HealthSouth
Wells Fargo Healthcare Conference

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Duncan Brown: Good morning, everyone. Thank you very much for being here on day two of the Wells Fargo Healthcare Conference. We are extraordinarily excited today to have HealthSouth with us; CEO Mark Tarr, CFO Doug Coltharp. We're very appreciative to have you guys here and making it and we appreciate it.

The presentation here is going to be a little bit off the slides and then we're going to get into the fireside chat format. So with that, Mark, if you want to kick it off?

Mark Tarr: Sure. Good morning, everyone. It's great to be here. As Duncan said, we want to start out with some prepared slides that we have that I think will help to give you a brief profile of the Company for those of you that aren't familiar with HealthSouth, as well as some brief insight into the strategic initiatives that we have going on at the Company.

Let me start first with the cautionary slides and forward-looking statements.

We are one of the nation's largest owner/operators in post-acute. The Company is made up of two operating segments, one facility based and one home based. The facility-based segment includes 125 IRFs, or inpatient rehabilitation hospitals if you're not familiar with that term, and account for 80% of the Company revenues, operating in 31 states and 2 facilities in Puerto Rico.

Within the IRF sector we are the largest in terms of revenues, licensed beds, and patients served. It's important to note that 39 of our hospitals operate as joint venture arrangements with acute care hospital systems which we think puts us in a real strong position from a strategic standpoint.

You want to put the slides back? There you go. Advance two more. Thank you.

The patients treated in our hospitals are medically fragile, suffer from conditions such as stroke, other neurological conditions. Our patients have complications from both traumatic and non-traumatic injuries, including hip fractures, brain injuries, and spinal cord. These conditions are nondiscretionary in nature, meaning that all patient admissions occur not from an elective event, but from a nondiscretionary event. So all of our patients need to be treated in an inpatient setting where another less acute setting is not an option for them.

Our home health and hospice segment accounts for the remaining 20% of the Company revenues and is the fourth largest provider of Medicare home health services. It has 193 locations providing home health and 37 hospice locations, together spread across 25 states. Like the IRFs, the home-based segment provides highly-specialized clinical

programs provided by nurses, physical, occupational and speech therapists, as well as social workers and home health aides.

It's important to note that we are developing a company that will be well suited for the future payment system. Our growth strategy includes building out both the IRF segment and the home health and hospice segment through de novo projects and acquisitions, while prioritizing the opportunity to create what we call overlap marketplaces, where we have both a hospital and a home health location within a 30-mile radius so that we can provide the continuum of care as the premium is now being placed on integrated networks and post-acute providers. We had 60% of our marketplaces fell into this category we call overlap marketplaces as of June 30th of this year.

You want to move it back one slide, please?

Okay. Why HealthSouth? We have a strong track record of proving that we can execute in those areas of our business that truly make a difference. With us it starts with the people. We put a lot of focus on our recruitment and retention of nurses and therapists. In both of those categories our turnover rates are significantly lower than the industry standard. As a company we make sure that we provide ample opportunities for both our nurses and therapists to receive ongoing clinical education and training, which we think increases the competency of our staff. It's also a major reason they see HealthSouth and Encompass Health as a great employer for them to search out and start their careers with, and retain within our system.

It also enables us to achieve the quality standards that we're very proud to distribute and have through both of our segments. If you look at our home health segment, they're compared on the national star rating system where we exceed the industry standards and 98% of our agencies have a level of three star or higher.

When you look at our inpatient rehabilitation hospitals, we have over 100 of our hospitals are certified by the Joint Commission, which is the major accrediting agency for stroke programs, which gives us an insight and opportunity to work together collaboratively with the acute care systems that have also sought out for stroke accreditation with their programs in the acute setting. And we're very happy with regard to our ability to get the patients in the home setting and prevent a very low percentage of these patients from having to be readmitted back to the acute care hospital. So our quality excels in both of our businesses segments.

I talked earlier about joint venture relationships. It's a strategy that we've had as a company since 1991. We now have 39 of our hospitals are partnered with acute care systems, which is one of the criteria that we use to evaluate any markets that we are looking at for de novo projects. It gives us an ample opportunity to work collaboratively with acute care systems where they would like to have the IRF as an option of care but don't have the expertise and knowhow to establish that within their system. So we've placed a great value on our joint venture relationships. Happy to say we've never had a joint venture relationship unwind in the history of our company.

Another thing that's important to know about our company and the segment we work in is the strong demographic trend. Our average age patient in our hospitals is 76. The average age for our home health is 77. So when you start looking at the growth CAGR, whether it's Medicare beneficiaries that's growing at a 3% rate, or you look out further than that, when you look at the age categories of that 75 to 85 range that includes our average age patient, in the out years it's projected to be at a 4.5 to 5.5 CAGR. So the bulbous of this aging population, the aging out of the baby boom generation, has just started and will continue to drive the need for inpatient rehabilitation and homecare setting services.

Most of our segments are the tops of the industry in terms of efficiency and cost effectiveness. We've done a lot to generate programs that help our management teams manage labor, as well as share with the scale that we can provide through our purchase services, opportunities, and our supply chain.

We have spent considerable resources as a company also developing our technology. We have the IT system through Cerner with our hospitals. We are in the fifth and final year of the rollout of the electronic medical records. Within our home health, it's home care/home based, it's the IT system that we work with in a home setting. So both of our segments are positioned well for the future when it comes to receiving and sharing the patient care information in an integrated network.

And then the final point I want to hit on here is the fact that we have a proven track record. If you look at our success over the last 35 quarters and our ability to generate and increase adjusted EBITDA, we've had 34 out of those 35 quarters that we have increased our adjusted EBITDA. So these are just a few points that we believe help separate the HealthSouth out from other providers and make our track record extremely strong.

The final area I'd point on is in July we announced that we would be undergoing a rebranding initiative, including a name change of the Company to Encompass Health effective January 1st of 2018. Our new symbol ticker will be EHC. And we have set this process to begin, which will end over a two-year period in 2019.

So with that I'll turn it over to Duncan.

Duncan Brown: Great. Thank you very much and I'm sorry about the slides there.

So this is meant to be much more of a conversation than anything else. So please, if anyone has any questions, just feel free to raise your hand and we'll make sure that we get that [in volume] and Mark and Doug can hear from you from whatever. I'm sure they'd much rather hear your questions.

But I'll kick it off with one and it's obviously topical. Can you give us thoughts on potential impact exposure of your facilities in relation to Harvey and Irma?

Mark Tarr: So we might start with Houston. We have six hospitals in the Houston marketplace that were operating at the time of Harvey. We had one additional hospital that was under construction in a suburb of Houston called Pearland. We had nine home health agencies in the marketplace. Overall, I would say that we came through it pretty well. It's tough to gauge what the financial impact of a storm will be and we didn't try to do that at this point.

We are showing signs of running back on a more normal basis. Five of our six hospitals are admitting patients. We have the one hospital that we were forced to evacuate, more from a cautionary measure than anything else. We had water on the first floor. We thought that the power generator, the backup power generator, would be complicated due to the flooding and therefore we chose to evacuate patients to one of our two other five hospitals that were operating.

We'll also see a delay in the operating start date for the hospital in Pearland. We initially had a startup date in the first two weeks of October. That will now be delayed. We're not sure how long it will be delayed. That's a hospital that we had actually not even taken ownership of yet because it was not completed, but we will see a delay there.

With regards to Irma, we are preparing the entire state. We have 12 hospitals there. We have 17 home health agencies in the state. So we are in the process of making sure all of our staff and supplies are necessary there to carry us on a period of 7 to 10 days after the storm. All of our hospitals, of course, are built to code structurally; high-impact windows. We have full-house generators in all of our hospitals. So we are as prepared as possible to weather the storm. We have evacuated our patients from our Miami hospital up to Fort Lauderdale, which should be in a better position in terms of overall exposure to the storm.

So, it's tough to tell right now in terms of what the impact will be with Irma. Not unlike Harvey, we would be impacted by the upstream impact due to the acute care hospitals. 90% of our patients come directly from an acute care hospital into our rehab hospitals. So to the effect that they have been interrupted and the full patterns will have changed, it's difficult for us to assess what downstream impacts we'll have in our hospitals and home health locations.

Duncan Brown: Okay. And then-- thank you for that. Can we talk a little bit about the TeamWorks initiative? And I think-- can you help maybe give us some examples of how that helps bring together your two business lines and provides a structure for growth going forward?

Mark Tarr: Yes. So we have done other TeamWorks initiatives. Those of you that are familiar with the Company know that that is our moniker for the establishment of standardized initiatives and standardized processes, where we take an issue that we see a lot of variations within our portfolio, where you have high percentage of success and a lesser percentage of success, and we try to see what those criteria, what the process needs to be in order to minimize the variation and execution across the portfolio. We typically address that with a group of subject matter experts, whether it's from the home health side or from the hospital side. In this case it involved both, where we took our staff. We're also working from a cost standpoint with KPMG who helps us walk through and lead us through the standardized processing initiative.

So we have put together what we call a playbook with the standardized process. We have rolled it out to five of our marketplaces. We brought it back in, we kind of tweaked it a little bit. Now we are rolling it out across all of our marketplaces that we have an overlap between our home health and our hospital based. And we hope that by refining the process it will lead to greater execution and our ability to drive what we call the clinical collaboration rate from where we currently were in the last reporting period of 28.6% to what we've listed as our overall goal over the next three years to closer to that 30% to 35%.

Doug Coltharp: So to give you a specific there, Duncan, one of the things that we identified when we looked at the disparity between those overlap markets that have a very high level of clinical collaboration and those overlap markets that have a low, was the way that the representatives from HealthSouth and Encompass were communicating with each other and with the patient and the patient's family during that patient's stay in our facility. On average a patient is going to stay in our facility for 13 days. And deciding when you're going to introduce the representative from Encompass because you believe that that patient is going to require home health care after discharge can have a significant impact in how much time that caregiver has the ability to get to know the patient, understand their conditions at home afterwards, and develop a plan of care.

So one of the things that's come out of this TeamWorks initiative is a definition of the patient's journey during that 13-day stay, and really breaking it down into all of the key segments that define that patient's plan of care while they're with us and help us determine the most likely plan of case post-discharge, and how we've set specific times when the care transition coordinator from Encompass will be receiving information on

that patient, and then specific times in the patient journey when they will begin interacting with both the IRF clinical team and with the patient and the patient's family.

Duncan Brown: That's helpful. And I guess can you-- and I think you sort of alluded to this in past conference calls, but how to think about the revenue EBITDA opportunity for the Company to get from that sort of 28 level? And what's the-- is it 30% to 35% is the goal or 35% to 40%? What's the target, if you'll remind us?

Doug Coltharp: It's 35% to 40% is our interim goal, which is over the next three years. And that is in existing overlap markets where, at the end of the second quarter, we were at almost 29%. It's not the height of our aspirations. So first kind of think about it from an economics perspective. We're looking to expand the clinical collaboration in two ways. One is, as Mark suggested, a significant portion of our growth plan is to increase the number of overlap markets, markets where we have both an IRF presence and a home health presence. So right now that's 60%. We'd like to see that go north. And then within those overlap markets we want to drive the clinical collaboration percentage upwards.

In terms of how you can quantify that, and these are just averages, but on average for a therapy patient being discharged from one of our facilities who requires home health, the revenue per episode from home health on those patients is between $3,100 and $3,200. And on average, each one of those patients will require about 1.2 to 1.3 episodes. And then in terms of the marginal EBITDA percentage on that, I would probably say you'd use something maybe in the 20% to 25% range and that way you can kind of get an estimate on that.

It's not a percentage. A lot of times we get asked, well, why can't you just drive that percentage up north? Well first, we can't dictate to Medicare patients that they choose our home health business. We think that in many instances, in most instances, it's in the best interest of the patient and we encourage them to do so. But there may be other reasons why a patient and their caregiver choose to go with another home health provider, including the fact that they may have already had an existing relationship with a home health provider before they come into our facility.

It could also be the fact that our hospitals are fortunate in that they-- many of them have a regional draw, where they will draw patients into our inpatient facilities from 100 or 150 miles away. And once that patient has been discharged back to their home, if they require home health care it's not logistically feasible for us to provide the home health care from the agency that is closer to the hospital. So there are reasons like that that are going to chip away at getting to 100%, but certainly 35% to 40% is not-- does not define the height of our ambition there.

Duncan Brown: What is the current dispersion within that 28-and-change percent? Is it-- what's maybe the low watermark and the high watermark?

Mark Tarr: Well, we have some high schools in Texas that are certainly over 50% on their collaboration percentage. They were some of the first. They were the ones that were the most familiar with utilizing a home health setting. And then we have some others that are certainly in that low 20s and are still learning the process and learning the benefits of being part of the integrated network.

I will say that, from a company standpoint, we-- the culture within our organization is one that our staff do accept standardization very well. We've had very high success rates on past TeamWorks initiatives and they truly embrace the opportunity to standardize the process.

Doug Coltharp: I would also suggest the name change and the rebranding effort is going to be a facilitator of clinical collaboration. Right now it is just confusing to many constituencies, including physicians who work in our hospitals and patients and their caregivers, when we say we are a single organization but we present them with two business cards that have two different company names on them.

Duncan Brown: Do we have any questions from the audience? All right, well if you do please just raise your hand.

Maybe we can switch gears to the home health side of things. Obviously a lot of moving pieces here. I imagine there will be other questions on HHGM from others, but one of the things that is early thrown out, does CMS even have the authority to do this given the lack of budget neutrality. Has there been any resolution on that in your minds?

Mark Tarr: Well, we question whether they do have the authority. I think the industry as a whole is questioning that. It is the federal government, so if they believe that they have the authority to do that then they will pursue that route. We also have to be careful. They are our number one payor source as well, so that is something that we want to be careful.

But certainly in our response back to CMS on the proposed rule and all of our lobbying initiatives that we have right now-- we're very active in Washington. As a matter of fact, the leadership from Encompass Home Health, our team right now is in Washington and they're having very consistent dialogue with the members of CMS. We've also utilized our two full-time lobbyists that we have based in Washington to work with members and the staff of members of Congress in those marketplaces that we do business to make sure that everyone understands what is included in the proposed rule and what the potential impact could be to the industry.

Duncan Brown: Could you maybe--

Mark Tarr: And the nation.

Duncan Brown: Could you maybe highlight the two or three selling-- the top selling points or talking points that your lobbyists are talking about regarding the issues with the proposed rule?

Mark Tarr: Well, I think the most profound change would be going from a 60-day episode to a 30-day period of care. And the vast majority of the patients that receive at least a rehab side of the care, and those that are of the acuity levels that we typically treat, have a care plan that extends the 30-day period. So part of our efforts from our responses, if they were to go forward, is our clinical teams would have to evaluate the opportunities to maximize the outcomes and working with the patients in a much shorter period of time. But that is a significant difference from the way the industry has been structured up to this point.

Doug Coltharp: And one of the things that the industry has spent a lot of time articulating to CMS and to members of Congress is the unintended consequence of the implementation of this rule in terms of the diminution of services to the Medicare beneficiary population, and that could arise out of a number of provisions in the rule.

First, one of the things that we have pointed out is that the rule would have a highly disparate impact on agencies based on their geography and based on where their patients are coming from and so forth. And that-- the diversity and that impact could cause a lot of agencies to stop doing business in certain localities, and it's perhaps possible that there would be a significant reduction in capacity to provide those home health services in certain geographies. And we're talking about significant geographies as well.

It's also possible that there could be some perverse consequences just regarding home health providers' willingness to take on a more acute, more medically complex patient. And that could result-- or if they do, to have to shorten the period of time in which they are working with that patient. And so that could actually wind up increasing the cost to the systems in two ways.

On the front end, if home health providers are not willing to take those more acute patients, those patients are likely to stay in whatever inpatient facility they're in, whether it's an acute care hospital or a post-acute inpatient facility like ours, for a longer period of time with increased costs. If they try to take that acute patient and are required to try to treat them over a shorter period of time and the patient doesn't fully recover, the risk of a hospital readmission goes up considerably and those things could add considerable expense to the program.

Duncan Brown: Do we have anything from the audience on home health?

Maybe switching gears-- please.

Unidentified Audience Member: (Inaudible - microphone inaccessible)

Doug Coltharp: Yes. So I think, as Mark said, the primary way that the industry is focused on whether or not Medicare has the legal ability to do this is not to threaten with lawsuits, but instead to point this out to members of Congress, and the thought being that the Congressional members are not going to be too excited about the fact that their legislative authority is being usurped by this overreach by CMS. And we think that is resonating with the members of Congress.

With regard to the timeframe, recall that home health is on a calendar-year basis, not a fiscal-year basis so the proposed rule is out. I'll remind you that the proposed rule normally gets dropped about July 1st of every year and this year it came out about three weeks late. And we think that is indicative of the fact that the inclusion of HHGM was deemed to be problematic by the more senior members of CMS who didn't become aware of its inclusion until late in the process. And the compromise was a delay in the release of the proposed rule, and then also not beginning implementation until 2019.

The timeframe that goes from here is, normally, a proposed rule in home health would become a final rule by about November 1st. And that's because we operate today on a 60-day episode and the new pricing that was embedded in the final rule would be applicable to any episodes that begin after November 1st of one year because they'll close out after January 1st of the following year. So that's the timeframe we're [charting] right now, to try to work on any resolution between now and November 1st. And we think we're gaining some significant traction.

Any number of things could happen. It could stay in exactly as it is, which we think is unlikely. It could be completely removed, which we think is a possibility. It could stay in and it could have its provisions modified in some way that make the impact-- perhaps reduce some of the unintended consequences. We think that would be difficult to accomplish between now and November 1st because it's highly complicated. Or, it could stay in with language considerably softened, so that instead of saying for instance that it's going to begin in 2019, it says something along the order of we're going to conduct further research and we're still considering it.

The language that's included in the final rule is important, because if it stays with a definitive date for implementation like it has right now, then when the rule becomes final it has to get scored. If it gets scored, it's got a savings associated with it and then any future revisions or revocations of that provision have to have an offset.

Mark Tarr: We've talked about our lobbying efforts. It's important to note that the industry is united on this. There's an organization called The Partnership For Quality Home Health which is a major trade association, which is the thrust of the lobbying efforts going on. Clearly we are a big part of that and part of the leadership of that. But the industry is very much united on the efforts-- lobbying efforts in D.C. and with CMS.

Doug Coltharp: And other industry segments are concerned about this as well. I mentioned some of the potential unintended consequences of having to increase the length of stay in inpatient facilities if there's a diminution in care or an unwillingness by home health providers post-implementation of a rule like this to take a more acute patient. The acute care hospitals don't want that. They want-- they have two objectives. One is to be able to push patients out of their facilities as soon as reasonably possible, and the second is to lower their readmission rates. And this would be in contrast to those objectives.

Duncan Brown: Mark, you mentioned when we were walking in a recent announcement from Cerner. Could you give us some color on that?

Mark Tarr: Yes. So Cerner is the vendor that we've worked now for almost seven years with on developing our electronic medical record. As I mentioned, we're in the fifth and final year of implementation of that in our hospitals. The past two years we have been working through the process of-- the start of data analytics, extracting data from our patients and their discharges to apply to a predictive modeling.

This last week we announced the development of a post-acute innovation center partnership between HealthSouth and Cerner on using a huge bulbous of data that Cerner has for us to develop clinical protocols, to advance our efforts on predictive modeling, and put us truly in a competitive advantage over the industry in terms of our ability to use data, both collected from our records and the 200 million records that Cerner has access to, in advancing our efforts forward.

Duncan Brown: Great. Well with that we're out of time. Mark, Doug, thank you very much.

Mark Tarr: Thank you.

Duncan Brown: And thank you all very much for being here. Thank you all.

Doug Coltharp: Thank you.

Mark Tarr: Thanks.