Encompass Health Corporation

Q2 2019 Earnings Conference Call

July 30, 2019

MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone, and welcome to Encompass Health's Second Quarter 2019 Earnings Conference Call. At this time, I would like to inform all participants that your lines will be in a listen-only mode. After the speakers' remarks, there will be a question-and-answer period. [Operator Instructions] You will be limited to one question and one follow-up question. Today's call is being recorded. If you have any objections, you may disconnect at this time.

I'll 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 second quarter 2019 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 second 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

31, 2018, and the Form 10-Q for the quarters ended March 31, 2019 and June 30, 2019 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 speaks 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 second quarter was another strong quarter for Encompass Health with consolidated revenue increasing 6.3%, adjusted EBITDA increasing 8.9% and adjusted earnings per share increasing 9.1%. These solid results reflect the strength and sustainability of our business model, a business model that is backed by favorable demographic trends. Doug will review the details of our financial and operating performance in just a few minutes. I'll spend my time providing an update on our strategic initiatives and the regulatory environment.

During the second quarter, we continued to expand our portfolio of inpatient rehabilitation hospitals by opening a new 40-bed joint venture hospital in Lubbock, Texas. We also added 81 beds to our existing hospitals, including the completion of our third bed addition at our hospital in Ocala, Florida. This hospital opened in 2012 with 40 beds and has now grown into a 70-bed hospital due to increasing demand for our services in that market. We anticipate three additional IRF de novo openings in 2019. Our 40-bed joint venture hospital with Saint Alphonsus in Boise, Idaho opened this past Sunday. We have wholly owned hospitals in Katy, Texas and Murrieta, California nearing completion.

Our inpatient rehabilitation hospital de novo pipeline remains robust with both joint venture and wholly owned opportunities. We continue to be an industry leader in successfully navigating the frequently complex waters of state regulatory agencies to obtain Certificates of Need for new hospitals. We recently announced our plan to build a new 50-bed hospital in Tampa Bay, Florida and we expect to make announcements later this year regarding our plans to build two new inpatient rehabilitation hospitals in Georgia.

During the second quarter, we also added one new home health location in South Carolina, and on July 1, we closed the acquisition of Alacare Home Health and Hospice, which added 23 home health and 23 hospice locations across Alabama to our portfolio, including three new overlap markets. Both the opening of our new hospital in Texas and the new home health location in South Carolina created new overlap markets for us, and the Alacare acquisition created three incremental overlap markets, enabling us to expand the benefits of clinical collaboration to more patients.

Our two segments continued to work together to increase clinical collaboration and achieved a 34.9% clinical collaboration rate in the second quarter of 2019, a 170-basis-point increase over the second quarter of 2018. We also continued our focus on meeting the needs of patients recovering from strokes. Currently, we have 117 hospitals that have earned The Joint Commission's Disease-Specific Certification (sic) [Disease-Specific Care Certification] (00:06:57) in stroke rehabilitation. We believe our expertise in treating stroke patients, combined with the clinical practice guidelines released by the American Heart/American Stroke Association and our strategic sponsorship of that organization is contributing to the growth in the number of stroke patients we treat.

Our three-year CAGR for all stroke patients is approximately 6%. For Medicare Advantage plans, our three-year stroke CAGR is approximately 13%. These growth statistics demonstrate that the value of our inpatient rehabilitative services for patients recovering from stroke are being recognized in the market. We will continue our efforts to educate physicians, payers and patients on the efficacy of stroke rehabilitation in the inpatient rehabilitation hospital setting and of our specific clinical expertise in the provision of these services.

Progress also continues in our development of post-acute solutions that focus on improving patient outcomes and lowering the cost of care by reducing hospital readmissions across the entire episode of care. In the first half of 2019, we continued to refine our 90-day post-acute readmission prediction model, and in April, launched a pilot project that combines this model with several other existing tools

for our inpatient rehabilitation hospitals in the Houston market. All seven of the IRFs in this pilot are part of overlap markets and clinically collaborates with our home health agencies.

Our hospitals also continue to prepare for the transition to the CARE Tool payment system for inpatient rehabilitation hospitals on October 1 of this year. We remain focused on working with our hospitals to improve the documentation that captures each patient's functional abilities under the new care elements and we continue to see improved interrater reliability across our portfolio. As disclosed previously and based on information included in the fiscal year 2020 Proposed IRF Rule, we continue to believe the transition to this new payment system will result in Medicare reimbursement rates for our company that would be flat to down 25 basis points in the fourth quarter of 2019 and for the first three quarters of 2020. We expect CMS to release the fiscal year 2020 final rule for IRFs any day now.

In home health, we continue to prepare for the implementation of the Patient-Driven Groupings Model or PDGM. Early this month, CMS released the 2020 proposed rule for home health. The proposed rule affirmed the implementation of PDGM on January 1, 2020, and updated CMS' proposal to adopt reimbursement cuts aimed at counteracting assumed provider behavioral changes that CMS believes could occur as a result of PDGM's implementation. We have updated the estimated impact to our home health business of implementing PDGM from negative 3.8% to negative 2.8%. The 100-basis-point improvement resulted from changes in our patient mix over the course of 2018 and the acquisition of Alacare.

Within the proposed rule, CMS increased the total behavioral assumption cuts from negative 6.4% to negative 8%. Within that amount, the assumed behavioral adjustments related to coding practices increased from negative 4.2% to negative 5.9%. We remain very concerned about the magnitude and nature of the unprecedented assumed behavioral adjustments contained in this rule and will continue to seek relief via discussions with CMS and through legislation.

Regarding the latter, pending bipartisan legislation in Congress called the Home Health Payment Innovation Act of 2019 would require CMS to use actual observed data and evidence derived from the new payment model. The bill would ensure any needed cuts would be phased-in in a manner that is more consistent with what past industry behavioral changes have looked like or within a range of 2% or less.

Bipartisan support is rare in this day and we believe the support home health is receiving shows the value of homecare is widely appreciated by both parties as not only a low-cost settings, but also as the

preferred setting for care for many of America's seniors. Over the next few months, we will continue to work individually and as part of our trade associations to provide feedback on the proposed home health rule to Congress and CMS as we await CMS issuance of the final rule or intervention from Congress.

Our preparation for PDGM includes the use of technology to generate objective, evidence-based care plans and to drive incremental efficiencies in administrative support functions. We are working with Medalogix to further refine our care plans for all home health patients we serve and are working with Homecare Homebase on key system enhancements to ensure the increased billing frequency PDGM will require as part of its move from 60-day payment periods to 30-day payment periods to not result in a doubling of our billing-related costs.

Also as a result of the continuing investments we've made in our Care Transitions program, we're seeing an increase in admissions from acute care hospitals. As we've stated previously and we'll continue to remind you, neither of the proposed new payment systems for our operating segments changes the long-term outlook for our company, which is predicated on demographic trend driving increasing demand for the services we provide.

We believe we are well positioned as a company to work through these changes and we've a proven track record of being able to do so. We will continue to expand our network of inpatient rehabilitation hospitals and home health and hospice locations, further strengthen our relationships with healthcare systems, provider networks and payers in order to connect patient care across the healthcare continuum and to deliver superior outcomes.

I also want to comment briefly on the finalization of our settlement with the Department of Justice. In June, we settled this investigation which was initially disclosed in March of 2013 for $48 million. The Department of Justice claim doctors in our hospitals misdiagnosed certain conditions to manipulate compliance with the 60% rule. These doctors are not employed by us and exercise independent medical judgment. In all cases, they stood by their original diagnosis.

The investigation lasted seven years and involved a great deal discovery. It produced no evidence of falsity or wrongdoing that somewhat releases all of our hospitals from 2006 to the date of the settlement. There is no Corporate Integrity Agreement, because there was nothing identified that needed correction. We believe this settlement is in the best interest of our shareholders as it avoids substantial cost of litigation and the internal burdens and distractions of a prolonged investigation.

I'll wrap up my comments with a discussion of our 2019 guidance. Based on our results for the first half of 2019 and our current expectations for the remainder of 2019, we are increasing our adjusted EBITDA guidance to a range of $940 million to $960 million. This guidance update includes our acquisition of Alacare.

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. Our Q2 results were again characterized by strong financial and operating trends in both business segments. Our consolidated revenues rose 6.3%, fueling an 8.9% increase in adjusted EBITDA to $252.2 million and a 9.1% increase in adjusted EPS to $1.08 per diluted share. Adjusted free cash flow for the first half of 2019 remains strong at $270 million, down modestly from the first half of last year, owing primarily to increased accounts receivable balances related to Targeted Probe and Educate or TPE reviews and a decline in collections of previously denied claims.

During the first six months of 2019, we used free cash flow and borrowings under our revolving credit facility to fund $184 million in CapEx, $44 million in common stock repurchases, $55 million in cash dividends on our common stock, a voluntary redemption of $100 million of our 5.75% Senior Notes due 2024, the $217.5 million acquisition of Alacare and the $48 million DOJ settlement. As a result of this activity, our funded debt increased by approximately $200 million from year-end levels and our leverage ratio increased modestly to 2.9 times. We expect the leverage ratio to rise further in the second half of the year as we fund the redemption of rollover shares and the exercise of stock appreciation rights in our home health and hospice subsidiary as more fully described on pages 5 and 19 of the supplemental slides.

Moving now into the business segment results, IRF revenues in Q2 increased 4.7% driven by 3.7% discharge growth and a 1.5% increase in revenue per discharge. Same-store discharge growth of 2.2% for Q2 was negatively impacted by approximately 20 basis points from the continuing effects of Hurricane Michael on the Panama City market. Revenue reserves related to bad debt increased 20 basis points over the same period last year to 1.4% of revenue. During the quarter, we did see the initiation of TPE reviews at approximately 30 hospitals under the jurisdiction of Palmetto. These are the first TPE reviews we have had with Palmetto and it is too early in the review process to draw any conclusions regarding their resolution.

We continue to have in excess of [ph] $135 million (00:19:25) in previously denied claims awaiting adjudication at the ALJ level. IRF segment adjusted EBITDA for Q2 increased 4.7% to $233.9 million. SWB in Q2 increased by 90 basis points to 50.8% of revenues, within the range of our expectations. Higher salaries and wages and an increase in group medical expense were partially offset by favorable trends in workers' compensation expense. Labor productivity improved during the quarter with EPOB of 3.41 as compared to 3.43 in Q2 last year. Other operating expenses for Q2 declined by 60 basis points due primarily to lower provider and other taxes and favorable trends in general and professional liability expense.

Turning now to our home health and hospice segment, revenue increased 12% in Q2 with an 8.7% increase in home health and a 35.7% increase in hospice. Home health revenue growth was driven by volume gains as admissions grew 11.2% in Q2, including 8.3% same-store growth. Revenue per episode declined 30 basis points due to the timing of completed episodes and the favorable resolution of the ZPIC audit in Q2 2018. Hospice revenue growth was primarily attributable to acquisitions, but also included strong same-store growth of 13.6%.

Q2 hospice ADC of 2,852 increased by approximately 35% over the prior year. Building scale in our hospice business remains a strategic priority and the increase in ADC is evidence of the progress we are making. The Alacare acquisition adds approximately 800 ADC to our hospice business. Home health and hospice segment adjusted EBITDA for Q2 was $49.1 million, an increase of 18% over the prior year and again benefited from the May 1, 2018 acquisition of Camellia. Growth in segment adjusted EBITDA was also driven by lower cost of services as a percent of revenue owing to our continued focus on caregiver optimization and productivity.

During Q2, our home health cost per visit was held flat on a year-over-year basis at $76 while visits per episode declined 17.1 as compared to 17.5 a year ago. Finally, our corporate G&A for Q2 again decreased in both nominal dollars and as a percentage of consolidated revenue as compared to Q2 2018, primarily due to the reduction in expenses associated with our rebranding initiatives.

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

QUESTION AND ANSWER SECTION

Operator: [Operator Instructions] We do ask that you limit your questions to one and a follow-up. Your first question comes from the line of Whit Mayo with UBS.

<A – Mark Tarr – Encompass Health Corp.>: Morning, Whit.

<A – Doug Coltharp – Encompass Health Corp.>: Morning, Whit.

<Q – Whit Mayo – UBS Securities LLC>: Hey. Thanks, guys. Mark, can you maybe just spend a minute talking about the development pipeline for de novos for inpatient rehab? And some of our survey work shows there is some growing interest around doing some partnerships and joint ventures on inpatient rehab. So, I'm just wondering if there are any new themes that you see developing in the market. Is this just a focus on stroke or post-acute? Just any thoughts would be helpful. Thanks.

<A – Mark Tarr – Encompass Health Corp.>: Yeah. I think it's a combination of all of the above, Whit. If you look back at our history, our first partnership facility is close to 30-years-old now, and about a third of our total portfolio of hospitals are made up of joint venture arrangements with hospital systems. As things have progressed and things become more and more difficult to service all the needs of all types of patients for acute care systems, they're looking to focus primarily on the acute care programs and service lines, and reserve their capital needs to service and expand those programs. And – but they also have the chance to look for someone like an Encompass Health to manage their rehab product line for them and grow that. And the vast majority of those times, that includes building a new freestanding rehab hospital and taking those patients out of their space, so they can expand their acute care programs and combine with us for our expertise and clinical backgrounds in needs of inpatient rehabilitation patients and home health patients.

<A – Doug Coltharp – Encompass Health Corp.>: Whit, I think it's also a function of a couple of things that we've been talking about for quite a long period of time. And that is in spite of the fact that we've been adding capacity by doing de novo hospitals and through bed expansions, if you look nationwide, the overall supply of licensed beds in the IRF space for about the last decade has been relatively flat. And that stands in contrast to the demographic trend that we've been talking about, where the CAGR for patients aged between 75 and 85 is approaching 5%. And so, there's this pending imbalance that I think is now being recognized increasingly by acute care hospitals and they recognizes, as Mark said, that they neither have the capacity nor the expertise to address those patients' post-acute needs.

<A – Mark Tarr – Encompass Health Corp.>: Whit, as I mentioned in my comments earlier, we – our pipeline contains both wholly owned opportunities like we mentioned in Katy, Texas, in Murrieta, California as well as a partnership opportunity. So, we feel very good about the size of our pipeline and the markets we have an opportunity to expand.

<Q – Whit Mayo – UBS Securities LLC>: That's great. That's helpful. And maybe my second question for April. Just wondering if there is anything new to share about your strategic plan for 2020, how maybe you're thinking about portfolio management or any targeted development. Just wasn't sure if anything maybe crystallizing your mind now that you've seen the proposal that reshape your views on 2020. Thanks.

<A – April Anthony – Encompass Health Corp.>: Yeah. I would say there's no reshaping of our views. I think the proposal came out pretty similar to our expectations. As we had talked about even last year, what we do find in PDGM is a lot of variance, I mean you find markets across the country that are going to be up 20%, you find markets that are going to be down 20%. We think it's one of the inherent flaws in the PDGM proposal is that it has these very long tails. And so, we're looking at those opportunities. We're looking at markets where we think there's going to be some geographic disruption across the industry.

And looking at the opportunities for growth and expansion in those markets for our organization, because of our high efficiency from a margin perspective, we think we'll fare better in the down markets than others will, and certainly in the opportunity markets where there are big increases expected based on the mixes of patients in those regions we would look from an acquisition perspective. But I think not particularly a changed view, but just to continue to lean into the opportunities that we find and take advantage of the efficiencies we've created over time.

<Q – Whit Mayo – UBS Securities LLC>: Okay. Thanks.

Operator: The next question comes from the line of Matt Larew with William Blair.

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

<Q – Matt Larew – William Blair & Co. LLC>: Hi. Good morning. I wanted to ask Doug about guidance, obviously, with EBITDA guidance moving higher, revenue and EPS guidance staying on track. Mark alluded to, obviously, some of the momentum we have with new IRF facilities and beds coming online, the Alacare deal closing and then, obviously, the strong performance in the quarter. Could you just walk us through what the various dynamics in the back half of the year are that expect some of those guidance changes?

<A – Doug Coltharp – Encompass Health Corp.>: Yeah. So, I think a number of things to consider. First of all, as we move into the second half of the year, and as you compare that to the first half of the year, some of the outperformance that we've had in the first year, much of that has been within the expense categories. In the home health business, we've had two quarters of very good performance with regard to productivity in the forms of both controlling cost per visit and managing episodes – or visits per episode. Those things become a little bit more challenging in the second half: A, because we're anniversarying some of the improvements that were made last year; and B, just as you get into periods where there's more PTO, the levers that you can pull to drive those metrics are a bit more limited. So, we've been I think a little bit more guarded with regard to building an assumption in the second half of the year, and this is for both home health and hospice that we'd see the same degree of upside on labor productivity there.

On the IRF side, again, we had some things that we weren't necessarily anticipating with regard to favorable developments on provider taxes that gave us some benefit in the first half of the year and that also helped us to – that was a component of what helped us to drive [ph] LLE (00:29:29) lower, so – and then, the wildcard always remains out there on volume. And so, really those are the things that are underlying. We basically have not changed our assumptions regarding the key line items for the second half of the year. We're halfway through the year and we'll see how those things develop. But we believe we had set out realistic expectations predominantly impacting the revenue line, which is the combination of our pricing and volume assumptions and we haven't seen anything materialize in the first half of the year because of the change in those assumptions.

With regards to Alacare, I know there have been some questions about that, bear in mind that although Alacare – with Alacare, we acquired a very well-run business and one that is highly compatible with our organization on multiple fronts. It nonetheless takes time and it takes money to successfully integrate an acquired enterprise of that size. And what we find is even for an enterprise that is on Homecare Homebase, the system that we use and Alacare falls into that category, there are retraining expenses and efforts that need to take place and those usually impact the EBITDA of the acquired company during about the first six months of acquisition under the best cases and we think Alacare falls into that category.

<Q – Matt Larew – William Blair & Co. LLC>: Okay. Thanks. That's helpful. And then, I wanted to follow-up on the IRF side. Obviously, strong same-store growth despite what was a difficult comp and revenue per discharge, again, pretty strong. You mentioned on the first quarter call some of the trends with stroke and Medicare Advantage pricing. I just wondered, Doug, if you could provide any additional color on either side, either what was driving same-store growth or revenue per discharge in the second quarter.

<A – Doug Coltharp – Encompass Health Corp.>: Yeah. Matt, we saw another strong quarter with regard to our Medicare Advantage book of business, and again, the growth was concentrated in the stroke and neuro categories, which I think really underscores our value proposition there. In the second quarter, our discharge growth within the Medicare Advantage book of business was in excess of 18% and the pricing growth was greater than 4% on a revenue per discharge basis. And I think as a result of those things, the discount between our Medicare Advantage book and our fee-for-service declined to 10%. And so, we continue to see very favorable developments there.

We're seeing good growth in Medicare Advantage on the home health side as well. Our Medicare Advantage grew about 20% in the second quarter in terms of the number of visits, but unfortunately Medicare Advantage still hasn't made the same progress with regard to reconciling payments towards the fee-for-service schedule in home health as they have on the IRF business. And so, it becomes difficult for us to take what are sometimes limited clinical resources in our home health markets and get excited about devoting those to Medicare Advantage. We think we'll continue to make progress there, but it's a bigger – there is more opportunity to close that gap on the home health side than there is on the IRF side.

<A – Mark Tarr – Encompass Health Corp.>: Matt, I think it's worth noting, as a percentage of our total discharges in our IRFs, last quarter was the highest quarter we've seen in a multiyear period for stroke. So, we're very pleased with how that program is trending. And as I mentioned in my comments, the relationship we have with American Stroke Association and reaching out in the local markets and building our brand.

<A – Doug Coltharp – Encompass Health Corp.>: The one thing to be cognizant although is that there is a little bit of a headwind that our growth in Medicare Advantage on the IRF side creates in terms of the clinical collaboration rate and it again relates to that payment disparity that exists between Medicare Advantage and Medicare fee-for-service on the home health side. So, whereas on a pure Medicare basis, our clinical collaboration rate both sequentially and on a year-over-year basis continues to make

significant strides as we see a higher percentage of patients, many of whom require home healthcare, on the MA side through the IRFs, and we're not quite keeping pace with that on the home health side that weighs a little bit negatively on the clinical collaboration rate. It's not a significant return and we're confident that that will be addressed over time, given the progress that we're making on establishing more favorable contracts with MA plans on home health, but there's a little bit of a disparity that exists right now.

<Q – Matt Larew – William Blair & Co. LLC>: Okay. Thanks for all that detail.

Operator: Your next question comes from the line of Matthew Gillmor with Baird.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Hey. Thanks.

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

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

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Hey, guys. Hey, everybody. Hey, I wanted to follow-up on some of the stroke discussions, especially with the Medicare Advantage growth rate on the IRF side. Either Mark or Barb, can you give us a sense for sort of how you target growth in that market? Is that more about demonstrating the value at the health plan level or is it more blocking and tackling with the discharge planners? And if you've any comment with respect to the sustainability of that double-digit same-store number for Medicare Advantage stroke cases?

<A – Barb Jacobsmeyer – Encompass Health Corp.>: Sure. It's actually both of those things. I will say that many times as with the case managers, it's about getting that referral and not having them be deterred by the thought that we will not get a precert. So, once we have that referral, there are times where our physicians actually have to do what's called a peer-to-peer, where our physician talks to the Medical Director of the plan directly to really emphasize the need for that precert. What we're doing on the backend then is when we get that precert and we have that successful stay and we get that patient home, we're following back-up with that payer, with that Medical Director to let them know of the outcome to reinforce that they made the good decision on the precert side and that's certainly helping us to get more of these precerts converted.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: And then, as a follow-up, I guess I wanted to ask about sort of how you develop care plans on the home health side and sort of in light with your work with Medalogix. And we saw the visits per episode come down a little bit year-over-year, but maybe just give us a sense for how care plans were developed today and kind of how that will work under PDGM with the Medalogix partnership.

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

<A – April Anthony – Encompass Health Corp.>: Sure, Matt. I think care planning is still a very patient-specific effort. And so, we absolutely are using Medalogix. We're using all the tools that we can within Homecare Homebase to make sure that we are deploying best practices for each patient. But at the end of the day, every care plan is really defined on a patient-by-patient basis based on their specific needs. But what we're finding with Medalogix is the ability to really lean back into our best historic practice. And one of the things the tool effectively does is let us go back and look in a way that you really couldn't do with just human effort through data intelligence to go back and sort of look at when did we achieve the best outcome for a patient that is the closest match to the one that we're looking at today.

And so, it goes back and really kind of challenges our clinicians to say we've had patients like this before. In the past, we've been able to accomplish their outcome this way, challenges us to think about how could we do that again for this particular patient. And so, in spite of the fact that we have the tool, we certainly don't ever just default to the technology. We blend that together with the observed realities that the nurse is seeing or the therapist is seeing to make sure that that patient is truly getting what they need to meet their individualized needs.

But I do think that by having that tool that challenges best practice and challenges us to think about our best combination of resources, it has helped our clinicians to be a bit more discerning about what is needed and to make sure that we are being as efficient, adding value in every single encounter as we can. And so, I think that that's helped us attune. And I think as we deploy the Medalogix tool across a greater base of our business, we will continue to have incremental improvements in that utilization statistic.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Got it. Thanks very much.

Operator: Your next question comes from the line of Brian Tanquilut with Jefferies.

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

<Q – Brian Tanquilut – Jefferies LLC>: Hey. Good morning, guys. I'll shoot my first question to April first. So, as we think about the proposed rule for PDGM, and I know you've revised the top line impact estimate, but I think there's some provisions in there that give the abilities to adjust on the cost side as well, such as PT assistants and other things like that. Is there anything that you can share with us, April, in terms of your thoughts on the levers that you could do to mitigate the PDGM cut?

<A – April Anthony – Encompass Health Corp.>: Sure. Happy to share some thoughts there. As it relates to the ability to use PTAs, that is limited to specifically – or the new provision is limited specifically to maintenance therapy. Less than 1% of our therapy episodes fall into the category of maintenance therapy. So, that incremental ability to use PTAs is really not going to move the dial in any material way for us, and frankly, I think that's consistent across the industry. Maintenance therapy is a very low utilized criteria for service for many of our home health agencies around the nation. So, I don't think we're going to see that be particularly a game-changer.

That being said, I think what has been a game-changer for Encompass in the past and what we will continue to improve upon is our use of PTAs, not just in the maintenance therapy area, but across all of our area, really optimizing our clinicians, whether it's PTAs, whether it's occupational therapy assistants, COTAs or whether it is with our LPN population in the nursing discipline, those have been some of the areas that have really helped us tune our efficiency and lower our cost per visit. The average delta, if you blend those three disciplines together, about $20 per visit more effective if I can send a PTA instead of a PT or an LPN instead of an RN. And so, that's a really significant driver to how we control costs. And when you add to that, making sure that we realize the productivity levels that we expect out of all of our clinicians, both the higher level element of the discipline as well as the professional level of that discipline, we're able to blend that together. And I think the combination of productivity and optimization is what drives our efficiency on the cost.

Secondarily, as we talked about a moment ago, being really efficient in our utilization will be the next most important driver, recognizing that under this PDGM rule, particularly in some of the therapy disciplines, there is just no room for excessive service. We're going to have to be very discerning and ensure that in every instance, as I mentioned earlier, we truly are adding value for the patient. We can no longer kind of come by and disconfirm things are going well or that you're still making progress.

Every visit is going to have to be very focused on an outcome-driven approach. And of course, we're that way today, but I just think this will heighten our focus on that and heighten our ability to really control utilization from that perspective. That will be a key driver.

And then finally, we're just going to have to gain efficiencies in our administrative system, utilizing Homecare Homebase more effectively than we ever have before, looking at some of our automated scheduling tools that Homecare Homebase is sort of releasing late this year, and the impact that they can have on next year to make sure that we do in fact realize some of those productivity and optimization areas and do it in a more administratively efficient manner. So, those are all – it's just a lot of fine-tuning. I wouldn't say there's one particular area that's going to move the dial by itself. It's just a lot of small adjustments that will together help us realize the outcomes we need for next year.

<Q – Brian Tanquilut – Jefferies LLC>: No. I appreciate that. So, I guess I'll pass it on to Doug next. As I think about your adjustment down of the PDGM impact and everything that April laid out and your thoughts on the IRF reimbursement change later this year, do you still feel like you can grow EBITDA in 2020?

<A – Doug Coltharp – Encompass Health Corp.>: So, it's a significant challenge, and let's walk through some of the math, and the pieces I'm going to use, the information is all stuff that is available in the materials that we furnish. But – so, what I think you got to do is look at the size of the challenge that is created by the rate cuts and the proposed rules against the base business from 2019 that will carry into 2020. So, if you make an assumption that home health revenue for this year is going to be somewhere in the $950 million to $1 billion range, and if you look at the payer mix that we have for home health, the division between Medicare fee-for-service and Medicare Advantage and the other payers, you get on that 2.8% PDGM specific a net price reduction for the full year of about 2.23% before you've updated anything for the 2019 patient mix. And so, that creates a revenue headwind against the same book of business from 2019 that you're carrying into 2020 of almost $22 million.

On top of that, although, we're going to continue to do the things that April has said to improve labor productivity through care optimization and visits per episodes and so forth, on the surface, you're going to have a headwind based on our anticipated increase in SWB. And so, if we stick with our assumption that SW increases 3% and benefits go up in that 6% to 8% category, that suggests that against that revenue shortfall, you're going to have about another $22 million or $23 million in SWB delevering. So, before you started the year and before you even looked at behavioral adjustments, you've got a $45 million EBITDA headwind in the home health business.

On top of that, to whatever extent the behavioral adjustments come through, every 1% of what comes through that we're not able to mitigate, doing the same math would create an incremental $16 million EBITDA headwind. Then you jump over to the IRF sector and do the same kind of math with the 0% to 25% reduction for the first three quarters and a more normalized increase in the fourth quarter, you run all of that through, you're going to wind up with a net positive pricing increase probably somewhere between 0.5% and 0.75% for the year. And so, that will generate incremental revenue somewhere between $25 million and $30 million. But against that level of price increase, you're going to continue to have the risk of SWB delevering. And so, that might create another $30 million or $35 million headwind.

So, that's the challenge that exists as you move in and you're going to be largely dependent on productivity gains, changes – or will be dependent on productivity gains, changes in patient mix in both businesses and then volume growth to get over that hurdle. And if you kind of do the math on it, it suggests that depending on the level of productivity gains you might get, you're going to get – you're going to need volume growth that's probably going to be in the high-single-digits in order to put yourself in a position where you realistically have a chance to grow EBITDA. So, we're not saying that that's off the table. It does create a challenge and there is a big role that the behavioral adjustments are going to play. If a significant amount of that 8% comes through and we remain somewhat concerned about our ability to respond to the three-quarters of that that relies on coding adjustments, it's going to be a very significant challenge.

<Q – Brian Tanquilut – Jefferies LLC>: All right. Got it. Thanks, Doug.

Operator: Your next question comes from the line of Sarah James with Piper Jaffray.

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

<Q – Sarah James – Piper Jaffray & Co.>: Thank you. Good morning. That math was incredibly helpful. I just wanted to ask a follow-up question on it. Earlier in the call today, you guys framed up PDGM as being a curve with very long tail and I imagine that the math you ran through was how you think about the average. But I'm wondering how different it is, how different that $16 million headwind experience could be if you're out in one of those tails?

<A – Doug Coltharp– Encompass Health Corp.>: Well, that is specific to our book of business from 2018, plus Alacare.

<Q – Sarah James – Piper Jaffray & Co.>: Okay. And then as you think about...

<A – Doug Coltharp – Encompass Health Corp.>: That is not, those aren't industry numbers. Those are our numbers.

<Q – Sarah James – Piper Jaffray & Co.>: Okay. And then, as you think about your geographic footprint, you talked about a competitive advantage being out in those tails, whether it was from tough areas where you have an operational advantage and you can gain share or if it's in the areas where maybe reimbursement is a little bit better. So, does that change how you think about wanting to wait your footprint in tail regions versus not? And to what degree are you locked in just by wanting strategically to overlap with IRF versus trying to optimize your home health footprint for PDGM? Thanks.

<A – Mark Tarr – Encompass Health Corp.>: This is Mark. We are committed to our ongoing strategy of creating overlap markets where we can integrate care between our facilities and home health. We think that that has long-term benefits and is where the payer methods and systems are going in the future. So, we're committed to that. As I said in my opening comments, if you look at our track record, both of our segments to take on changes in regulatory environment and come out on the other side of those in very good form, very good fashion. That's how we feel about what's coming up and facing us with these two regulatory changes in both of our segments at this time. We're committed to this strategy. The fundamentals of both of our segments are very strong driven by the demographic trends. So, we see nothing on the short-term here that deters us from our long-term strategy.

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

Operator: Your next question comes from the line of Frank Morgan with BC Capital Markets (sic) [RBC Capital Markets] (00:49:09).

<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. Most of my questions has been answered, but let me just ask a high level one here. Let's just say you're right and you can't offset this, but you don't upcode or you don't affect this behavioral change that you're being penalized for or let's say, the industry is right and there's no legislation, nothing gets passed, and let's say, revenues or spending on Medicare for home healthcare actually decline next year year-over-year. Given that this is supposed to be budget-neutral, what happens at that point with CMS? Thanks.

<A – Mark Tarr – Encompass Health Corp.>: Well, there's a requirement – supposedly a requirement that they'll do a reconciliation, a look back and make future period rate adjustments to offset the unintended consequences of the rule implementation and get it back to budget-neutral over a multiyear period. The problem is if that reconciliation mechanism has not been well-tested and it can be complicated and take a lot of different forms and the enforceability of it is suspect. So, there's supposed to be a mechanism that rides the ship, but it is untested at this point.

Operator: The next question comes from the line of Kevin Fischbeck with Bank of America.

<A – Doug Coltharp – Encompass Health Corp.>: Kevin?

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Yeah, great. Thanks. So, I guess going back to PDGM for a second, how did you think about the – this proposal versus last year? I guess the core rate seem to be up a little bit. The behavioral adjustment was higher. Is that net awash in your view? And then just to understand, it sounds like you're mostly worried about the coding adjustments component of the behavioral adjustment. Do you feel confident you can offset the other components of behavioral adjustment?

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

<A – April Anthony – Encompass Health Corp.>: Yeah. So, Kevin, we do think that the coding adjustment is going to be the hardest one to fully realize. If you will recall what Medicare has assumed is that 100% of the time, if there is a secondary set of patients experiencing, it would yield higher reimbursement than their current primary code, but the industry will upcode that. We think that there is, based on our research of past episodes and going back and looking had this coding program been in place last year,

we think there are situations where that simply will not be a compliant behavior where we will not be able to actually do that and be able to feel good that we are following appropriate coding guidelines.

And so, it's hard to know what percent of the time we will be able to do it. We absolutely believe that there are some times when it is appropriate, when you've got a patient who's kind of running parallel courses in a couple of different areas and if one area is a more lucrative code than the other that there's ample justification to choose that, because they're really a comorbid and sort of equal part issues. So, it's a matter of trying to look on a patient-by-patient basis and find those situations where it is clinically appropriate. But we certainly do not anticipate that that will be 100% of the time.

As it relates to the LUPA adjustment, we also think that that one is a little bit [ph] suspects (00:52:42). We think there will be certainly occasions where perhaps you're one or two visits away and you can redistribute care either within the two 30-day periods or potentially add care. Again, it seems unlikely to us that you would be able to increase or increase visits enough to offset the LUPAs to the degree that Medicare has assumed. And we think if you go back and look at historic LUPA practice where frankly that was super easy in the old world, where all you had to do was the fifth visit to get there and yet the industry still averaging 6% or 7% LUPAs, we just think that the reality is some patients have lower needs than others and that we're not going to always be able to realize those opportunities.

The comorbidity adjustment, I think we should be able to realize most of that, if we do a good job of collecting data. So, I think that one will be a little bit easier. But obviously, the LUPA and the comorbidity adjustments are pretty small. It's really the success of whether or not you'll be able to mitigate the behavioral change should it come in as proposed will be in that coding realm. And that's where it's just hard to predict, because it's such a patient-specific situation what percentage of time we'll be able to realize that. But if I had to guess that and I would say, I think it's probably in the 50% to 60% range where we'll find it to be clinically appropriate to do that, but I just believe it is absolutely not a 100% of the time situation.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Is there anything that you're looking for? I think, obviously, CMS seems to be assuming that this is something that industry can do and will do and I guess theoretically doesn't have a problem with, and obviously, there's other regulatory agencies that will look at this. Is there anything that you're looking for from any government agencies or companies you've had that could get you comfortable that you can and should be doing this 100% of the time or is that just not ever-likely to happen and you really need Congressional changes to ensure that this is done more smoothly?

<A – April Anthony – Encompass Health Corp.>: As we understand the coding guidelines, we do not believe that there is any free pass that any of the regulators are going to give us to say disregard the coding rules and just always upcode. And so, absent that free pass, because it's going to be really – the audit process that you're going to have to defend the choices that you made there and we just don't see anything that says we expect you to do this and we've told our auditors to turn a blind eye when you do. If they said that, then I've got technology, I could make that happen 100% of the time without question if I knew it was an accepted behavior and then I wasn't going to come back later and have to defend that decision.

But when we look at the coding guidelines as they stand today, we don't see that free pass being offered to the industry. And so, we think it is completely unrealistic to assume that honorable agencies that are compliant, that follow the rules like we do are going to disregard longstanding coding practices and just automatically upcode. Unfortunately, there are some dishonorable agencies that will do that. And so, this rule really benefits those who make wrong choices, but we're not going to be one of those agencies in spite of the fact that we may be penalized for doing that.

<A – Mark Tarr – Encompass Health Corp.>: Kevin, I just want to add on. As April said, she does not expect CMS to come out and change what they have recommended up to this point or clarify their statement. But that doesn't mean we are giving up on having dialogue with members of CMS. As a matter of fact, we have a team there that's doing that today. In my comments, I talked about the legislative front and having the two bipartisan bills that are out there, one in the House and one in the Senate, and gaining momentum there with Members of Congress to help understand what has been proposed and understand how it impacts the patients, and I feel good about the momentum we have going there and that perhaps may be our best shot to have significant changes made to this by the year end.

Operator: Your next question comes from the line of John Ransom with Raymond James.

<A – Doug Coltharp – Encompass Health Corp.>: Morning, John.

<Q – John Ransom – Raymond James & Associates, Inc.>: Good morning. Doug, it's always dangerous when I attempt math. So, we're going to attempt some math and you're going to tell me all the mistakes I'm making. So, if we think about Alacare, they said historically $117 million in revenue, 800 ADC in hospice. If we do the math at $150 a day, that's about $43 million, $44 million of hospice revenue, so the rest would be home health. And just thinking about a little bit of growth in maybe high-teens, low-

20s margin, could this one be north of $20 million in EBITDA contribution once you get through the transition or are we not thinking about this correctly?

<A – Doug Coltharp – Encompass Health Corp.>: No. I think you're not far off. The keywords that's used are once it gets through transition, it's not the run rate of that today.

<Q – John Ransom – Raymond James & Associates, Inc.>: Okay.

<A – Doug Coltharp – Encompass Health Corp.>: But certainly, that is within the range of expectations we have for the business in the future.

<Q – John Ransom – Raymond James & Associates, Inc.>: And so, if we think about the back half maybe half that run rate or something like that for the contribution, so like a $10 million annualized, maybe a $5 million contribution or something like that in the back half of the year?

<A – Doug Coltharp – Encompass Health Corp.>: No. Well, again, what I said previously was: A, it's not at that run rate right now; and B, any time we make an acquisition of this size, we have a very deliberate and very successful series of processes that we undertake to integrate that business and to make sure that the acquired business adopts all of our business practices from sales and marketing through to coding through to caregiver optimization. And it takes about six months in a good case and we think we're dealing with a good case in Alacare and it takes some time and expenses to get that moved over which will impact on the EBITDA contribution from that business over the next six months.

<Q – John Ransom – Raymond James & Associates, Inc.>: I mean, just to be clear, the $5 million would assume into that $10 million run rate now to $20 million. So, I was trying to haircut it for what I think it could do. So, $5 million in the back half would be a $10 million run rate I assume versus the $20 million you talked about. So, that's what we're trying to figure out.

My other question for April would be on the glass half-full take on PDGM. Even though, it appears CMS is remaining fairly hostile, the industry has had a year to bang away at CMS and they really haven't budged kind of surprisingly I guess. But is the glass half-full take, there really hasn't been a ton of M&A in home health. We saw an announcement this morning of [ph] LACG (00:59:42), you guys did this deal with Alacare. But will this at least maybe break the dam a little bit and say, well, the haves and the have-

nots, there'll be a chance to pick up some of the have-nots that relatively bargain prices versus kind of what we've seen over the past couple of years?

<A – April Anthony – Encompass Health Corp.>: John, I definitely think that we're going to see some acquisition opportunity in 2020. And as much as anything, I think PDGM will be a contributor to it, but I think in particular, the new proposal that came out in the July proposed rule that dropped RAPs to 20% in 2020 and down to zero in 2021, that's going to be the real catalyst for these smaller, call it, sub-250 patient agencies that really live off the cash flow. When they see a 40% decline in their RAPs from the current 60% level to the 20% level, I think many of them, once they get in the flow of that new lower RAP payment amount are going to find themselves really struggling to make cash flow ends meet.

And as a result, I think like we saw in the 1997 to 2000 period in the home health industry, I think there's going to be a lot of fallout from that and I think some of these small agencies will become available to purchase. And in particular, I think if you combine those markets, they're going to have a financial struggle with PDGM and then a cash flow struggle with this change in the RAP philosophy, that's going to push some opportunity and it will be very cost-effective opportunities consistent with how we saw this happened during the IPS-PPS era.

So, we do think that next year maybe a year where we're less likely to find a really large scale acquisition in the home health space, because you're going to watch PDGM play out, but you're going to find significant opportunities in the smaller, more cost-efficient deals. And so, we were definitely queuing up our development engine for that and trying to make sure that we're the first call for some of those agencies as they hit moments of distress from a cash flow perspective.

Operator: The next question comes from the line of Kevin Ellich with Craig-Hallum.

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

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

<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>: Hey, guys. Sorry, I know the call is going on a little long here and a lot has been discussed, but just wondering if you could polish your crystal ball and kind of help us on PDGM again. With the bipartisan legislation that's out there, what's the most likely bill or

other legislation you think it could be attached to? And I guess, what sort of visibility do you think we might get in terms of timing when that could pass?

<A – Mark Tarr – Encompass Health Corp.>: Well, we don't know exactly which bill it could be attached to. We think that there'll be a number of opportunities that will apprise themselves and particularly given last week's discussion with the budget proposal that came out, the cost discussion, and so we think there'll be some opportunities. We think that those opportunities will be at the end of the year.

<A – Doug Coltharp – Encompass Health Corp.>: Yeah. There is – I think with the budget deal that came out here most recently, there may be some opportunities as the appropriations process starts to get something done sooner rather than later. Had it not been for the budget deal last week, I think we felt it was probably going to be a last-minute Hail Mary attached some kind of extender bill or to a debt ceiling raise. So, there are now, if anything, increased opportunities for that to happen earlier in the process.

<A – Mark Tarr – Encompass Health Corp.>: But as you said, get out your crystal ball, so we – I just want to show you that we're very active there, not only as a company, but also as a trade association and we'll continue to work that. We're very happy with the momentum that we've gotten in the past six months and the attention we've gotten from Members of Congress. So, we think that that momentum has built over the last couple months.

<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>: Sounds good. Thanks, guys.

Operator: With no further audio questions, I would now like to hand the call back to Crissy Carlisle for closing remarks.

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

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

Operator: This does conclude today's conference call. We thank you for your participation and ask that you please disconnect your line.