way care is distributed across the 60 days.

But, I think, it's really going to be – the primary focus will be on making sure that we're truly adding value with every single encounter that we have with the patient and that that we're really doing our very best to drive as much value through each interaction as possible so that we can potentially cut one or two interactions out without diminishing in any way the quality or the outcomes that we deliver for the patient.

<A – Mark Tarr – Encompass Health Corp.>: Then on the rehab rule, IRF.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: On the IRF rule, there were questions around on the FIM tool. You always did it by burden of care. And on the CARE tools, there was this – you score the patient based on usual and customary.

So, there was a lot of confusion around what does that mean and what was the timeframe that you scored the patient? So, we got some clarification on that you really looked at the patient's burden of care until therapy was initiated. So, some good clarification to help us, at least, give a direction and time frames to our staff on how to evaluate the patients initially.

<Q – Sarah James – Piper Jaffray & Co.>: Got it. That's helpful. And last clarification here on rates. So, when I think about the change to 30 days from 60 days, and trying to get the pace of treatment right, how do you think about on average what percent of total treatment costs are happening in the first 30 days for Encompass given your mix and how is that varying from the industry or what you can tell so far of CMS' view of how they'd like to set up the split?

<A – April Anthony – Encompass Health Corp.>: Yeah. I don't have the specific data on the split between proportion of care in the first 30 to the second 30 days at my fingertips. I don't think as we looked at it globally, we saw anything that led us to believe we looked materially different than the average across the industries, but I don't have that exact data in front of me.

Operator: And your next question comes from Kevin Fischbeck with Bank of America.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, Kevin.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Good morning. Thanks for taking the question. So, I think you mentioned before that your MA continues to grow on the IRF side of things. [ph] You've talked a little bit (45:25) about on the home health side of things if you could give maybe a similar kind of view about where MA rates are there and whether they're trending back towards fee-for-service?

<A – Mark Tarr – Encompass Health Corp.>: I'm going to ask April to weigh on that, Kevin.

<A – April Anthony – Encompass Health Corp.>: Yes. So, when we look at Q3 2017 to Q3 2018 we see our Medicare Advantage rates remained pretty static from 9.6% of our total patient population to 9.4%. And we think that part of that slight weighting down was really more about the Camellia locations which were in a little less intensive Medicare Advantage markets in Mississippi in particular.

So, we haven't seen dramatic changes in that. I think what we have seen within that category is continuing to push toward the types of Medicare Advantage relationships that can really work successfully for us. And so, although the percentage is relatively flat, I think we've had some puts and takes with our individual relationships. And what we've done, just as Doug mentioned, on the IRF side is that we've actually driven up the value of those relationships and the relative revenue that we can drive from those relationships continues to improve.

It's a slow evolution. Overall, I would say to the Medicare Advantage world that we are just continuing to see more and more opportunities for acceptable relationships in that segment.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: And I guess maybe just building on that, what's driving that increased dialog? Is it still within the same types of services? So, it's just really about convincing them about the rehab capabilities or when I talked to the MA plans, it seems like they're actually a lot more interested in treating chronic patients, and I almost wonder why there's a change in reimbursement that we're looking at here with this new model taking money out of rehab and putting it into other non-rehab things might open up more MA relationships, if you will, if you're starting to treat some of the patients that they really want to get control of?

<A – Doug Coltharp – Encompass Health Corp.>: I think that's absolutely the case on the IRF side. Again, Mark used the term value proposition. And what we're seeing, it started with stroke where we think we have a fantastic story to tell just about the clinical expertise that we have and the results that's producing on a consistent basis. It's now expanding the dialog around other neurological complexities.

And really, the higher acuity patients for whom there's no opportunity to bypass a post-acute inpatient setting all together where it's clearly better to have that patient discharge from acute care facility in a reasonable period of time, both in terms of the patient's outcome and the cost of the payer and that really aggressively managing length of stay on the post-acute inpatient stay it's produced negative consequences for those clients as well.

So, we find it particularly at the top end of the acuity spectrum on the IRF side are much more willing to engage in dialog and to have us manage the patients the way that we believe is appropriate and not have a case manager on the phone with us on a daily basis.

<A – April Anthony – Encompass Health Corp.>: I think in the home health side, what we're seeing is patients that are being sent directly home from the acute care hospitals and not making that intermediary, say, in a skilled nursing facility and we're finding that our payers are recognizing that if the patient has the right home support and the right caregiver support that they can really accomplish with home health, much the same outcome as they accomplish with [ph] this stay (48:51) at a much lower cost. And so, we're seeing kind of those chronic comorbid patients that are frequent flyers to the hospitals that these Medicare Advantage plans are looking more to home health than nursing homes to solve those issues.

Operator: [Operator Instructions] And your next question comes from Kevin Ellich with Craig-Hallum.

<A – Mark Tarr – Encompass Health Corp.>: Hi, Kevin.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, Kevin.

<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>: Good morning, guys. Thanks for taking the questions. I guess, just going back to, I think, Frank might have asked a question about mitigation for the potential reimbursement changes. Going to April, for PDGM, what from a topline perspective can you do? I think there is maybe some benefit from seeing more admissions into home health from hospitals? Could you kind of expand upon that?

<A – April Anthony – Encompass Health Corp.>: That is correct. We do also see that as we shift mix to a more post-acute discharge patient, that there are higher revenue levels associated with those patients that are coming out of not only acute care facilities, but also inpatient rehab, LTAC and even SNF patients have some higher opportunities.

So, I think, we are seeing with the growth of our Care Transitions Coordinator Program, where we're working with hospital facilities, to bring patients home sooner. We see that as an opportunity.

And as Mark and Doug mentioned previously, part of the reason that we're uncomfortable really committing to the impact in 2020 is that, we do believe there will be significant changes to our business mix, and a lot of that change will be driven by the effectiveness of this Care Transition Coordinator Program that was put in place, actually, about a year ago, but is really beginning to gain some momentum as it relates to bringing patients out of hospitals and directly home.

<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>: Great. And then, April, since I got you, can you comment about the legislation going through D.C. right now? And, I guess, you've seen this happen in the past with home health reimbursement changes, wondering how the support looks this time versus in the past and if you think if it's different this time versus what it's been like in the past.

<A – April Anthony – Encompass Health Corp.>: I think we feel encouraged by the bipartisan support that we've had both at the House and Senate level on the bills that are floating around. Obviously, it's still early in the progress with those bills.

But when you look at this idea that Medicare is going to presume a 6.4% behavior change, which is exponentially higher than any actual behavior change that's been seen over the course of the last 20 years as there have been varying changes to the reimbursement model, it's not that difficult to get support to say, hey, this is not a reasonable expectation.

And then when you drill down further to what Medicare has said their expectation is, why they got to that 6.4% number, you read some of that and you say, boy, that would be a very unusual outcome that, for example, that a 100% of the time, we could alter the way coding is addressed for particular patients that have a secondary diagnoses that might have a more valuable primary diagnoses.

And so, when you look at the details of how Medicare got to that, it's just not that hard to rally support to say, hey, we are happy to be subject to an adjustment for where our behavior does change. But it's really an unfair approach to presume what we will do, particularly when your presumptions are as aggressive as theirs are in this case. So, I think we found pretty good support and believe that it will not be that difficult to rally support behind those bills because of the dramatic effect that these presumed changes would have on the industry.

Operator: And your next question comes from A.J. Rice with Credit Suisse.

<A – Doug Coltharp – Encompass Health Corp.>: Welcome back, A.J.

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Hi, everybody. Two quick things. First of all, on the capital deployment, I know you haven't done any share repurchases this year. And I wonder if you'd just comment on your thinking about that in the context of overall capital deployment. I know it may have something to do with saving dry powder for the Encompass rollover shares that potentially get bought out early next year. But any comment along the lines of what you're thinking there?

<A – Doug Coltharp – Encompass Health Corp.>: A couple of things there, A.J. First of all, yes, we do view the acquisition of that third of the shares from the management shareholders in our Home Health and Hospice subsidiary that were put to us in September or in the beginning part of the year as a form of share repurchase.

The second is, you noted that in July, our board replenished the stock repurchase authorization back up to $250 million level.

But the third is, we really are optimistic about the growth opportunities that are going to be presented to us in three specific business lines, on the IRF side, in Home Health and in Hospice where we continue to want to build scale.

We are very optimistic about the opportunity to deploy capital to grow our presence in all three of those businesses in 2019 and beyond because there will be, again, some trepidation with regard to providers across these segments regarding the rule changes, and we want flexibility to be able to capitalize on that because the long-term growth and demand in all three of these business lines is not going away.

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Okay. That's great. And this is obviously very specific to Q4, but if I look at your Q4 implied EBITDA guidance at the midpoint, it's around $206 million sort of a flattish to slightly down year-to-year assumption. I know you've highlighted these $4 million to $5 million of negative impact around the hurricane, but alternatively I guess you still have some benefit year-to-year from the contribution from the Camellia acquisition.

I don't know what the underlying assumption on bad debts and medical expense whether that's changed in any way. Are you assuming that sort of goes back to the historic bounce back versus what you're seeing so far this year? But anyway, I'm just trying to understand the puts and takes that lead you to something that's sort of flattish even recognizing your $4 million to $5 million negative impact from the hurricane.

<A – Doug Coltharp – Encompass Health Corp.>: So, it's three line items, all of which are within the IRF segment. And it's the anticipation that both group medical and bad debt revert back to historical levels and not to levels that we've experienced within the last few quarters here.

And those would be pretty significant increases. And then the third again is just the increase in NCI that we're seeing as a result of the composition of our beds between joint venture relationships and wholly owned and also where the more substantial portion of EBITDA [ph] increases accrue (56:03).

Operator: And thank you. I would now like to turn the call back over to Crissy Carlisle for any closing remarks.

Crissy Buchanan Carlisle, Chief Investor Relations Officer, Encompass Health Corp.

Thank you. If anyone has additional questions, please call me at 205-970-5860. Thank you again for joining today's call.

Operator: And thank you. This does conclude today's conference call. You may now disconnect your lines.