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Encompass Health Corp. (EHC)

Barclays Global Healthcare Conference

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MANAGEMENT DISCUSSION SECTION

Steven J. Valiquette
Analyst, Barclays Capital, Inc.

All right. Good. Welcome to Day Two of the Barclays Healthcare Conference. I'm Steven Valiquette, the healthcare services analyst. I'm going to kick things off with Encompass this morning. For this session, we have Mark Tarr, the company's CEO, and also Doug Coltharp, the CFO of the company, and we have Mark Miller from Investor Relations in the audience here as well. This will be a fireside chat. So I guess we'll just dive right in.

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.

Perfect.

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QUESTION AND ANSWER SECTION

Steven J. Valiquette
Analyst, Barclays Capital, Inc.

Q

All right. Great. So you may want to start with kind of talking about some of the key growth drivers for the company. I think for 2022 to 2026, you guys talked about 6 to 10 de novo openings per year. On top of that adding now 80 to 120 net additions per year to existing facilities and having all that culminate in a 6% to 8% discharge CAGR. So I guess when thinking about some of that expansion and entering new markets and, I mean, one of the most important criteria that you're looking at, competitive landscape is key, but what about patient referral sources? Just dive into how intense the effort is on sorting out the expansion?

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.

A

So we evaluate a lot of criteria in the marketplace. I would say that the primary driver's demographics. You've probably heard us say before that our average age patient is 76. And as you look at the aging population and the bulbous of baby boomers starting to age out into that 76, 77 year age cohort, that is a driving factor in terms of the increased need for our services. So, demographics and having a core population of Medicare eligible patients is a primary driver. We of course look at competition; is there are other freestanding IRFs in the marketplace; are there units within acute care hospitals in the marketplace; are they well run.

Of course we look at labor, the availability of nurses and therapists and physicians in the marketplace. Then I would say one of the other aspects we really evaluate is how closely aligned is the physician community with the health system. In other words, if there's two health systems and they employ all the physicians in the town that has to be factored in terms of our ability to go in independently versus working from a partnership standpoint with one of the systems. And then we're starting to look at costs of construction and land has really kind of become a major factor as well as these last couple of years. So those are just some of the few criteria that we examine. But we do a deep dive in all of our marketplace before we make a commitment.

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

A

And to Mark's point, we start with some general screening for each market that evaluates things as he mentioned with regard to demographics and competition. And then it gets very specific. So, we can look upstream at all of the acute care hospitals that service that market and the CMS 13 discharges that are coming out of those facilities and to what specific zip code they're getting discharged to.

So we can start to heat map that. We will then look at the percentage of those CMS 13 eligible discharges that are winding up in a current IRF bed, which is the current IRF conversion factor. If it's low, that suggests an opportunity to come in. And ultimately we're calculating what we believe is both a current and a future IRF bed need in that market. And if it's large enough to justify a hospital, then we start looking at some of the other economic factors that Mark cited.

Steven J. Valiquette
Analyst, Barclays Capital, Inc.

Q

Okay. Great. I guess when you think about in-patient rehab facilities versus other parts of post-acute care and even acute care for that matter, the good news is there's pretty strong demand. So you actually get some benefits

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from all the de novo openings, et cetera. So, I guess the question around that would be could you increase the number of new IRFs open per year if you wanted to? Or what are the limiting factors that makes the number that 6 to 10 the right number as far as what you guys are doing on an annual basis?

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.

A

So, the total addressable market is significant. And Doug alluded to just the fact that the IRF eligible patients are being discharged according to their diagnostic categories from the acute care hospitals versus those that actually end up in an IRF is significant and it's the need and for the services is there. And one of the ways we look at the opportunities in marketplace if that conversion rate of those eligible patients is low.

Other words, if they're going to a skilled nursing facility and we know that they're IRF appropriate patients, that's an opportunity for us to go in and increase that conversion rate from the discharge acute to an IRF. So we see that as a real opportunity, we've seen that play out in markets that we have gone into. We've also seen a big benefit the last couple of years in terms of our ability to treat a higher acuity patient than clearly what skilled nursing facilities have.

I think if you look at the market share gains that we've made, it's part of our growth story. We have really made some nice strides in our marketplaces since 2020 with the pandemic, and we were able to take these COVID patients. We showed that we could get over 80% of them back home. We kind of proved ourselves in terms of our outcomes given the higher acuity patient that we were able to treat.

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

A

You know, Steve, prior to 2020, we never opened more than four de novos in a year. And in 2021 we opened eight, 2022 we opened nine and [ph] we scaled (00:05:57) we'll open 8 again this year. So we've been operating at the high end of that range. It's a tremendous undertaking to open up a new rehab hospital. It's not like opening, with no disrespect, a Starbucks or a Subway. We say Subway specifically because we have a board member...

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.

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We have a board member.

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

A

...who is the CEO of that business. And he used the analogy himself. To begin with each 50 bed hospital has a core staffing level of 97 FTEs, and so that ranges from the CEO and their administrative staff right down to a full clinical complement of nurses of various licenses and therapists of different types all the way into housekeeping. And it's a lot to be able to recruit and retain 97 FTEs at each one of these facilities as well. I think from our prior discussions also the way that we're organized internally is our hospitals are currently divided into eight geographic regions.

Each one of those geographies has a regional president, a regional HR person, a regional marketing person and a controller that oversee a group of hospitals. The current span of control for each one of those regional presidents is between 15 and 25 hospitals. The primary determinants of the span of control are the geographic proximity of those hospitals, the number of JVs that are included within their particular region. Because JVs are

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wonderful relationships, they are more complex to manage, which is a limiting factor. And then also the experience level of the regional president.

And so if you're opening eight to nine hospitals per year you're essentially creating a new regional team every two years and if you just think about our position in the marketplace specific to IRFs versus any of the competition, it's not as if there are other companies out there that are serving as a farm system for us. We have to develop a lot of homegrown talent.

So I would say that the primary limiting factor on not currently going above that level, I'm not saying we never will, is just the availability of resources at all levels. When you get internally even beyond those regional teams, the number of people that we have to deploy from the corporate office to make sure that the IT gets up and running, supply chain on day one, all of those things is also very complex. We have perhaps defaulted into making it look a little bit more easily than it is the last several years.

Steven J. Valiquette
Analyst, Barclays Capital, Inc.
Q

Okay. Great. That's certainly some helpful color. Maybe one or two more questions around facility and volume growth and we'll switch to some other topics, labor and rates and other things people want to hear about. So, I think you just touched on some of the JV stuff, so maybe we'll skip over that. But just around the volume side, we're kind of asking this question of every company at the conference. It's up to you if you're able to respond or not. But just curious if at a high level you're able to talk about how patient volumes are trending thus far in calendar 2023 relative to your expectations?

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.
A

So we released an 8-K earlier this week, and overall, we're pleased with volume growth. We've seen some nice momentum come out of 2022 and then into the start of this year. I think we did make a note that March has a lot of spring break in it and the historical has as well. So that would be just caveats just in terms of that can impact volumes from time to time. But, overall, we're very pleased with what we see from our volumes and coming out of the gates this year.

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

You may recall we released our Q4 earnings on February 7 of this year. And at that time because January had already concluded, we commented that volumes in January had been very strong, but we did see some disruption the first week in February related to winter storm activity around the Southwest and the Southeast. The 8-K that we put out yesterday said February also posted strong volume. So we overcame that disruption in February to see strong volumes during the month. And as Mark said, we haven't concluded the quarter yet. So we put out this qualifier just around spring break activity in March. But that's not meant to necessarily dampen the enthusiasm from what we saw in the first two months of the quarter.

Steven J. Valiquette
Analyst, Barclays Capital, Inc.
Q

Okay, that's great. Okay. So moving on to the labor and rates, I guess first just to kind of frame things a little bit. So for the IRF business EBITDA was up slightly in 2022 versus 2021, EPS was down a little for the overall company. Back at the time of the spinoff and middle of last year, you talked about you expected a decent amount of operational improvement in the back half of 2022 versus the first half. We all know labor was the biggest

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wildcard, but either including or excluding the labor piece, how did those key variables ultimately trend relative to the expectations?

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

A

We made very nice progress particularly on labor. I think it's worth stating that early in 2022 we really saw nice volume growth and we told our CEOs at the time, go out, find the labor. We want to go ahead and make sure that we can accommodate the volume that we're seeing, take the market share, we'll figure out how to handle the labor cost after. And so that was the first half. And so the second half of 2022 we did just that.

We made really nice progress on hiring nurses to fill those open slots. We saw our contract labor FTEs go down. We started to see some softening on the contract labor rate. So we made a $30 million progress in decreasing contract labor in the second half of the year than we did the first half of the year. So that was a matter of filling these open positions and working the rates down with the contract agencies. We continue to see the need in certain marketplaces to have sign on bonuses and shift bonuses. Those continue into 2023. But we can expect to see continued normalization and improvement throughout the rest of this year as well.

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.

A

If you look back at 2022, we saw good volume increases in every quarter of 2022. But, for the first three quarters we were fighting a lower than certainly justified pricing increase out of the Medicare program, which was also being offset by the reimplementation of sequestration. So the positive revenue growth that we were showing was all coming on the backs of volume at the same time that labor costs were elevated. We hit our peak in terms of contract labor FTEs and also the monthly expense rate in March of last year. And for the balance of the year we were able to reduce the number of FTEs and the contract labor expense every month sequentially until the end of the year.

The first half of the year we were also seeing the ramp-up in pre-opening costs associated with the nine de novos that we mentioned earlier. So as a result, in spite of seeing revenue growth in each of the first three quarters, EBITDA decreased on a year over year basis. The fourth quarter that flipped, we not only saw strong revenue growth but we saw even stronger EBITDA growth and the EBITDA growth in the fourth quarter was sufficient to take us to a positive growth rate on a year over year basis for full of 2022. That gives us a lot of momentum as we enter into 2023. We have tried to temper some of the enthusiasm regarding the EBITDA growth in Q1. We are going to see improvements on a year over year basis in those labor expenses. But just based on volume flows and a number of other factors and the level of pre-opening expense we'll have with our de novo activity in 2023, we expect it to be a little bit more moderate and then more pronounced in the last three quarters of the year.

Steven J. Valiquette
Analyst, Barclays Capital, Inc.

Q

Okay.

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

A

One thing we did that really helped our labor front is we consolidated our talent acquisition specifically around nursing recruitment and made the investment to do that. I think it's positioned us extremely well. We took that burden off the individual hospitals and brought that in-house as a manner to support those hospitals. And we have

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professional recruiters right now doing that work for us. And that's been a really nice add to our ability to find and recruit nurses.

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.

A

And so staffing that centralized talent acquisition area, which now has about 73 FTEs putting the money behind the marketing efforts for recruiting that we did last year. And then also the relocation expense associated with those recruiting efforts caused the aggregate expense for that cost center to increase from a little over $12 million in 2021 to north of $24 million last year. The good news as we look at 2023 is we're not going to see that same level of growth. We would expect that to grow maybe another $2 million to $2.5 million during the course of the year. So you're going to begin getting a lot of leverage off of that function as well.

Steven J. Valiquette
Analyst, Barclays Capital, Inc.

Q

Okay. Great. Maybe final question on labor then we'll maybe hit on the rates. First of all, I commend you guys for the level of detail you gave around the labor expense and all the components makes our lives a lot easier trying to decipher all that. You guys give raw dollar amounts per quarter and everything. So that's fantastic. But also thinking about it as a percent of revs, the salaries and benefits expense. So I guess what's more important, the raw dollar amount from your perspective or the percent because you guys were tracking around 51% to 52% as far as salary and benefit expense as a percent of revs pre-pandemic in 2017 to 2019, that's moved up to around 55% or so, give or take last year.

So in this current environment and also you mentioned the challenges on staffing, the new de novos and everything else, maybe some higher labor costs, what's a reasonable number for that salary benefit expense as a percent of revs over the next couple of years, give or take, it may get back down to where we were pre-COVID? Or is that [indiscernible] (00:16:13) maybe slightly elevated?

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.

A

We certainly expect to see improvement from what we believe was the peak in 2022. I think it's probably still too early to call the ball on exactly where that percentage ultimately kind of settles in. We would anticipate that we'll see another nice year of pricing increases in the fourth quarter of this year just based on the cost of input that should be flowing through the Medicare market basket update calculation. If you look at our guidance assumptions, though, we put in a more modest assumption for Q4 because frankly we've seen CMS play games with the productivity adjustment but we hope that that proves to be conservative.

Offsetting the improvement that we're going to see in kind of contract labor and the overall wage rate inflation this year is going to be what we would expect is a bit of normalization in our employees per occupied bed, which is our primary labor productivity measure. During the pandemic that had reached a low point of about 3.28, and that's versus a normalized run rate before we entered the pandemic of around 3.4.

All of that meant that we were still meeting all of the requirements for nursing and therapy that by law both federal and state were required to meet, but that puts a lot of incremental stress on the staff. And in a tight clinical market you want to find ways to alleviate that incremental stress on the staff by having that EPOB gravitate up a little bit more on the assumption that we've put in for 2023 is 3.4 versus 3.35 in 2023. We think that's going to show benefits in terms of improved retention for our clinical workforce.

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

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Hospital level retention is a huge focus for us this year. We've mentioned about all the nurses we've hired. We want to make sure we keep them in our system. I think if you look at the industry-wide, there's a pretty significant turnover for nurses particularly within that first year after hire. So we are making a real effort at the local level to make sure that we [indiscernible] (00:18:21) nurses, that we mentor them. We make sure that they feel clinically confident before they go out on the floor. So that will be, you'll hear us talk about that in terms of just the initiatives surrounding labor.

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.

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So I think the bottom line there, Steve, is we expect that percentage to come below 55%, but don't have line of sight right now to get back to the kind of 52% range.

Steven J. Valiquette
Analyst, Barclays Capital, Inc.

Q

Okay. Got it. Okay. Maybe shifting to rates a little bit, you just answered one of the questions, which was going to be is it in the spirit of CMS to try to make up for higher labor expense within the IRF rate update, it sounds like that's still TBD.

But we might also just tackle one of the other key questions here around the home health transfer rule policy. For those that don't know, just for two seconds for background, the OIG recommended back in 2021 a change in the health policy around patients being transferred, I guess, earlier potentially out of IRFs into home health. So now there's some elevated concern this year that this could be baked into the IRF rate rule for fiscal 2024. That's one of the reasons why your stock, I think, has underperformed over the past couple of weeks or so.

So I guess maybe one or two questions around that. First, are you able to discuss whether you guys think this may or may not be included in the rate update this year for various reasons, maybe they are higher probability or lower probability, we'll start with that first. Or if you can't comment that's fine too but just curious whether you think you may or may not be in there for this year.

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

A

We really have no basis to make an assumption whether it will or won't. We don't have any inside knowledge on that at all. We are obviously aware of the report that came out from the Washington Analysis Group that said that that may be introduced this year. But there's no new information has come out from CMS regarding the transfer rule.

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.

A

Now, certainly the fact it was included in any form in a proposed rule last year means that it's at least on CMS's radar screen.

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

A

Yeah.

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Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.
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And so we have to be aware of that. If you look at the discussion within the proposed rule last year, it was bare bones, it was very high level. And that makes it extremely difficult to try to frame what kind of impact might be and what kind of mitigants might be available. And so the OIG report basically came out and said if you take any discharge from an IRF that has less than an average length of stay that went to a home health for any reason, and you put those all on a per diem, that it would save the industry about $500 million a year.

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

Yeah.

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.
A

Well, there are a number of things that are flawed with that. And the primary rationale for the OIG pointing that out is there is an analogous policy that has existed for about the last 20 years for the acute care hospitals. But there are some very big distinctions between the broad based rule that are outlined for the rule that was included in the CMS IRF proposed rule last year and what's in place at the Acute Care Hospital.

So, to begin with, the implication in the proposed rules that would apply to all such discharges coming out of an IRF. In the acute care hospital it's more narrowly defined. It's only 283 CMGs. There are also a couple of important carve-outs within the acute care hospital rule that are not mentioned in the proposed rule for the IRF. One is if the reason for initiating home health post-discharge is unrelated to the primary diagnosis that was treated in the acute care hospital, the per diem does not apply. The second is if that care is not initiated until at least three days post discharge, the rule does not apply.

You start applying just those filters to a proposed rule for the IRF, that $500 million starts to come down very quickly. There are a lot of reasons why patients get discharged at less than the average length of stay or more than the average length of stay coming out of an IRF. The average age of our patient is 77. They have multiple comorbidities. They've undergone a serious malady which has landed them in the IRF in the first place and the rates of recovery can vary dramatically, even from two patients presenting themselves with roughly similar characteristics on day one when they're ultimately ready to be discharged. So we would caution people against jumping to any conclusions regarding the magnitude of any impact from a rule that we don't even know is forthcoming at this point in time.

I will also tell you that if you get deeper into the current reimbursement mechanisms for an IRF, it's really complicated. A component of determining the reimbursement level for any CMG is the average length of stay. Within that calculation, if you flip any particular discharge from a CMG basis into a per diem basis, it gets eliminated from that calculation. So if you implemented a rule like this and started taking the average length of stay, those with a lower average length of stay out of the calculation, what happens to the average length of stay? It goes up. So the reimbursement goes up for the residual discharges within that CMG. So it's a little like pushing on a balloon. It's just a lot more to it than simply saying we're going to enact this rule.

Steven J. Valiquette
Analyst, Barclays Capital, Inc.
Q

Okay. That's certainly helpful for some extra color around that. So a lot of scenarios but ultimately just if you are able to talk about this and that but let's say if there were none of those adjustment factors at that full throttle level

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of $500 million per year, the numbers that OIG used, I mean, are you able to discuss whether or not Encompass has a lower than average number of discharges to home health or whether your shorter stays are less than those industry averages that they talk about when they use their own calculations? I'm sure you guys have done this work internally, but are you able to share any of that or is it just still too early to really give any numbers around that?

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.

A

We're hesitant to share any specifics simply because we don't know what the rule would look like. I think it's very unlikely that it would look like the construct that came out of the proposed rule last year. We don't think there's any reason to believe that we're an outlier either with regard to the percentage of our overall discharges that go to home health or the average length of stay of those. Again, because everybody's kind of managing around an industry average length of stay. So again, just no reason to believe that we're an industry outlier. I will also say, Steve, the other thing that to be considered is budget neutrality. And you can't just whack an industry. CMS does not have the ability to just whack an industry about $500 million with a new rule. That's not going to meet the budget neutrality test.

Steven J. Valiquette
Analyst, Barclays Capital, Inc.

Q

Okay. And thinking about this, too, in terms of any spillover on the commercial side. Well, first of all, just what's the outlook on commercial pricing as far as being able to claw back some better pricing around labor? But also whatever happens around this whole home health transfer policy, does commercial ultimately sort of mimic what's coming out of CMS on the Medicare side? Whether, maybe not word for word or every component, but just in the spirit of whatever on the net rate is, that commercial tends to follow that. Just curious to get your thoughts around that, too.

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.

A

We're not having discussions specifically with Medicare Advantage payers on this topic yet, which I think is another reason to suspect that maybe it's not fully baked. But about 90%, a little bit less than 90% of our Medicare Advantage revenues are tied specifically to the fee for service CMG. And so those normally move in concert. Whatever happens on the CMG happens with Medicare Advantage. That aside, with regard to the level of rate increase we're anticipating, we've kind of penciled in 2% to 3%. That's not the height of our aspirations, nor is it what we think we can do. But we think that's a decent operating assumption for 2023.

Steven J. Valiquette
Analyst, Barclays Capital, Inc.

Okay, I got it. But with that I think we're over time here by a minute or two. So I'm glad we were able to hit on some of the key topics. I want to thank you guys for your time today and...

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

Thank you, Steve.

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.

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Enjoy the rest of the conference.

Steven J. Valiquette

Analyst, Barclays Capital, Inc.

Thank you.

Douglas E. Coltharp

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

Appreciate it.

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