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Encompass Health

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Steven Valiquette: We'll start our next session here. The next session is going to be with Encompass. And I'm Steven Valiquette, by the way, the Health Care Services analyst here at Barclays. To my right is Doug Coltharp, the company's CFO. And also joining us on the stage is Barb Jacobsmeyer, who is the President of the inpatient hospitals segment within the company. So this will be a fireside chat. And with that, I guess we'll just dive right in and get right down to business.

Doug Coltharp: All right.

Steven Valiquette: All right, great. So maybe starting a little bit more high level since some members of the audience may be a little bit newer to the Encompass story. It might make sense just to start by having you just provide a quick overview of the two main segments and also where they fit in the post-acute spectrum. So we'll just start high level and then just go deeper from there.

Doug Coltharp: Sure. And for anybody who may have missed it and is sitting there wondering, who is Encompass Health Corporation, well up until January 1st of this year, we were known as HealthSouth. And we changed the name of the company to Encompass Health Corporation. We changed our ticker symbol to EHC. And we'll begin changing the names and the brands on our field assets, both the inpatient rehabilitation hospitals and the home health and hospice agencies, in rolling waves starting on April 1st of this year. That's a process that will take us through about mid-2019 to complete. We've talked a lot in some previous forums about the strategy and the impetus behind that name change. It was really to reflect the company that we are today, which is an integrated provider of post-acute services that is operating on a national basis.

Steve mentioned that we operate in two business segments. Our largest business segment is comprised of inpatient rehabilitation hospitals. Those are specialty hospitals that serve the post-acute sector. We are the largest owner and operator of free-standing inpatient rehabilitation facilities in the U.S. We currently have 127 of those facilities. We have a market share that is comprised of 22% of the licensed beds that are out there in the U.S., but we actually served, in 2017, 29% of the Medicare beneficiaries who received treatment in an IRF setting.

Of our 127 IRFs, we have a somewhat unique strategy of operating a lot of those in joint venture relationships with acute care hospitals. The primary purpose for doing so is that about 90%-92% of the patients who flow into an inpatient rehabilitation facility, be it one

of ours or one of our competitors', come from an acute care hospital. So in terms of providing integrated care, it makes sense for us to consider these joint venture opportunities. And one-third of our 127 hospitals are operated in such joint venture relationships; so 42 of them. Total revenue for the IRF segment in 2017 was just about $3.8 billion.

Our second business segment is home health & hospice. We have 200 home health locations across the U.S. or actually across 30-plus states. And then we have a smaller hospice business, just 37 locations right now. The total revenue for that business segment in 2017 was a little under $800 million. So it's the smaller of the two business segments.

I mentioned previously that our strategy is to provide integrated care delivery. And so we measure our ability to provide that integrated care on the post-acute side in a couple of different ways. Two important metrics that we look at are, first, the number of markets in which we have an overlap between our two business segments, meaning that we operate both an inpatient rehabilitation facility and a home health agency in that market. And for lack of a better definition, we chose a 30-mile radius as defining a market. I will say that in some markets that's a very good proxy for what you can capture, and in other markets there may be a river or some kind of other barrier that makes it a little bit less reliable. But that's our definition and we apply it consistently. So currently, we have a 60% market overlap. So in 60% of our IRF markets we have a complementary home health agency.

And then the second metric we look in that regard is one that we have labeled clinical collaboration. We entered the home health segment about three years ago when HealthSouth acquired Encompass Home Health & Hospice, which gives you some indication as to where the Encompass in our new name came from. We did so because we recognized the movement towards more episodic and integrated care and that 55%, and a growing portion, even higher than that now, but at that time 55% of the patients who were discharged from one of our IRFs required follow-on home health setting -- home health care. And so we wanted to be able to provide those services, A, so that we could capture the revenue stream, but more importantly, so that we could control that patient's care for a longer period of time during the episode.

So what we look at now is in those overlap markets, those 60% overlap markets, of the 55% to 60% of the patients on a market-by-market basis who are being discharged to a home health setting, how many of those patients are being discharged to our home health agency. And in the fourth quarter of this year, we posted a clinical collaboration rate of 31.7%. That was an improvement of about 350 basis points over the fourth quarter of last year, and it reflects a concerted effort to work more closely together by the clinicians in both of our two business segments. And specifically, we worked during the course of 2017 to identify the best practices for our two business segments working together and to codify and then implement those best practices across the overlap markets throughout our franchise. That's a process that you'll hear us refer to as clinical collaboration teamworks, and we think that substantial increase in the clinical collaboration rate in the fourth quarter of this year is reflective of the efficacy of that effort.

The last thing I'll comment on just with regard to an overview of our business is that we are a business that has been defined and enhanced by a commitment to technology-enabled business processes. On the IRF side, even though we, as post-acute provider, were not mandated by the Affordable Care Act as were the acute care hospitals to adopt an EMR, and even though, unlike the acute care hospitals, we were not entitled to a subsidization of any investment in EMR based on the achievement of meaningful use standards, we made the decision beginning in 2012 that if we were truly going to serve as

an integrated provider, both upstream and downstream, we need to be fully converted over to an electronic medical record.

The problem we encountered as we set out on this was that were no EMRs that were specifically defined for the IRF setting; that where they were in place, they were largely modified versions of an acute care facility and we found those versions ill-suited to serve the patients in an IRF. So we formed a relationship with Cerner. We tailor made an EMR for the IRF sector. And at a cost exceeding $200 million, in waves we rolled that EMR out across all of our hospitals and it is now fully deployed in all of our system.

On the home health side, the founder of Encompass Home Health & Hospice, April Anthony, was also the founder of Homecare Homebase, which is the leading provider of software support for home health agencies in the U.S. And to suggest that we are a power user of Homecare Homebase I think is an understatement. It is by far the best software that is out there and available for home health care providers. And we have integrated our Homecare Homebase platform with our Cerner-designed EMR in the IRF segment, which gives us a seamless flow of patient information, allows us to really ensure that clinicians in both of our business segments are following prescribed clinical pathways and achieving better results for our patients.

Steven Valiquette: Okay, great. Maybe just kind of diving a little bit deeper at least on one part of the answer that you gave. So again, sticking with that theme around the post-acute spectrum, needless to say that pretty much every managed care company the goal is to really push patients into lowest-cost settings wherever and whenever possible. I think it's pretty safe that I think everybody kind of agrees that home health fits nicely in that spectrum.

When it comes to IRFs or inpatient rehab facilities, maybe just spend a little more time on kind of where they are on the sort of that cost-benefit within the overall push in the system to move towards lower-cost settings and also when it comes to contracting on value-based care. When you were talking about clinical collaboration, I'm not sure if that was your sort of phrasing for value-based care contracts. So maybe just talk about how that all sort of fits in. Because I think, again, there's probably a consensus view on where home health fits in that, but maybe for IRFs it's still less clear to people. Just to give a little more color around that.

Doug Coltharp: Sure. Barb, you want to talk a little bit about our value proposition?

Barb Jacobsmeyer: Sure. So I think initially when some of the bundling came out and even to your point on managed care, there sometimes is this thought process that skilled is cheaper. And so maybe to go into a per diem setting to a skilled facility would make sense. I think what the bundling has allowed everyone to see is that there's a greater picture than just their first post-acute setting. And when you start looking at 30 and 60 and 90 days and you see readmission rates, skilled facilities many times have more than double the readmission rates than our inpatient rehab hospitals do. And so when you start looking at the bigger picture and cost of readmissions, many times we have a strong value proposition; that when someone receives care at an IRF setting and we're able to get that patient home and they stay home, that whether you're talking managed care or Medicare, that there's a strong value to that.

Steven Valiquette: Okay. And maybe, again, somewhat tied into this, as far as reimbursement to the company on commercial versus Medicare reimbursement. I mean just talk about some of the differences that you see in terms whether it's going to ebb and flow over time where reimbursement has been better on one side versus the other. Or do they really just kind of mirror each other over time in whatever trend they're going in?

Doug Coltharp: So in both of our business segments, maybe we start with the payer mix. If you look at the IRF side of the business -- and the payer mixes aren't too distinct, but there's a little bit of a distinction. If you look at the payer mix on the IRF side, you start with kind of 72%, in that ballpark, Medicare fee-for-service. Another 8 or 9 points are going to be Medicare Advantage. Then you'll have 16 to 18 points commercial and a relatively small piece of Medicaid.

On the home health & hospice side, you have a higher proportion of Medicare fee-for-service. We're about 86% fee-for-service there. Another 7 or 8 points, again, would be in Medicare Advantage. And then a very small commercial piece and very small Medicaid piece as well. So by far, the two largest payers are traditional Medicare and Medicare Advantage.

What we've seen over time is -- and for us, Medicare fee-for-service has always been the highest payer for both of those two segments. And what we have seen over time is that the gap that exists between Medicare fee-for-service and Medicare Advantage has been narrowing. In each of the last five years, that gap has narrowed. At the end of 2017, it was approximately 14%.

And part of the reason that it has narrowed, a significant contributor, is we have been successful by establishing our value proposition for the services that we provide with the Medicare Advantage companies, we've been successful in converting more of those contracts from a per diem basis to a case rate basis. And now about 85% of the contracts that we have in place, about 85% of the payments that we're receiving through Medicare Advantage contracts are coming on a case rate basis. And we expect that trend to continue for the foreseeable future.

Steven Valiquette: Okay. All right. That's helpful. Now again, kind of coming back to that theme around the post-acute spectrum. Given kind of what we've talked about, not surprising to see that you've had some pretty strong same-store admissions growth within the home health area in particular. Maybe just talk about the sustainability of some of the strong trends you see there. Whether it's over a one-year or three-year, five-year time horizon, just talk about kind of what you see for organic growth within that part of the business.

Doug Coltharp: Yes. The last couple of years we've had very favorable admissions growth in the home health segment. And we've been running kind of in the mid-teens for total admissions growth with same-store being in the low double-digits as a component of that. And out of the same-store growth, we've typically seen that somewhere between 15% and 20% was generated as a result of the clinical collaboration, which is, in fact, our term that is existing between our IRF segment and our home health segment.

What we have stated is that over the next three years we believe that we can continue to grow admissions in the low double-digit range and that the breakdown between new store and same-store and the contribution from clinical collaboration probably stays relatively constant. And our confidence in being able to continue to generate that growth really stems from a number of things.

The first is the general demographic trend that is driving increased demand for these services. If you look at both of our business segments, the average age of the patient that we treat is 77. And so the CAGR in the U.S. for the population aged 65 and greater is greater than it is for the overall growth in the population. And that is a result of the aging out of the baby boomer generation. And I remind you the baby boomers were those that were born between 1946 and 1962. The vanguard of the baby boomer generation,

therefore, has just achieved age 72. The average age of the patient we're treating in both of our segments, as I just mentioned, is 77. So that tailwind is still front of us and so we believe for the next 10 years or so we're going to see demand for these services in both of our segments increase at a greater rate of supply. That's factor number one.

Factor number two, in terms of the confidence around our growth, is that home health in spite of some recent consolidation activity remains a highly fragmented business. There are still 12,300 licensed home health agencies in the U.S. About 95% of those have revenue of $500 million or less. It's not lost on anybody that there has been a prolonged difficult pricing environment facing the home health industry. It's actually going to continue for at least a couple more years. And at the same time that pricing has been difficult, costs have been difficult to rein in because of increased requirements on the regulatory side around things like quality reporting and so forth. So margins have gotten squeezed, and for a lot of the lesser capitalized agencies that are out there it means that they can no longer continue to operate independently. So there are going to be pressures on capacity coming out of the system just as demand is increasing. And so our ability to also take market share is going to contribute to growth.

And finally, we continue to believe that we've got further upside on clinical collaboration both by creating additional overlap markets and by driving the clinical collaboration rate in those overlap markets north of its current level. And we've set a near-term goal within the next two years to have that clinical collaboration rate north of 35%. So add those together and they form our confidence around that low double-digit admissions growth for the foreseeable future.

Steven Valiquette: Okay, great. This next question will be tied more to the IRF side of the business in particular. I think for all these post-acute subsectors, from an analytical perspective it's always important to analyze what MedPAC might be recommending to reimbursement and kind of their assessment of the business versus what's CMS actually does as far as reimbursement rates. Maybe talk a little bit about the recent history on the correlation of what MedPAC is recommending versus what CMS actually does as far as reimbursement on the IRF side.

Doug Coltharp: I didn't realize there was a correlation. Barb, do you want to address that?

Barb Jacobsmeyer: Sure. So one of the things that we always point folks to is to look at when we look at, particularly our margins, our margins are not because we're actually paid more. When you look at, actually, the majority of the IRFs out there, they're actually paid more than we are because they rely more on the outlier payments. Our efficiency and our margins really come because we are efficient providers.

Now some of that we gain because of scale. Most of our hospitals are the 40- to 60-bed range; some of them as high as 100-plus. So we certainly benefit from the scale of our hospitals.

But we also benefit from our efficiencies. No different than Doug mentioned about our analytics as it relates to our electronic medical record, we also have robust analytics as it relates to things like staffing and supply chain. And so those things really help us to be able to receive our margin by our management and not necessarily the dollars that we are paid for from Medicare.

Doug Coltharp: I think if you look specifically at MedPAC recommendations on the IRF side, for at least the last four years the recommendation has been a 5% cut. And we haven't seen that yet.

Steven Valiquette: Okay. And to the extent that same question is relevant on the home health side, do you want to talk about that as well, as far as MedPAC correlation to real-world CMS action?

Doug Coltharp: So for at least the last three years, their recommendation has also been 5% there. They're not terribly creative in that regard. Home health has really gone through a pretty extensive multi-year rebasing in its pricing. And it's been a tough environment. And you've seen margins in that business come down pretty dramatically.

I like to think that we're getting towards the end of that. This year, we are estimating that we will have, even with the extension of the rural add-on, which was a positive, this year we're anticipating that we'll have about a 0.5 point price decrease in our Medicare reimbursement rate for home health. This will be the fifth consecutive year we've had a Medicare price decrease in the home health business.

So I think much of what CMS and MedPAC would have hoped to have accomplished over the last five years with regard to curtailing the demand curve in home health services and weeding out some of the bad players, I think there's a lot of evidence that that has really occurred through some of the regulations and some of the pricing pressures that have been out there. It's not to say that we believe that home health is completely out from underneath the target zone. There's still a lot of discussion about some form of HHGM and moving away from the therapy utilization based payment system. We think is that's done in a thoughtful way, it's going to be a real positive for the industry. And we're encouraged by some of the more recent discussions and some of the more recent promulgations through CMS or to CMS about how any further changes to the payment system need to be done in a collaborative manner with the industry.

Steven Valiquette: Okay. Two quick follow-ups around that. As far as the history of at least the recommendation of some more severe cuts, is that still tied to everybody's going to chip in to help pay for health care reform? Is it kind of the aftermath of that? Or have we kind of moved beyond that? That's part one. Then I have another question tied to that.

Doug Coltharp: I don't see it as directly tied to that. I think it's more generally trying to control the overall cost curve for Medicare spending.

Steven Valiquette: Okay. The other thing I find kind of ironic when it comes to post-acute spectrum is that some of the lowest-cost settings where you can have a lot of savings are also some of the smaller industries that may not have quite as deep of a lobby effort in D.C. to prevent more severe cuts. Some of it is a function of maybe home health and IRF just don't have the lobby effort to avoid at least the proposal or at least the recommendation of severe cuts just given the size of the subsector. It's kind of unfortunate it works out that way. But that's just one of my personal observations. I'm not sure if you want to comment on that or not.

Doug Coltharp: Well, home health has gotten a lot better in terms of industry lobbying groups. We participate very actively in the Partnership for Quality Home Health. And I think that body played a very effective role in ultimately getting HHGM removed from the final 2018 rule.

I'll tell you; we always experience it to a larger degree on the inpatient rehabilitation side because whereas we get lumped in, sometimes effectively, with the acute care players, we're a very big fish in a relatively small pond on the IRFs and there are a lot of free riders behind us. The good news is we have a 29% share of Medicare beneficiaries in the IRF sector. The bad news is with a 29% market share so those who are behind us can

look upstream and said "Hey, if there's lobbying to be done, we can really rely on Encompass Health to do that for us."

Steven Valiquette: All right.

Doug Coltharp: But the home health players have definitely gotten a lot more organized, born out of necessity three years or so.

Steve Valiquette: Yes, okay. We've got a minute or two left here. Maybe as a CFO you can talk about capital deployment. Every company has to decide, A, do we go aggressive on M&A? Do we do share buybacks instead? Maybe just talk about kind of what you see for the next one, two years in terms of where the focal point is for you guys.

Doug Coltharp: Sure. One of the real attractive things about our business is that we generate very high and consistent levels of free cash flow. We've laid out the assumptions in our investor reference book and some of our other materials about what we think our adjusted free cash flow will look like in 2018. It's a range of about $325 million to $425 million.

The deployment is going to look very similar to what it's looked like in the last several years. We believe that we have, largely due to the demographic tailwind and some of the industry characteristics that I mentioned to you previously, we believe that we have a lot of continue opportunities to add capacity to both of our business segments. And so the bulk to that free cash flow is going to be deployed towards growth opportunities remaining within our two business segments. Within home health & hospice, maybe a little bit more emphasis on the hospice business than previously, but not a sea change.

Our balance sheet is in great shape. We ended 2017 with a leverage ratio of 3.1 times. We like to say that it's not just a matter of how high is your leverage ratio, but what's the composition of your debt capital as well. And we have a bifurcated debt capital structure with a very liquid bank revolver on the front end and then layered maturities of senior unsecured notes. The nearest debt maturity we have is in 2022 and that's our bank facility. So we've got a lot of strength on the balance sheet and so no need to apply free cash flow to reduce debt.

And then we are one of the few players in the post-acute space that pays a common dividend. And so right now we're at $0.25 a share or a $1.00 a year. It's about $100 million a year and we'll continue to deploy capital in that manner.

Steven Valiquette: Okay. That sounds great. With that, I think we're out of time so we'll end it there.

Doug Coltharp: All right, great. Thank you.

Steven Valiquette: Thank you. All right. We'll have a breakout in Poinciana 3. Thanks.