Encompass Health Corporation

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Andrew Mok: Good morning. Welcome back to the Barclays Global Healthcare Conference. My name is Andrew Mok. I'm the Facilities and Managed Care Analyst here at Barclays. And I'm pleased to welcome Mark Tarr, CEO; and Doug Coltharp, the CFO of Encompass Healthcare. Welcome.

Mark Tarr: It's good to be here.

Andrew Mok: Maybe to start, we can hit on a topic that's been on top of a lot of people's minds for the last three weeks. How is Encompass affected by the disruption at Change Healthcare, and what are your first impressions of the new HHS plan to address these issues?

Mark Tarr: So we've had no disruption to our operations. We've been able to treat patients and service our patients the same as we always would have. We have caught up on our billing in terms of submitting the claims, and we expect a little bit of possible increase in receivables, just given the delays in terms of payment. But we've had no impact on our operations of our hospitals.

Doug Coltharp: With regard to the HHS offered assistance, we simply don't qualify in terms of the financial need for that. And we have more than adequate liquidity, particularly now that it looks like Change is going to resume processing as quickly as a week from now. We have moved volume to alternative vendors, and so far, the processing from those vendors is proceeding satisfactorily. As Mark said, we are current with regard to claim submissions with all payers. Because those claims have not yet been fully processed, we don't know if we'll experience any delays in actually getting paid. But we don't anticipate it being any kind of significant working capital or liquidity issue.

Mark Tarr: We have a centralized billing office, and they've really done a nice job on making sure that we were caught up and found other ways to get the claims submitted.

Andrew Mok: Got it. When you say you're switching vendors, is that a temporary decision, or do you think that you're looking at this more holistically and saying maybe you'd diversify vendors a little bit after an event like this?

Mark Tarr: I think it's the latter. I think we'll evaluate that. But certainly, the last three weeks has reminded us that it could be in our best interests to diversify around (ph).

Andrew Mok: Great. Moving on. Doug, you just finished one of the best years of revenue and EBITDA growth at Encompass. You outperformed your initial 2023 guidance by nearly $100 million. What in particular drove the strength in the underlying operations in 2023? And was there any change to the guidance-setting process for 2024?

Doug Coltharp: Yes. So I'd say the outperformance in 2023 was really attributable to two factors: volumes throughout the year came in a bit stronger than we had anticipated; and, at the same time, we had anticipated at the outset of the year that we'll see further improvements in premium labor. And by premium labor, we're referring specifically to the utilization and the rate on contract labor, as well as the utilization of sign-on and shift bonuses to recruit new employees and to fill gaps in the schedule.

And we actually saw those two categories of premium labor decrease by about $67 million in 2023 from 2022, and that was greater than the rate of improvement that we had anticipated.

With regard to did it inform our guidance or cause us to change our procedures for setting initial guidance for 2024, we always try to be a learning machine and to ascend the learning curve based on what has (ph) most recently transpired. Having said that, we also try to be very consistent in setting our guide. We feel like it's hard to argue with the umpire if he's calling balls and strikes consistently, so I would say that the guidance that we have established at the outset of 2024 very much adheres to the principles that we have used in prior years.

Andrew Mok: Great. And I think your guidance assumes SWB per FTE is increasing 4% to 5% in 2024. Where do you end the year in 2023, and what's driving the higher assumption for 2024?

Doug Coltharp: If you look specifically at Q4, you've got to break the SWB into its components. We had each of those parts kind of moving in directions. Though the underlying rate of inflation in Q4 for internal salaries and wages was about 4.9%, so just under 5%, the actual SWB inflation for Q4 all-in, which would include the contract labor, sign-on and (ph) shift, and bring benefits into it, was up about 2.2%. And the delta between those two is that contract labor and sign-on on shift, those premium labor categories that I referenced earlier, were decreasing on a year-over-year basis.

And we also had some favorable out-of-period adjustments to our benefits expense. Included within our benefits expense are the costs related to our self-insurance, worker's comp, and general and professional liability. I mean, based on an actuarial assessment that we conduct twice a year, mid-year and then at the end of the year, we made some favorable adjustments to prior-year claims. Those were out of period.

And the last thing that helped drive that benefit expense down is we had a very favorable in-period experience in terms of our Q4 claims under our group medical program, which is also self-insured. So as we evaluated the Q4 performance to set our guidance for Q1, we really looked back to that internal inflation rate, which was that 4.9%, and saw that being roughly equally offset by the other two factors; which is, as we progress into 2024, it's our anticipation that the aggregate amount of premium labor dollars that we expended in Q4 represents a rough proxy for the run rate we anticipate throughout 2024.

And that will fluctuate a little bit from quarter to quarter based on seasonality, but if those aggregate dollars are staying the same at the Q4 level, but not only going down on a year-over-year basis but because volume is increasing, you're getting some leverage on that.

The leverage that we're getting in this (ph) premium labor categories is going to be roughly offset by a normalization of the benefits expense as those one-time items that I mentioned previously come out of the picture. And the resulting underlying inflation internal SWB per FTE, that 4% to 5% that I mentioned will flow through.

It's very possible that 4% to 5% is being influenced not only by normalized merit increases on our workforce, but also by the anticipation that we'll need to make some continued market adjustments in order to keep our turnover down. And it's possible that, as we get into the second half of the year, based on market adjustments that have been made over the course of the last four to six quarters, that we may be able to see some favorable leverage on that. But right now, the best visibility we have is to call the ball (ph) at that 4% to 5% level.

Andrew Mok: Got it. That's helpful. Maybe moving on to volumes. You share how volumes are tracking to start this year. I noticed you didn't mention Spring Break and any sort of 8K that you released yesterday. So how should we be interpreting that? Are volumes strong and on track to start the year?

Doug Coltharp: As we said, we like to think that we're a learning machine and practice continuous learning. So we confused everybody by mentioning Spring Break when we were here last year, so we did not mention Spring Break. We pulled our guidance, which had just been issued the first week in February in conjunction with our Q4 '23 earnings release, forward yesterday. And what that should signal to everybody is that all of the operating trends we've been able to observe on a quarterly basis are consistent with our initial expectations.

Andrew Mok: Got it. But you have the 6% to 8% volume discharge target. At first blush, that looks a little bit aggressive. But when you peel it back, it's very easy to understand how you get there. And a lot of it, frankly, is just being well-positioned in the sweet spot of aging baby boomers as they transition into that 75-plus age cohort. What I find interesting is that, not only is that some of the highest volumes across the peer group, but I'd argue that it's also the strongest visibility into that volume growth. How does that benefit you, from a planning perspective, to have such high visibility into that variable volume growth over a multi-year period?

Mark Tarr: It's definitely been a big part of our de novo initiative. As we identify markets that we want to add hospitals, or markets where we have an existing hospital but we want to add beds, the demographic tailwind is definitely continuing to drive increasing demand for inpatient (ph) (inaudible) purposes. We have the capabilities of identifying per-market what we refer to as the rehab CAGR of qualified rehab patients that are coming out of the acute care hospitals. So we do have a lot of insight in terms of referral patterns, in terms of the rehab-appropriate patients.

Andrew, as you said, I mean, per average age patient's (ph) right at 76, 77. So as (inaudible) baby boomers continue to age out right into our age cohort, we've really seen some nice increase in demand. And I think we're also taking market share from other providers, specifically the nursing homes that had a tough go of it, and I think it's clear that our outcomes that we've been able to achieve on our patients really gives and can support our value proposition as to the first versus (inaudible).

Doug Coltharp: And I think, just to elaborate on what Mark said, if you just take the period, for instance, from 2010 to 2020, during that timeframe, the age cohort in the U.S. over 65 was growing at a CAGR of just about 4%. And yet, over that entire decade, the supply of

licensed IRF beds in the U.S. was relatively flat. Where you had a big schism (sic - chasm?) developing between the supply of IRF beds and demand for those as the population aged, the incidence, the maladies treated in IRF really didn't change at all as a percentage of that increase aged population.

On top of that, if you look right now at just as a proxy for the market penetration of IRF in total, only roughly 13.5% of CMS-eligible 13 (ph) discharges coming out of acute care hospitals in the U.S. are finding their way into the IRF. Now, there's a reason why it shouldn't be 100%. Some of those patients are going to meet medical necessity criteria. But in a lot of instances, it's either because, within that market, there isn't a sufficient supply of IRF beds, or because the IRL community isn't familiar with and isn't educated on the differentiation between IRF services and steps (ph). You combine that with the fact that the underlying demographic is still growing. Combine that also with the fact that we've gotten a lot of traction, particularly on the higher acute patients with Medicare Advantage. There's evidence by the CAGR in our Medicare Advantage discharge (ph) growth over the last four or five years, and we just think that there's significant upside.

The discharge volume growth that we're seeing is coming from two buckets that are highly complementary. We've been adding a lot of capacity to our system, both with the opening of de novos, eight opened last year, we'll see another six open this year, and adding beds to existing facilities. But we've also seen strong underlying same-store growth.

Andrew Mok: Got it. When you think about the 6% to 8% discharge target that you have, how do you think that breaks down between same-store and new-store growth? Is there a static kind of breakdown, or does that fluctuate?

Doug Coltharp: It's going to fluctuate from year-to-year based on the timing of the new capacity coming on board, and then also the comp that you're up against in the same-store (inaudible). We have a great deal of confidence about that aggregate number. Balance between same-store and new-store is going to fluctuate a bit from year-to-year, and that's to be expected. And it's really part of the design.

Andrew Mok: Great. And it seems like, every year with these de novo facilities, you get more efficient at opening them. What are some of the specific examples that you can give to that may not be obvious to people looking at it from the outside that you've gotten better at each year?

Mark Tarr: I think, first of all, the more you do something, the better you get. And we're certainly evidence of that. But our teams have really become quite adept in terms of going out and developing a marketplace in terms of identifying potential referral sources, educating referral sources on what an inpatient rehabilitation hospital is, particularly in markets where there's not an existing hospital or IRF.

And at the same time, just the process of recruiting and hiring staff, initial staff to start up the hospital with, whether that's leadership or staff nurses. We've really done a nice job in making sure that we have the capability of hiring staff. We've developed the marketing team. We've developed (ph) referral sources, all in advance of opening the hospital.

So I think we've just gotten really efficient at all the processes that go into that. And there are a lot of steps with that, so we often tell people we've really made this look

almost too easy in terms of bringing on these new hospitals when, in fact, it's very difficult and a lot of work on (inaudible).

Doug Coltharp: Yes. I would say it's really a function of critical mass and specialization. And those two go together. So by critical mass, when you're opening anywhere between six and 10 de novos per year, you've got enough volume that you can set up a dedicated team, or teams, based on function, that focus specifically on opening those facilities.

And when they are focused in that direction, it not only makes us more efficient at getting that new facility open, making sure that all the elements that need to be in place for a successful opening and a quick ramp-up are there, but it also means that we're not detracting from existing operations by devoting resources who otherwise are necessary to meet the daily needs of our hospitals to open up the new facility. There is some cross-pollenization there. For the most part, we allow the existing hospitals to continue to operate uninterrupted by the activities associated with our de novo program.

Andrew Mok: Could you remind us what the occupancy and break-even targets are for your de novos? And do you see a meaningful difference between the new and existing geographies?

Doug Coltharp: There's certainly a ramp-up period associated with de novos. Prototype that we have been operating with for a period of time is typically a 50-bed, all-private room facility. We have seen those achieving kind of break-even occupancy, which would be about that 70% level, anywhere from as rapidly as three months to as long as 18 months, depending on the market.

If it does fluctuate by market-to-market, situation-to-situation, two of the primary determinants that kind of help the ramp-up accelerate a bit are, one, if we are operating in a market that is -- or if we're opening a new facility in a market that is proximate to existing markets, you tend to have the familiarity already established with your (ph) referral sources, payer contracts, can be leveraged. We can leverage the existing resources in those hospitals that are there to kind of help acclimate the staff at the new facility, and so forth.

The other factor that can be very helpful, and we cited this, is something that led to the better-than-anticipated contribution of our de novos in 2023 is if you've got a joint venture. There's an established referral source who's bought into the concept of the IRF value proposition. And so we typically see an accelerated ramp when we've got a JV.

Mark Tarr: I think when you look at, like, the state of Florida where we've had a lot of growth, we've added a lot of hospitals there. You start to get this market density factor where you develop the brand name. people are familiar with rehab hospitals. We've seen benefits just from our staffing, where we'll have accomplished staff that are looking for a professional growth opportunity still (ph). They'll be able to transfer from one of our hospitals over to the new hospitals, and the hospitals we opened there last year, and so far what we plan for this year, almost half of our management team will come from other Encompass Health hospitals. All that helps in eliminating risk of having a startup in the ramp-up process.

Doug Coltharp: And to elaborate on that, I think it's important to note, we (inaudible) get back to this concept of critical mass, with us having more than 160 hospitals. This is all we do, and we believe that we do it very well. Our market share is substantially larger than anybody else in this industry, but it really allows us to continuously hone (ph) every aspect of our operation. And we've done that with developing personnel, as well.

So about eight or nine years ago, we started something called the DFCEO program, which is Developing Future CEOs. And we recognize, because there isn't a deep pool outside of our company of individuals who would be qualified to run a freestanding rehabilitation hospital, that we had to home-grow talent. And so we identified ambitious and talented younger professionals within our organization, and they can come up on the administrative side. They could come up through therapy or through nursing. We've seen them come from all of those specialties. And we put them in a program where they get mentored for a period of time with the objective, when there is an opening in a new hospital either because we've got (ph) something through a de novo activity or there's turnover, that they are now ready to move into a CEO role. And that has proven it's highly effective, both in terms of developing a bench (inaudible), and it also leads to our retention of those individuals because they have a defined (inaudible).

Andrew Mok: Great. Maybe (ph) moving on in the last few minutes, I want to -- on the capital deployment a little bit. Even with all the growth CapEx in 2023, you still delivered excess free cash flow, I think over $250 million. As your cash position improves further this year, how are you thinking about the priorities of excess cash and likelihood of capital deployment (inaudible)?

Doug Coltharp: Yes, so 2023 was really a turning point for us. If you want to clock back to 2022, we had total cash net (ph), both maintenance and discretionary, of about $600 million, and the dividend on our common stock, cash dividend of about $16 million (ph), and those two together roughly equaled the amount of free cash flow that we generated in 2022. So we were relatively break-even.

We had the same assumption as we moved into 2023, that being that we'd be roughly even from adjusted free cash flow perspective. And the outperformance that Andrew mentioned earlier that we experienced during 2023, together with some favorable working capital flows, actually allowed us to generate substantially more free cash flow than we had anticipated; and at the same time, the improvement in EBITDA on flat leverage dollars brought our -- debt (ph) dollars, I should say -- brought our leverage down from 3.4X at the end of 2022 to 2.7X at the end of 2023.

So that creates the capacity to potentially augment what we're doing with regard to our growth CapEx with an additional lever. As we've evaluated those levers, and these are decisions that, ultimately, the Board will make, we think that the most likely place to deploy that incremental capital is going to be towards additional shareholder distributions, either with what would likely be modest increases in the dividend from time to time, and then complementary share repurchases.

As we do that, we'll look to keep the leverage at a relatively modest level. We've historically said that our long-term target is about 3X. again, we're (inaudible) that now. We're not necessarily trying to spin the dial so that we stay right on that number, but we recognize, if we get much below the current level, it starts to point to some potential inefficiencies within the capital structure.

In terms of the need to refinance or reduce debt, we really have a debt capital structure that's in a very good place, both in terms of maturity profile and the existing rates.

Andrew Mok: Great. Maybe last point here. We're a few weeks away from seeing the preliminary rate notice for 2025. Any expectations about the upcoming rate from CMS?

Mark Tarr: We've got 2.5% to 3% built in the guidance, so that's kind of what our expectations are. We hope there's always a chance it could be more if they factor in all inflationary factors, but that's what we've put in the guidance.

Doug Coltharp: And question that everybody asks, and we spent a lot of time talking about last year, is is there any anticipation, or do you have any insight, as to whether or not there'll be any mention in the proposed rule about a potential home health transfer policy. And we have heard absolutely nothing out of Washington, but we wouldn't necessarily expect to.

Andrew Mok: Great. Well, with that, we're just about out of time. Thank you so much for joining us here today, and thank you, and please enjoy the rest of the conference.

Mark Tarr: Thank you. Appreciate it.

Doug Coltharp: Thank you all.