CRH Medical Corporation

First Quarter 2018 Results Conference Call

Date: **May 1, 2018**

Time: **11:00 AM ET / 8:00 AM PT**

Speakers: **Edward Wright**

Chief Executive Officer

Richard Bear

Chief Financial Officer

Jay Kreger

President, CRH Anesthesia Management

Kettina Cordero

Director, Investor Relations

Operator:
Welcome to the CRH Medical Q1 2018 Conference Call. As a reminder, all participants are in listen-only mode and the conference is being recorded. After the presentation, there will be an opportunity to ask questions. To join the question queue, you may press star, then one on your telephone keypad. Should you need assistance during the conference call, you may signal an Operator by pressing star and zero.

I would now like to turn the conference over to Kettina Cordero, Director of Investor Relations. Please go ahead.

Kettina Cordero:
Thank you, Operator, and good morning everyone. I'm joined today by our CEO, Edward Wright, our CFO, Richard Bear, and the President of CRH Anaesthesia, Jay Kreger.

Before we start, I would like to remind everyone that certain statements you will hear today constitute forward-looking statements within the meaning of applicable securities laws. For important assumptions, definitions and cautionary statements about forward-looking information and the risks inherent to our business, please refer to the cautionary notes in our financial report for the quarter ended March 31, 2018, and the Risk Factors section in our most recent Annual Information Form.

During this call, we will discuss non-IFRS measures as indicators of our performance. You can refer to our Management Disclosure and Analysis for the quarter ended March 31, 201 for reconciliations of non-IFRS measures to reported IFRS measures. These documents are available on SEDAR and on the Investors section of our website.

In addition, please note that we use the abbreviation GI to refer to gastroenterology.

Finally, please be advised that our reporting and functional currency is the U.S. dollar and that all dollar figures referenced today are in U.S. dollars.

Now, I leave you with Edward Wright.

Edward Wright:
Thank you Kettina. I'd like to start by talking about our second anaesthesia acquisition of 2018, which we announced this morning. Our longstanding relationship with this O'Regan customer, dating back to 2009, created the opportunity for us to acquire a 51% interest in Western Ohio Sedation Associates, a customer based in Dayton, Ohio. We continue to leverage our O'Regan relationships to drive anaesthesia growth. Today, CRH has 17 anaesthesia practices with exclusive professional service agreements, servicing 39 ambulatory surgical centers, and is providing anaesthesia to approximately 272,000 patient cases annually. It is important to note that 15 of the 17 acquisitions we have completed since December of 2014 are a result of the relationships we have with our O'Regan customers.

Yesterday, we announced positive results for the first quarter of 2018, an outcome attributable to the successful management and organic growth of our existing anaesthesia business. The relationships we have cultivated with gastroenterologists who have adopted the O'Regan system continue to be a strong conduit for our anaesthesia acquisition pipeline.

In 2018, we expect to invest a similar amount as we did in 2016 and 2017 in anaesthesia acquisitions. These acquisitions will be financed through internally generated cash flows and our $100 million credit facility, which has an interest rate of LIBOR plus 250 to 300 basis points. At March 31, 2018, we had approximately $40 million available on our credit facility. This, combined with our free cash flow, will give us ample funds to continue executing on our growth strategy.

I will now turn it over to Richard for his commentary.

Richard Bear:
Thank you, Edward. I'd like to start by reminding everyone that in accordance with International Financial Reporting Standards, also known as IFRS, we report consolidated financial statements, which

means that our financial statements include those of the subsidiaries in which we hold a controlling interest, such as the anaesthesia practices that we own or in which we hold a majority interest. This practice is in keeping with current accounting standards.

In addition, please note that effective January 1, 2018, the Company adopted IFRS 15. As a result, we restated prior year revenue and operating expenses. The restatement had no impact on net income or any other forms of income. Please refer to Note 3 of our unaudited interim financial statements for more information on this.

During the first quarter of 2018, we reported total revenue of $24.7 million. Anaesthesia revenue grew 19% year-over-year to $22.1 million. Average revenue per case for the first quarter was $383, 12.5% lower than in the first quarter of 2017. The decrease is primarily due to the impact of the CMS final fee schedule and the execution of contracts with a number of our commercial payors for previously acquired anaesthesia entities. During the first quarter of 2018, we serviced 57,657 patient cases, which is 36% more than in the same period of 2017. Sales of the O'Regan system during the first quarter were $2.6 million, compared to $2.8 million for the same period of 2017.

Total adjusted operating EBITDA for the first quarter was $12.4 million, representing 50% of total revenue. Adjusted operating EBITDA attributable to our shareholders was $8.2 million.

In the first quarter of 2018, we generated $4.4 million in free cash flow. We define free cash flow as cash provided by operations less payments made for interest and other finance expenses, and less distributions to non-controlling interests. As of March 31, 2018, we had $4.8 million in cash, $11.4 million in working capital. In addition, we had just over $40 million available on our credit facility to fund future growth.

With that, I will leave you with Jay for his update.

Jay Kreger:

Thank you, Richard. As Edward stated earlier, we were very active on the acquisition front lately. During the first quarter, we acquired 100% of Shreveport Sedation Associates, which was our first

acquisition in the state of Louisiana; and then earlier today, as Edward said, we announced the acquisition of a 51% interest in Western Ohio Sedation Associates, also our first acquisition in that state. In total, we've now spent approximately $15 million on acquisitions so far in 2018.

CRH Anaesthesia is now present in nine states. These states and the footprint that they represent has been a product of the opportunities that have been presented, as well as an acceptance of anaesthesia as the standard of care within each geographic region. As the standard of care continues to expand nationwide, we expect that our footprint will broaden accordingly.

As we've discussed before, our MAC development program, which is in Washington state, is a result of this standard of care acceptance. As you would expect, more MAC programs should be in our future. As far as the Washington program goes, it's still on track and we expect to exercise our purchase option later this summer in 2018.

Given these recent acquisitions and an active second half of 2017, we have continued to focus on our operations and the ability to effectively and efficiently integrate newly acquired businesses. Our platform continues to evolve, as we support best practices as the GI anaesthesia partner of choice. Our Business Development Team is continuing to work closely with our O'Regan Team each day in order to further grow our acquisition pipeline and uncover new opportunities for the rest of 2018, and beyond. As Edward stated earlier, we're very optimistic that we will continue our investment pace from the last couple of years. Our financial and operational resources are in place to support these continuing acquisitions, and so I look forward to the remainder of the year to come.

I now leave you back with Edward for his closing remarks.

Edward Wright:
Thanks, Jay. We look forward to reporting our second quarter results in approximately 90 days, and with that, I'll open the call up for questions.

Operator:
Thank you. We will now begin the question and answer session. To join the question queue, you may press star, then one on your telephone keypad. You will hear a tone acknowledging your request. If you're using a speakerphone, please pick up your handset before pressing any keys. To withdraw your question, please press star, then two. We will pause for a moment as callers join the queue.

The first question comes from Lennox Gibbs of TD Securities. Please go ahead.

Lennox Gibbs:
Good morning, thank you. In November, you estimated the cost of the CMS reimbursement cuts at 12%. Having seen the Q1 result, are you holding to that guidance?

Richard Bear:
Prior to our first quarter results, we estimated the impact being 12%. Based on data in the first quarter that we analyzed and studied, we believe the impact is going to be 10.5% and don't see any reason why that would change throughout the rest of the year.

Lennox Gibbs:
So, we should now look at this as 10.5% going forward.

Richard Bear:
Correct.

Lennox Gibbs:
Good, okay. Secondly, can you step us through what the revenue growth trajectory might look like for your recent acquisitions? Starting with the bump that you usually get, you typically get from revenue cycle management once you go in, then the reset as you move through in-contract terms, and finally the sustainable organic growth phase, if you could just kind of illustrate what that might look like.

Richard Bear:

Good question. It's hard to quantify it, because each market is different. In the case of Western Ohio Sedation Associates, that's a new entity that was created for the sole purpose of the joint venture with the GI group that we're partnering with. Right now that entity, effective today, would be non-contracted with all the major payors. Working with the GIs, we would develop a payor strategy which payors to go after first, we may be contacted by certain payors as part of the normal course; but it will take months, sometimes quarters, or longer, to get to a point where we're fully contracted, and in some cases we're never required to be fully contracted. So, we would expect during the initial phase of Western Ohio Sedation Services, no different than any other entity, that we'll be non-contracted, and as a result, will have a higher revenue per case and that will ultimately, over a period of 12, 18, 24 months, again depending on the market, go down as we contract to what we would call a steady state. Just to add to that, it's that steady state where we think we'll end up; it's how we value that business. We don't value the business on anything that we expect in a non-contracted environment.

Lennox Gibbs:

So, talk a little bit more about that steady state. I guess what I'm wondering about is can you give us a sense as to what long-term sustainable organic revenue growth might look like?

Richard Bear:

We always talk about 3% to 5% in terms of organic growth. The revenue at any specific site is going to vary based on the payor mix of that site, commercial or federal, and even within the commercial because each payor has a different reimbursement strategy and when we contract with them some rates in a contracted environment can be 2 X others who are also contracted in the same market. So, it's difficult to really get on that steady state and provide what that steady state is on an individual entity basis.

Lennox Gibbs:

Well, suppose we thought about it overall on a corporate level, how should we think of the long-term sustainable organic revenue growth?

Richard Bear:
Again, it's going to depend on just the make-up of our payor mix with the new entities that we acquire and it's not that we would be able to say 3% to 5% on the case growth, but the revenue, I don't have the visibility into the future to tell you how acquisitions would impact our overall revenue per case.

Lennox Gibbs:
Okay, good. Thanks very much.

Richard Bear:
You're welcome.

Operator:
The next question comes from Noel Atkinson of Clarus Securities. Please go ahead, Noel.

Noel Atkinson:
Hi, good morning. Thanks for taking my call. Specifically, on the GAA side, did you see any negative payor mix impact on reimbursement rates there similar to what you saw in Q1 of 2016 and 2017?

Richard Bear:
I am happy to report that we had no impact of payor mix changes in GAA in the first quarter of 2018.

Noel Atkinson:
Okay, great. On trying to bring the payors from the 2016 acquisitions in network, so it didn't happen in Q1. What's your expectation for how it rolls out in the rest of the year? I'm sorry if I missed this already.

Richard Bear:
No. So, in our last call, last reporting, we talked about the 12% in CMS cuts, which is now 10.5%. We also talked about a 5% decrease in revenue per case as a result of going from non-contracted to contracted for acquisitions prior to December 31, 2017. We still believe that 5% to be a fair number. There are contracts that will go into effect during Q2 and others that will go into effect later in the year as a result of our conversations. So, we stand by those numbers that we provided.

Noel Atkinson:
Okay. The IFRS 15 adjustments, moving the bad debt from OpEx to I guess netting against gross revenue, would have that been a 6% number in the quarter against gross revenue?

Richard Bear:
Yes, I mean, the simple example that I'd like to use is, prior to the adoption of IFRS 15, we would record $100 in revenue, $6 in bad debt, which is reflected in OpEx, for a net of $94. Now, we just reflect the $94 as revenue. Interesting, income, operating income, EBITDA attributable to shareholders, any form of income doesn't change, so when you look at margins, the numerator, the income on top of the equation stays the same, but the denominator, revenue, is decreased, which results in actually, on a comparative basis, that we get three extra points of margin. Please keep that in mind, it's not that the margins of the business are improving, it's that it's a mathematical equation as a result of IFRS 15.

Noel Atkinson:
Okay. Then, finally, just on the acquisition side, now that the CMS rate reimbursement changes have flowed through into revenue and all the different practices are seeing how things have gone, what does the acquisition pipeline look like? Has it changed at all as some of these GIs have seen what has happened on the anaesthesia side?

Edward Wright:
Jay, would you take that question please?

Jay Kreger:
Sure. Noel, good question. I think what we've seen, number one, is our pipeline is as strong as it's ever been, and some of that may be a result of the physicians who have experienced these cuts and realizing that there is payor risk or perceived payor risk into the future. I think also the fact that we have just continued to grow and get our name out there, as well as our continued strength from O'Regan relationships, has led to that stronger pipeline. Therefore, we don't see the CMS necessarily as a good thing or a bad thing from an acquisition standpoint. The values have been reflected that we are paying

from CMS going forward, so it doesn't affect valuations at all. We just look at it as another talking point when we speak to physicians about the value proposition that we can present to them.

Noel Atkinson:
Okay. Well, nice quarter. Thanks very much for taking my call.

Edward Wright:
Thanks, Noel.

Operator:
The next question comes from David Martin of Bloom Burton. Please go ahead.

David Martin:
Good morning. First question. The Adjusted EBITDA was higher than we expected, and we know that was in part because you got no new commercial payors shifting to in-network from out-of-network and the lower impact of the CMS cuts; but I'm also wondering, were there any expense reductions that you were able to achieve that exceeded your plan?

Richard Bear:
No.

David Martin:
No, okay.

Richard Bear:
There was no expense reductions;, there was no material expense reductions. There's two sets of numbers. There's consensus, each of the individual analysts have their numbers, and then we have our numbers. I would say the results came in very close to what we expected and we're pleased with the results, with the exception of the CMS change.

David Martin:
Okay. So, maybe differently, leaving aside what I expected, did you trim in any areas and are those trims expected to be sustained, or were they one time?

Richard Bear:
Yes, every opportunity we have, David, we look at how we can do things better, faster, cheaper. There's nothing to note that had significant benefit over something else. We're always looking at every opportunity to manage expenses and manage expense growth, but obviously the focus is ensuring that we're providing the highest level of service to our patients and to our customers.

David Martin:
Okay. Second question. Going back to one of the ones that Lennox asked, when you make an acquisition and you indicate what you expect the revenues to be at that acquisition, is that the revenues immediately out of the gate, while you still have everyone or most of them out-of-network, or is that the steady state revenues that you expect for them, you know, once everyone we want comes in-network?

Richard Bear:
I would say it's more the latter, the steady state, because until we have reimbursement history, it would be difficult for us to say what the revenue that we collect on a non-contracted basis is, because it truly is different by state, by payor. What we're able to receive non-contracted from United in Texas is going to be different than what we get non-contracted United in Ohio.

David Martin:
Okay. I guess the books that you see of the businesses that you buy reflect a steady state of payors being in-network, and they just shift out-of-network as you make the transition.

Richard Bear:
Sometimes. I mean, sometimes they reflect in-contract, sometimes they reflect non-contract. Mostly what they reflect is a lack of knowledge of how to really bill for anaesthesia, and so when we look at the things that we can do, it's not just rates, it's not just our ability to contract, it's a full gamut of process

improvements based on our best practices that many individual billing organizations don't have any proficiency at.

David Martin:
Okay, and a last question. When I started covering you guys, it seemed like deep sedation was more popular on the East Coast than on the West Coast. Are you seeing any increase in use of deep sedation on the West Coast?

Edward Wright:
Jay, would you take that call, please?

Jay Kreger:
Sure. As I alluded to, David, that continues to be the case, but the further west we go, it is starting to change. As I mentioned, in the State of Washington, medical necessity was an issue just a few short years ago and that's now not the case. We would expect the remaining states that haven't accepted deep sedation as a standard of care, they will continue to do that over the next few years, which of course will present new opportunities for us.

David Martin:
Okay, that's it. Thank you.

Edward Wright:
Thank, you David.

Operator:
The next question comes from Doug Cooper of Beacon Securities. Please go ahead, sir.

Doug Cooper:
Hi, good morning, guys, and congratulations on a nice quarter. I just want to get back to a point David brought up. Just on the costs, Richard, I did notice that costs per case was down about 7%, driven by

employee-related; cost per case was down almost $11 a case, I guess. So, is there just more efficiency to driving that employee-related cost down?

Richard Bear:
You're comparing Q1 2018 to Q1 2017?

Doug Cooper:
Correct.

Richard Bear:
Okay, and you're acknowledging those are adjusted numbers, adjusting for IFRS 15?

Doug Cooper:
Correct.

Richard Bear:
Yes. I would say that when we look at Central Colorado, when we look at Raleigh, when we look at Alamo, that their cost per case, the employee's cost per case in those markets are cheaper than where the average was prior to those acquisitions. So, when you look at it the way you're looking at it, it's really more of the composition of our portfolio in Q1 2018, compared to the composition of our portfolio of properties in Q1'17, that's driving that. We're always looking for ways of streamlining and doing things again better, faster, cheaper, but that's primarily what we're seeing. Jay, anything to add?

Jay Kreger:
Yes, I would also, just to piggyback on Richard's point there, every center has a different staffing model. We have centers that use anaesthesiologists in unison with CRNAs, which is a more expensive staffing model, and then other centers that use only CRNAs, which of course would be less. All of the acquisitions that we did in 2017 were of the latter example, only CRNAs, that would be less. So, that may account for a very small portion of that. But, again, the staffing model is something that we're, for the most part, inheriting, based on either the comfort level of the physicians that we are working for or mandated by the states or the commercial payors that would require anaesthesiologists.

Doug Cooper:
Okay. Just going forward, per case, it was $383, you talked about the—you still think the 5% is going to come. The 5% off the $383, so for modeling purpose $360, $365, rev per case, is that a sort of a good number to go with?

Richard Bear:
Yes, I mean, our adjusted revenue per case for 2017 is $414, you take 10.5% off of that for CMS and that's $370, and you take 5% off for the other cases we talked about, it's $352.

Doug Cooper:
Okay. Just on the CMS—obviously, the cut in January of this year—when would they re-examine for future cuts? Is that something that can happen at any time, or are they—when is the next time they re-examine that?

Richard Bear:
The next natural cycle, the next cycle, from our understanding, that it would come up for any examination would be five years. Unless they feel that there's abuse or technology's changed or the skill sets changed or there's been changes in how they surveyed that, we wouldn't expect any changes with that review.

Doug Cooper:
Okay. So, pretty much good for five years, is what you're saying.

Richard Bear:
We think we're good beyond that, but yes.

Doug Cooper:
Okay. Just on the acquisitions, it looks like Shreveport, you paid about 2.7 times sales, Dayton maybe 2.1 times sales, I guess if you paid 5.6 for your 51% share. Is that sort of the ballpark, somewhere in that range, and what would reflect the differences in that 2.1 versus 2.7 price?

Richard Bear:

Just so you know, sales is one component, expenses is another component, and we value on the third component, which is income. Not all entities are created equal, they have different reimbursements, different staffing, different costs of staffing. So, we look at income and we typically come in, on an effective basis, between 4.5 and 5 times, and these deals are consistent with that.

Doug Cooper:

Okay. So, together, the Shreveport and Dayton, on a consolidated basis, on an EBITDA margin profile, is it essentially in line with what you just reported?

Richard Bear:

If you look at the individual, what we just reported would be anaesthesia revenue less anaesthesia expenses gets you an anaesthesia margin, and that margin divided by revenue would get you the percentage. Keep in mind that's inside those anaesthesia expenses and not just the expenses of the individual entities, but the expenses of Jay and his team, our operations group. So, when we look at the margins of a Shreveport or a Western Ohio, you would expect those to be higher than our average because we're not burdened with that overhead.

Doug Cooper:

Right. Okay, that's it for me. Thanks very much.

Richard Bear:

Thanks.

Operator:

The next question comes from Doug Miehm of RBC Capital Markets. Please go ahead, Doug.

Douglas Miehm:

Thanks. Richard, just a single question here and it has to do with the mix between the types of procedures you're seeing. We have seen a change since last year, and then most recently you

indicated the 50%, 14% split. Have you seen doctors changing the way they're treating based on the change in units? So, have those numbers changed again, are they consistent with the guidance you just gave last time?

Richard Bear:
I'm not quite sure what you're referring to.

Douglas Miehm:
Well, what I'm trying to understand is the mix between 8x1s, 8x2s, 8x3s, because I—

Richard Bear: Yes, okay. So, just for everybody else on the call, 8x1, which is 811, is a diagnostic screening, meaning that they found something, 8x2 is a pure screening, 8x3 is a double, where they do upper and lower endoscopy at the same time. Doubles are really out of patient convenience, because if a patient needs both an upper and lower endoscopy, it's easier for the patient to come in at a single time and have that. It's also better for them from an out-of-pocket experience. We don't expect that to change, but, again, that's not our decision, that would be the decision of the doctors or the facilities. 811 versus 812, the coding is really based on did we find something or did we not. So, those are not a judgement call.

Douglas Miehm:
So, just to be clear, nothing's changed since the last time you provided the breakdown of those cases. What I'm trying to get at—

Richard Bear: That breakdown that we provided was based a lot on the feedback we got from our GI partners, because prior to this CMS change, we weren't collecting the data to get to that level because it wasn't necessary for our billing. We haven't communicated that information since then and we'll look at updating that and communicating that, if that's important information for people to have.

Douglas Miehm:
I'm just trying to understand if that's the reason for the difference between the 12% and the 10.5%.

Richard Bear:
Fair enough.

Douglas Miehm:
Okay. Thank you.

Operator:
As a reminder, if you'd like to ask a question, please press star, then one. The next question comes from Prakash Gowd of CIBC. Please go ahead, Prakash.

Prakash Gowd:
Thanks very much. Richard, I just wanted to clarify your expectations for dollar per patient case. I think you kind of alluded to it a little bit on an earlier question. If we fast-forward 12 months, for example, and assume no further changes in reimbursement beyond what is already expected, and we assume no further acquisitions, what is your best guess of revenue per patient case in that steady state?

Richard Bear:
I can only answer that question how we've answered it previously, and that is if you're looking at all our acquisitions prior to December 31, 2017, we would expect that range to be around $350. I don't have enough data on the new acquisitions, Shreveport and Dayton, to be able to blend that in and give you a blended number.

Prakash Gowd:
Okay, and the $350 would also assume that whatever contracting happened also happens; correct?

Richard Bear:
Yes.

Prakash Gowd:
Okay.

Richard Bear: That assumes the contracting that we are expecting to occur during 2018.

Prakash Gowd:

Perfect. Okay, that's all. Thank you very much.

Operator:

There are no more questions at this time. This concludes the question and answer session. I would like to turn the conference back over to Edward Wright for any closing remarks.

Edward Wright:

I'd just like to thank everyone for joining us and, as I said earlier, we'll look forward to updating you on our Q2s in about 90 days. Thank you.

Operator: This concludes today's conference call. You may disconnect your lines. Thank you for participating and have a pleasant day.