Encompass Health Corporation

Q2 2018 Earnings Call

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 – Chief Financial Officer & Executive Vice President, 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.
Joanna Gajuk – Analyst, Bank of America Merrill Lynch
Kevin Ellich – Analyst, Craig-Hallum Capital Group LLC
A.J. Rice – Analyst, Credit Suisse Securities (USA) LLC
Dana Hambly – Analyst, Stephens, Inc.

MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone, and welcome to Encompass Health's Second 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] You'll be limited to one question and one follow-up question. 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 second 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 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 earnings release. During the call, we will make forward-looking statements which are subject to risks and uncertainties, many of which are beyond our control.

Certain risks and uncertainties that could cause actual results 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, 2017 and the Form 10-Q for the quarter ended March 31, 2018 and June 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 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 solid operating and financial results in both segments. Consolidated revenue and consolidated adjusted EBITDA both increased 10.5% and adjusted earnings per share increased 39.4%. These solid results reflect the strength and sustainability of our business model that focuses on serving the most rapidly growing segment of the U.S. population.

Doug will review the details of our financial and operating performance in just a few minutes. I would spend my time providing a brief update on our strategic initiatives and focusing on regulatory developments, including proposed rules for inpatient rehabilitation and home health.

During the second quarter, we continued to make significant progress on our key strategic initiatives. Beginning with growth and capacity, on May 1, we completed the acquisition of Camellia Healthcare, which added 18 hospice and 14 home health locations to our portfolio. The integration of Camellia is on track; and as expected, training and other integration expenses impacted our cost of services and productivity in the second quarter.

We also opened three home health locations in Georgia, Alabama, and Idaho; and acquired one hospice location in Nevada. In our inpatient rehabilitation segment, we began operating our new 34-bed hospital in Shelby County, Alabama in April, and began operating our new 38-bed hospital in Hilton Head, South Carolina in June. Later this year, we expect to open new inpatient rehabilitation hospitals in Murrells Inlet, South Carolina, and in Winston-Salem, North Carolina with North Carolina being a new state for us.

We also remain focused on those strategic initiatives that help us ensure we consistently provide high-quality, cost-effective care and position us for success in the evolving health care industry. We continue making great progress in terms of collaboration which is resulting in lower discharges to skilled nursing facilities and improved patient satisfaction in our overlap markets. Our clinical collaboration rate for the second quarter was 33.2%, an increase of 460 basis points over the prior year and consistent with the increase we experienced in the first quarter of 2018. This provides us further evidence of the efficacy of our teamwork's clinical collaboration initiative.

We remain focused on achieving our near-term objective of a 35% to 40% rate. Our rebranding and name change is also going well. On July 1, we completed the second wave of transitioning our [ph] fill (00:06:42) assets to our new brand. At this time, approximately 40% of our hospitals and agencies have transitioned to the new brand, with our next wave scheduled for October 1.

We also continued our work with the post-acute innovation center to develop advanced analytics and predictive models to enhance clinical outcomes and reduce 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 are continuing to on board additional data to enhance the patient longitudinal record and make other enhancements based on feedback from the Tyler project.

We also continued our work to develop a 90-day post-acute readmission prediction model to identify patients at risk for readmission across all post-acute settings. Phase 1 of this project use IRF and home health data, while Phase 2 of the model development will incorporate acute and other post-acute datasets into a longitudinal patient record.

Turning now to the regulatory front. In April, CMS released its 2019 proposed rule for inpatient rehabilitation facilities. It's implemented as proposed. We estimate the rule would increase our Medicare reimbursement rates by approximately 1.2% in fiscal year 2019. The 2019 proposed rule also included a proposal to implement budget-neutral changes to the patient assessment and case mix system for rehabilitation hospitals in fiscal year 2020.

A system that would be based on data collected over a one-year period from the new care patient assessment tool which has been running concurrently with the established functional independence measure or FIM tool. We have worked individually as well, as part of our trade associations, to provide constructive feedback to CMS and Congress on this proposal and why it should not be implemented at this time.

The proposed new functional assessment items were developed under the IMPACT Act. That law was enacted to collect clinical data and information to examine the feasibility of implementing new payment methodologies such as a post-acute care prospective payment system and not to change existing site-specific post-acute payment systems.

We certainly appreciate the ongoing efforts of HHS and CMS to reduce regulatory burdens, which is why CMS proposed these changes. However, in this instance, the benefits of collecting only one set of patient assessment data do not outweigh the burdens of collecting two sets, as too little is known about the accuracy, consistency or efficacy of the data and their ability to be used for payment policy purposes. We expect CMS to release the final rule for fiscal year 2019 soon.

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 re-weightings that are redistributing payments based upon most recent changes in resource used 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, we were pleased to see that CMS proposed to allow home health agencies to include the cost of remote patient monitoring as an allowable cost in cost reports, a cost many providers in the industry have borne for years. If implemented as proposed, these costs would be factored into a home health agency's cost per visit and thus the margins going forward.

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, albeit relying on assumed behavioral changes to achieve this status.

We continue to support the movement away from volume-based payment mechanisms to those based on patients' need 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 non-accounting for a relative intensity of care between initial and subsequent 30-day periods could result in unintended consequences related to Medicare beneficiary access to care.

As we've done in the past, we'll 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 this process. It remains too early to assess 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 LUPA 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 18 months and both the current and subsequent rulemaking processes to prepare for any resulting changes to the payment system. And as we have demonstrated repeatedly in the past, we are still at adapting.

Finally, on May 29, CMS announced its intention to restart the pre-claim review demonstration in home health, no earlier than October 1, 2018. The new version of the pre-claim review now called the Review Choice Demonstration or RCD, differs from the original program. The Review Choice Demonstration gives home health agencies three options to participate; a pre-claim review, a post-payment review and a minimal post-payment review with a 25% payment reduction on all claims. We believe RCD is better than the previous program primarily by providing a way for providers to come off the program [ph] for good (00:15:16) performance.

Basically, to provide or achieve a 90% affirmation rate on pre- or post-claim reviews, a provider becomes subject only to periodic spot checks. The program will be implemented in a staggered manner starting in Illinois, then expanding to Ohio and North Carolina, and later to Texas and Florida. On a combined basis, our home health locations in these states represented approximately 47% of our 2017 home health Medicare revenue. We believe we're prepared for this demonstration and have been working with Palmetto, the MAC included in the demonstration to better automate the review process as much as possible.

Now, moving to guidance. As a result of our strong performance in the first half of the year, we are raising our full year guidance ranges as follows. We're increasing net operating revenues from a range of $4.11 billion to $4.21 billion to a range of $4.2 billion to $4.275 billion. We're increasing adjusted EBITDA from a range of $845 million to $865 million to a range of $865 million to $880 million. And we're increasing adjusted earnings per share from a range of $3.30 to $3.45 per share to a range of $3.45 to $3.58 per share.

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

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

Thank you, Mark, and good morning, everyone. As Mark highlighted, Q2 was another strong quarter for our company, as both of our business segments generate solid revenue and earnings growth and we leveraged our corporate G&A expenses.

Our Q2 consolidated revenues and adjusted EBITDA both increased 10.5% over Q2 last year. And adjusted EPS, which benefited from a lower effective tax rate, increased 39.4%. Cash flow generation remained strong in Q2 as well, driven by adjusted EBITDA growth and favorable working capital changes primarily related to improved collection of accounts receivables.

Adjusted free cash flow for the first half of 2018 was $281.4 million, an increase of 10.8% over the first half of last year. The strength of our free cash flow generation in the first half allowed us to fund the purchase of the Home Health Holdings rollover shares in Q1 and the Camellia acquisition in Q2, while still markedly reducing our leverage ratio to 3.0 times at the end of the second quarter.

The strength of our balance sheet and the consistency in our cash flow generation were factors considered by our board of directors in raising the quarterly cash dividend on our common stock to $0.27 per share and replenishing our common stock repurchase authorization to $250 million. These actions, notwithstanding the prioritization of free cash flow utilization, remains the high-quality growth opportunities we see present in both of our business segments.

Moving on to the segment results. IRF segment revenue increased 7.3% over Q2 2017, driven by volume and pricing growth. Discharge volume increased 5.2% with same-store growth of 3.6%. Net revenue per discharge increased 2.5%. The increase in revenue per discharge was higher than expected due to lower bad debt, which is now a component of revenue and favorable prior-period price adjustment. Our revenue reserve related to bad debt in Q2 was 1.2% as compared to 1.6% in Q2 2017.

As can be seen on slide 21 of the supplemental slides, new pre-payment claims denials in Q2 declined both sequentially and year-over-year. As we discussed on prior calls, we attribute the reduction in ADR activity to the implementation of TPE across all MACs and to the transition of our largest MAC contract from Cahaba to Palmetto. We are very pleased with the year-to-date experience we have had with our MACs regarding ADRs, but we still do not have enough experience with Palmetto or TPE to assess sustainability of the bad debt levels realized over the past several quarters.

Additionally, we have still seen no progress on resolving substantial backlog of claims which is approximately $160 million for our company alone, that were awaiting adjudication at the ALJ level. Accordingly, our updated guidance assumes bad debt revenue reserve of 1.6% to 1.9% for the second half of the year. IRF segment adjusted EBITDA for Q2 increased 7.2% to $223.5 million, driven by strong revenue growth and effective labor management.

Expense ratios for the quarter benefited from the lower revenue reserve related to bad debt as well as the favorable retroactive price adjustments. Q2 SWB as a percent of revenues declined 80 basis points to 49.9%. Labor productivity improved during the quarter evidenced by a year-over-year decline in EPOB from 3.46 to 3.43. SWB also benefited from a reduction in expenses related to workers' compensation.

Our group medical expenses for the first half of 2018 increased a modest 2.2% over the first half of last year. Given the favorable performance we experienced in group medical expense during 2017 which occurred without any significant changes to our program structure or beneficiary population, we entered 2018 assuming group medical expenses would be mean-reverting and increase in a range of 8% to 12%.

In the first half of 2018, we continued to benefit from a relatively low incidence of high-dollar claims and the absence of any significant new pharma solutions. Nonetheless, we believe it is still prudent to assume an increase in group medical expenses for the second half of the year. Our other operating expenses in Q2 increased as a percent of revenues by 70 basis points. This was primarily attributable to an increase in contracted services. Recall that we touched upon this in our Q1 call, as well as an increase in provider tax expense which can be a bit unpredictable.

Moving now to our home health and hospice segment, Q2 revenues increased 23.5% with home health up 19.1% and hospice up 67.5%. Revenue growth for the quarter was aided by the acquisition of Camellia which we completed on May 1. Segment revenue growth was driven by volume as home health revenue per episode declined 0.2%. Pricing was somewhat better than expected, however, as the impact

of Medicare reimbursement rates was partially offset by the favorable resolution of a prior period ZPIC audit.

Home health admissions for Q2 increased 10.4%, with 5.1% in same-store; and episodes increased 17.5%, with 11.1% same-store growth. Please recall that home health is comping against the 13.3% same-store admissions increase in Q2 2017, which benefited from improvements in the former CareSouth agencies. Hospice admissions increased 61.3% in Q2, with 35.2% same-store growth. We continue to seek opportunities to add scale to our hospice business and the Camellia acquisition is a nice step in that direction.

Home health and hospice segment adjusted EBITDA for Q2 increased 26.8% to $41.6 million. Cost of services as a percent of revenue increased 50 basis points primarily due to merit increases, changes in patient mix and Camellia integration expenses. Support and overhead costs as a percent of revenue decreased by 120 basis points, primarily due to operating leverage on revenue growth.

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, Matt.

<Q – Matt Larew – William Blair & Co. LLC>: Hi. Good morning, guys. Thank you for taking my questions. I first wanted to ask about same-store IRF discharges which have averaged around 4% over the last three quarters. Just hoping you could maybe give us additional color on what is driving that, and then put it into the context of the longer-term target of 2%. Yeah, so just any comments on that would be helpful.

<A – Mark Tarr – Encompass Health Corp.>: Yeah. I'll start first and then ask Barb Jacobsmeyer to weigh in her insight. But we've been very pleased with the execution of ourselves and marketing teams across the portfolio of our hospitals. I think that they've done an excellent job in articulating the value proposition, particularly when it comes to focusing on the outcomes that we achieve with particularly high acuity level of patients in our hospitals.

We've talked a lot about the stroke population and our ability over the years to shift away from the lower acuity patients and be able to deliver excellent outcomes on the stroke population. I think those are all really gaining traction and allow us to take market share from not only other IRFs in the marketplace, from also those [indiscernible] (00:26:34) that historically had been the recipient of a number of these referrals. But I'll ask Barb to weigh in as well.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: Yeah. You all noticed that we had a nice increase in our Medicare Advantage growth. And to Mark's point, a lot of that is up going out and talking about the value proposition and our ability to not only get the patients home, but make sure that they remain at home which prevents those readmissions. So, we're helping us to be able to not only have our sales force out there with the referral sources of acute care hospitals, but also with the payers that are ultimately approving these admissions.

<A – Doug Coltharp – Encompass Health Corp.>: And Matt, we've been reluctant to change the target for – I can say, the target for the expectation with regard to discharge growth. They're solid, for instance, on the demographic tailwind that we've pointed to you because as we've described before, the average age of the patients that we're treating in our IRFs is 76 and the Vanguard and baby boomer generation has just turned 72.

So while although we believe we are starting to benefit from that demographic trend, we think that the bulk of the impact that's still in front of us. That said, we were very pleased with the same-store discharge growth and the total discharge growth we experienced in the first half. And every quarter will give us another data point as we think about what the true long-term expectations ought to be.

<Q – Matt Larew – William Blair & Co. LLC>: Okay. Thanks for those comments. And sticking here with IRFs, and Barb, maybe I had asked you to comment, we're about one year out from the announcement of the post-acute innovation center and obviously you've given us nice updates on the Tyler, Texas pilot. Could you just maybe give us an update again with what's going on there and then plans for further pilots? I know that's something you've discussed in the past. Just another update, Barb, would be helpful on that.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: Sure. So we continue to work to increase the data analytics that we have, not only as we look at narrowing the networks of the downstream providers that we use from our IRF setting, but also as we looked at healthy acute care hospitals determine the best setting for the patients to go to, looking at what is the potential for that patient's readmission, so that if maybe they would have thought in the past that that patient would go to skilled, it may make more sense

with the physician supervision at the IRF setting if they can prevent a readmission for those patients to receive the care to IRF setting. So we're continuing to dialog with additional acute care hospitals like we did with the Trinity Mother Frances to [indiscernible] (00:29:00) to help them with their post-acute navigation.

<A – Doug Coltharp – Encompass Health Corp.>: And Matt, as you might expect, this concentration is going to start primarily first with our existing joint venture partners.

<A – Mark Tarr – Encompass Health Corp.>: So, Matt, we're – I'll just wind it real quick. We're very pleased with the progress we're making there in Tyler. And as you know, as we discussed, longer term we see the ability not only to roll this out to other marketplaces, but also to have other diagnostic categories roll up under the same tool where we can bring value to not only one marketplace, to one diagnostic category, but cover a number of different assets or facets of care.

<A – Doug Coltharp – Encompass Health Corp.>: I will say that, with regard to extrapolating this and then that is certainly in our near-term plans, we're applying the same philosophy that we have with virtually every other strategic initiative we pursued which is getting it right is better than getting it fast.

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

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

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

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Hey. Good morning, everyone. Hey, I wanted to ask about the organic bed additions for the IRFs and how that's impacting the volumes. And I think you all target something like 100 beds to add to existing facilities and last year you did above that, 166. And the question really is, given the strong volume trends and it seems like those beds are filling up, is there an opportunity to increase that target and how would you go about assessing that?

<A – Doug Coltharp – Encompass Health Corp.>: Yeah. So, there is no doubt that the organic bed additions are helping with the discharge growth. But as some of our colleagues here are quick to point out, the bed additions – the organic bed additions where we do have bed expansion, that's in response to demand that exist in a market. So that occurs because our folks in the field are doing the right things to sell our value proposition, the demand exists and we're able to backfill with that.

As we've mentioned previously, we do a constant assessment across our entire portfolio of occupancy levels and perceive changes on a market-by-market basis in the competitive dynamic to determine where there are opportunities for bed expansions. The ability to do a bed expansion in specific market is also influenced by things like whether or not there [indiscernible] (00:31:26) need or license requirements associated with that and whether or not there are any physical constraints on the plant which we're operating.

We think the existing target of about 100 beds per year for right now is the right one. But we also believe that as we start to see the benefits of this increasing demand for our services because of the demographic tailwind that that number could go higher in the future.

<A – Mark Tarr – Encompass Health Corp.>: All the de novos that we build have the potential, we build them with the intent of having potential to add that, so we construct accordingly, buy enough land that would accommodate debt expenses as well. So as Doug said, we are constantly evaluating opportunities for this both near term and long term.

<A – Doug Coltharp – Encompass Health Corp.>: If you look back over the last 10 years in spite of the fact that we've been increasing our capacity in the IRF segment, the overall supply of licensed IRF beds in the U.S. have been relatively flat. And that just doesn't align with what we see happening

demographically. So, we do think there are going to be opportunities for further capacity expansions in the future.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Got it. Thanks. And as a follow up, I did want to ask about the grouping model changes on the home health side for 2020, and I appreciate all the comments Mark made. And the question I had was, as you think about the rate impact that you talked about, I think you said a little over 5%. Do you have a number or maybe some sort of indication you could give us in terms of how much of that could be offset through evolving your patient mix. Just wanted to sort of understand what your ability [ph] was to offset it (00:33:10) with change in the mix?

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

<A – April Anthony – Encompass Health Corp.>: Yeah, and it's probably just a touch early to have the details. We're still working through our modeling with the rule just coming out in early July, to understand the full impact on a kind of diagnosis by diagnosis, patient by patient basis. But our anticipation based on our study of the rule so far and our initial indications is that, as we can increase our percentage of referrals from acute care hospitals, that will be a key mitigating factor because as you look at the inherent elements of the rule of the post-discharge patient from a hospital, receive notably more reimbursement than the patient coming out of the community.

And so we think the continued growth in that program, the good news is our sales force has been doing a strong job growing that percentage of our population. And so, I think over the course of the next 18 months, we have a lot of opportunities to continue to expand that. The other area of concern to some extent is the significant decrease in reimbursements that we're seeing in some of the – not all therapy episodes, particularly some of the high-volume therapy, patient needs.

And so, in those instances we're going to have to really look at our care planning approach and determine if there are other ways that we can supplant the effort of the therapist with more nursing or aided services and find a better way to sort of balance some of that care. I'd say, at this point we'd have to be pretty general in our responses, but we think over the course of the next few weeks we will continue to have more and more information to be able to get at a much more granular level of response.

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

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

<Q – Joanna Gajuk – Bank of America Merrill Lynch>: Good morning. Actually, this is Joanna Gajuk filling in for Kevin today. Thank you so much for taking the questions here. So actually I want to stay on the topic of the groupings model proposal, and I appreciate the comments about it's still early and you have given us some of the ideas around, I guess, changing a little bit referral sources, maybe focus more on the acute and the therapy, I guess, provision.

So, on that front – because we also worry a little bit about the labor cost, right, so now I guess if you might need fewer therapists, that's I guess good, but then you might need more of these additional home health aides or other forms. So can you talk about how that would kind of change the labor cost dynamic for the home health business, given that you might be changing, I guess, the type of care providers that you might require going forward?

<A – April Anthony – Encompass Health Corp.>: Certainly, if our mix shift is a little bit more towards nursing and away from therapy, it will inherently drive our costs down. Our cost per visit for nursing is notably cheaper than our cost per visit for therapy. Frankly, it's one of the issues that we're bringing forth to CMS. And our comment is that, we believe the way they have allocated cost between discipline by using cost report data instead of using Bureau of Labor Statistics data, is resulting in a flaw in their model.

And one of the things we'll be pointing out in our comments likely both this year and possibly the opportunity to do so again next year; it's not fully resolved, but we think there is a pretty significant kind of

misallocation of resources. And so, we certainly think that there are opportunities to improve some of those elements through the rule-making process. But if in fact the answer has to be that we move to a more heavily nursing and aid-based utilization of services, we certainly understand that that economically is a more cost-effective approach if we can accomplish those outcomes with those lower-cost discipline.

And we haven't had a supply issue in those disciplines. Really, we haven't had – on the home health side, we really haven't had a significant supply issue in any of our disciplines. But definitely do not have a particular concern about our ability to increase our proportion of nurses and aids we seem to because of our culture of being a best place to work and [ph] had a good run of lots of (00:37:25) meeting our needs from a staffing perspective on a global basis. There are always exceptions on a market-by-market basis on a periodic basis, but not globally. Do we see any concerns there?

<Q – Joanna Gajuk – Bank of America Merrill Lynch>: Exactly, that's what I was going to ask. So I know – I understand the costs per, I guess [indiscernible] (00:37:42) will be lower when you have more nurses or therapists. I was just thinking about, yeah, whether there is any issues around shortages or things of that nature? But it seems that you are not expecting to have issues kind of finding these incremental home health aides to replace, I guess, if need for you for the therapy provision. So I appreciate the comment.

And also, any other I guess major pushbacks or major comments you plan to include in your response to CMS. I mean, any other major sort of surprises or disappointments with the proposal?

<A – April Anthony – Encompass Health Corp.>: Well, I guess, I would say that the second thing that we think is of most significant magnitude would be the assumed behavioral change that has been built into the model, that's roughly 6.5%. We think that is – we don't think, we know that is inconsistent with any prior-year behavior that the industry has demonstrated. If you go back and look over the years, the average impact in any single year has been well below the 6% level, something more in the 2% to 3% range.

And so, we think it's a little bit disingenuous for Medicare to assume that in one year the industry is going to react as significantly as a 6.5% kind of baseline adjustment would suggest. And so, that will certainly be something that we will comment on and propose an alternative approach that even if you do prospective adjustments that you need to face demand in a manner that's more consistent with what past industry behavior changes have looked like. So, something again in that 2% range.

So, we think that's probably the second most significant or really the first most significant thing, and then the use of a cost report data rather than Bureau of Labor Statistics probably the second from a magnitude perspective. There are a number of other [ph] unworthy (00:39:33) issues around questionable encounters and some of the coding classifications, but those are a little bit more nuance than the first two that I mentioned.

Operator: 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. Going back to your comments about remote patient monitoring that would be a lot in the cost reports. Wondering if that's factored into guidance or how – what sort of benefit could we see in terms of how this would help with your margins next year?

<A – Mark Tarr – Encompass Health Corp.>: Well, we haven't given any guidance for next year.

<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>: True. But let's say, the final rule is implemented as is, how big of a factor is this? Is it modest?

<A – Mark Tarr – Encompass Health Corp.>: I would say, very modest.

<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>: Okay, that's helpful. And then...

<A – April Anthony – Encompass Health Corp.>: And in reality, all its really going to do is change future payment policy because the ability to include the cost of remote monitoring in the cost reporting, all that really does is inform CMS about the true total cost of care which today they've been excluding those costs and that is a valid cost of care, albeit not one that has historically been allowed to be considered.

And so, when you hear MedPAC and CMS and others report the margin of the home health industry, there are these areas like remote patient monitoring that have historically been excluded from our cost base and yet very much a part of how we care for patients. And so, there is no immediate impact. I think it simply informs the regulators both CMS, MedPAC and others, about the true cost of care by allowing us to report that in the cost report, but it will not have any immediate reimbursement effect.

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

<A – Mark Tarr – Encompass Health Corp.>: [indiscernible] (00:41:28) it may take some of the information out of MedPAC's reports on the trends in home health margins.

<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>: Okay. Okay. And then, [ph] actually (00:41:39) leverages have come down a little bit and cash flow remains pretty strong. Could you remind us about your capital allocation priorities? And given – and also a little bit of color as to what you're seeing on the M&A front in terms of your pipeline. There's certainly been some high valuations for some hospice deals and wondering where you guys plan to allocate capital. Thanks.

<A – Doug Coltharp – Encompass Health Corp.>: Yeah. I think, the capital allocation remains very consistent with the priorities that we have stated previously which is, we continue to believe that we have good core growth opportunities in both of our business segments. As Mark mentioned, we got two new hospitals opened up in the last quarter. We've got two additional openings slated for the balance of this year, and we think there are going to be opportunities to add capacity both in the forms of new hospitals and better decisions on a go-forward basis.

We'll continue to grow our home health and hospice business predominantly via acquisition. We were very pleased to be able to complete the Camellia acquisition on May 1. Again, it was roughly a $135 million transaction. There are others like that that are out there that will be a candidate to purchase. And as we've stated a number of times here recently, we also have a specific objective to increase the scale of our hospice business and that is likely to happen predominantly via acquisitions as well.

So, we think that there are good opportunities that are out there. We feel like the development pipelines in both of our business segments remains sufficiently robust and that will be the top priority in terms of allocating both free cash flow and utilizing the leverage that's built into our balance sheet.

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

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

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

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Hi. First off, just when I look at the way the guidance weighs out, I think year-to-date you've been up EBITDA about 11%. And if I look at the second half outlook at this point, would it implies at the midpoint it's about a 1.5% increase? I understand what you're saying about continuing to be conservative [indiscernible] (00:43:54) around bad debts and health benefits. But I just wonder, is there anything – I mean, is it basically – let's just be conservative as you'll

see the year unfold or is there anything that would make the rate of increase that you're seeing moderate to that degree in the back half of the year?

<A – Doug Coltharp – Encompass Health Corp.>: A.J., you've hit on the two key assumptions which is, it was really beginning in the second half of last year that we started to see this substantial reduction in new ADR activity influencing the bad debt number on the IRF side and that's because it was in July of last year that TPE was piloting and then ultimately rolled out, and it was in August of last year where the Cahaba contract was [ph] relapsed (00:44:39).

And so, we have made the assumption that we're not going to anniversary that favorable bad debt performance in the second half of the year. That would be in contrast to the year-to-date trend. But as we have stated, we don't believe that we have enough data points right now to call the ball at a lower level. We'll continue to see how that trend develops with subsequent quarters and then it's the really kind of a similar story on group medical.

Again, we came into this year anticipating that because 2017 medical expenses were essentially flat with the level that we had in 2016, that the odds were against us and we couldn't put together two years like that in a row, particularly without having made any significant changes in either the structure of our benefits program and we really didn't see any changes in the underlying beneficiary population. Well, for the first half of the year, we were up just over 2% for group medical; that could change pretty quickly. So our guidance assumes that we're going to get back into that 8% to 12% level of year-over-year increase for the back half of the year. And those are the two primary things that are set up in the guidance as headwinds.

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Okay. And then just quickly on – maybe following up in a different way on the acquisition and commentary. First of all, obviously you've had, I guess, Camellia for two or three months now. Any update? And is that trending as you've expected, any change in your thoughts there? And then when you think about acquisitions in the home health and hospice area, is the PDGM proposal having any impact on the pipeline, either your thinking about what you're willing to pay or people's desire to do something ahead of that. Any flavor for that?

<A – April Anthony – Encompass Health Corp.>: Yeah, let me take that second question first. So, I don't think yet that we've seen PDGM affect the pipeline. I certainly think that it is possible as people begin to process the impact that that rule can have. We've had a few really small players who can just use it as another reason to sort of throw a final straw in a haystack.

But I do think that we will see some players that just began to say, the combination of regulatory challenges, reimbursement challenges, cash flow challenges [indiscernible] (00:47:01) from a cash flow perspective as well and how some of those 30-day reimbursement payments happen and so forth. I think all of that could certainly yield to an expanded pipeline, but we haven't necessarily seen that materialize at this early stage.

<A – Doug Coltharp – Encompass Health Corp.>: And then back on – A.J., on your first question. I think we've been really pleased with the first two and a half months here, almost three months now, of the Camellia integration process.

<A – April Anthony – Encompass Health Corp.>: Absolutely. And I would just echo Doug's comment there that Camellia, I think, we've been – acquisitions always result in a few surprises. And I would say, our surprises in Camellia have been pleasant ones that we've been pleased with what we've found and the quality of the leadership team. Certainly, we've been able to bring in some processes and enhance some efforts and work together to continue to professionalize the business to match up with our Encompass locations throughout the region. But we are very pleased with where we are so far and feel like it's going to really be a strong part of our organization, as they get fully acclimated to the Encompass way of operating.

Operator: [Operator Instructions] And your next question comes from Dana Hambly with Stephens.

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

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

<Q – Dana Hambly – Stephens, Inc.>: Hey, good morning. Thanks for entertaining my questions. Just to follow up on Camellia. Could you give some rough direction on what you would expect the growth rate and the margin profile to look like and maybe just roughly speaking, time to integrate that fully?

<A – April Anthony – Encompass Health Corp.>: Yeah. So, I mean, Camellia was a strong performer from a margin perspective when we acquired them. I don't necessarily think the enhancements that we're making are going to completely be margin-driven. I think they're going to be more long-term sustainable that they're going to be based with solid [indiscernible] (00:49:05) processes that allow them to continue to grow.

But I don't necessarily anticipate that we're going to see big margin enhancement out of that business, simply because it was a high performer when we bought it. But we just think we're going to sort of create stability around that high performance and take some of the risk of volatility out of it with our approach to operation.

<Q – Dana Hambly – Stephens, Inc.>: Okay. And then a follow up on the proposed IRF rule. I generally understand your opposition to the replacement of the functional independence measure. But could you help me understand a little bit better what the practical and financial implications would be, if that proposal were to make it into the final rule?

<A – Mark Tarr – Encompass Health Corp.>: Yeah. We don't know a lot about the financial implication, but let me talk about just the practical implementation of the tool. And first of all, we don't make sure we're clear. We don't oppose the potential of having the CARE tool replace the FIM. The whole point of having a CARE tool is; one, it's a common assessment tool across the various areas of post-acute which we support. But we support it under the pretense that it will be data-driven that the information that they collect from this tool which we have been using in addition to the FIM tool now since October of 2016, have been reporting that data.

Our main objection is, it's just too much too soon. And to rule out a new assessment tool like the CARE tool, it takes a lot of education for entire nursing staff and therapy staff which use it to assess every patient that comes in. There is a lot of nuances relative to the use and implementation of this, and working an entire group of clinicians off of the FIM tool which is essentially been in place now for couple of decades.

So, we think that that's one of the areas that CMS has maybe underestimated the impact of rolling out a new tool that is as comprehensive and as involved from an operating standpoint in the industry and just having a little bit over one year data to change the entire system, like I said, it's too much too soon. So we like to see a couple more years of data collected, so that CMS can adopt a CARE tool that is fully based upon the data that's been turned in by the industry and really have a tool that is going to be applicable for the long term.

<A – Doug Coltharp – Encompass Health Corp.>: And just following up on that. As a result of the worst case were to happen and if the rule were to get implemented exactly as it is right now with this becoming the basis for payment in 2020, the impact would likely be relatively short-lived because with each subsequent year of data gathering under the CARE tool and with each subsequent year of utilization of that as the primary tool by IRF providers such as ourselves, the dataset that's informing the reimbursement mechanism is going to get better. And the underlying characteristics of the patients who today require rehabilitation services in a nerve setting and who will in the future, is not going to change.

So, it'll resolve itself over a period of time. But avoiding that kind of significant disruption potentially impacting Medicare beneficiary access to care in years like 2020 and 2021, is one of the primary objectives of the feedback that we're giving to both CMS and Congress.

Operator: And your next question comes from [indiscernible] (00:53:02)

<A – Mark Tarr – Encompass Health Corp.>: Hi, [indiscernible] (00:53:05)

<Q>: Hello. Good morning. A couple of questions. I think in the release you mentioned that there was a retroactive price adjustment that impacted the second quarter results. Can you give us a size of that retroactive adjustment in that segment?

<A – Doug Coltharp – Encompass Health Corp.>: Yeah. The impact was about $2 million.

<Q>: Okay. So not very big. And then, on slide 30 in the deck, just clarification for me; I read it a couple times, but I just don't get it. You're saying that the June 30 valuation for those rollover shares is $195 million. Is that reflective of the ballpark 16% holding or is that $195 million is reflective of 11.1% which would be after that February transaction?

<A – Doug Coltharp – Encompass Health Corp.>: It's the latter.

<Q>: Okay. Thank you.

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

<Q – Joanna Gajuk – Bank of America Merrill Lynch>: Hi. This is Joanna. Thank you so much. I have a follow-up actually on the IRF proposal, but I guess you were trying to answer that question because my concern was that CMS estimated a cut – almost 2% cut for the full profits, but you're saying that you would view it more as a short-term lessen over time it will work itself out.

And my second follow-up question actually on the comment you made on the pre-claim review demonstration that was easy to do, I guess by CMS. So previously you talk about income per cost that you estimated back then to be $1 million to $1.5 million or so. So any change to that? Do you include anything in your guidance for that?

<A – April Anthony – Encompass Health Corp.>: We don't have a firm start date yet. And...

<Q – Joanna Gajuk – Bank of America Merrill Lynch>: All right.

<A – April Anthony – Encompass Health Corp.>: ...because it's not yet defined when it would move into some of our larger markets of Texas and Florida, we have not yet put that into our estimates. We do believe there would be some incremental cost. Some of the details of the proposal would have to come out before we'd really be able to pinpoint what that would be. But we think it'll be relatively small for those first three states because we don't have huge volume in those states. Texas and Florida is when it will start to add up for us.

<A – Doug Coltharp – Encompass Health Corp.>: The part we're benefiting from here as well, Joanna, is that the scale of our home health and hospice business has continued to increase. And the scale of those incremental costs to conform to this new demonstration, probably aren't increasing much. So it's kind of getting to the point where the incremental level of cost may not be worthy of a specific call out.

<Q – Joanna Gajuk – Bank of America Merrill Lynch>: Makes sense. Thank you so much.

Operator: And we have no further questions at this time. So I would like to turn the call back over to Crissy for any closing comments.

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: And thank you. This does conclude today's second quarter 2018 earnings conference call. You may now disconnect your lines.