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Encompass Health Corp. (EHC)

Barclays Global Healthcare Conference

CORPORATE PARTICIPANTS

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

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

OTHER PARTICIPANTS

Andrew Mok
Analyst, Barclays Capital, Inc.

MANAGEMENT DISCUSSION SECTION

Andrew Mok
Analyst, Barclays Capital, Inc.

Hi. 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 be joined on stage with Mark and Doug, CEO and CFO of Encompass Health. Welcome.

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

Great to be here.

QUESTION AND ANSWER SECTION

Andrew Mok
Analyst, Barclays Capital, Inc.

Q

Maybe to start, Encompass has delivered about 6% same-store discharge growth for the last two years now, which underscores the strength and durability of the business. When you breakdown the same-store number, what's the contribution to growth from existing capacity, bed additions, and maturing de novos?

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

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Yeah. So, within that discharge growth and through the fourth quarter of 2024, we have had 10 consecutive quarters where the same-store component has been 4% or greater. And within the 4% same-store growth, you've got a number of things going on. You've got increasing occupancy at the legacy plant that is out there, and that has been enhanced over the years through some of the capital expenditures that we have made running through the maintenance CapEx line to convert semi-private rooms to private rooms, which boost the theoretical occupancy.

When we do bed additions to existing hospitals, that is additive to same store as well. And then the other benefit is, as we ramped up our de novo openings beginning in 2020, those facilities moved into the same-store calculation after they have been open a year, and it's typically about three years before they have reached what we would view as a mature level of occupancy. So, they're still in that ramp-up mode and contributing to the same-store number when they do that. As we have now had multiple years of opening roughly eight new de novos per annum, that's certainly been beneficial there.

So, it's hard in any particular year to break down that 4-plus percent in the same store between those various categories, because it really depends on when the beds have come online and when new stores are moving into the same store. They're all contributing, and it certainly is a base number that we feel good about. The balance between that 4% and 6% to 8%, which is our target for discharge growth, a CAGR, multi-year CAGR, is really just the contributions from new stores that are opening in a particular year. This year, for instance, we'll have another seven de novos plus one freestanding satellite, which is really the equivalent of a de novo, all contributing.

Andrew Mok
Analyst, Barclays Capital, Inc.

Q

And I think most of your de novos now are about 40 beds or so, maybe a little bit lighter versus your kind of consolidated bed count. Maybe walk us through why start with a lower bed count? And I think you typically expand to that over time.

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

A

Yeah. Actually, we have, over time, one of the – for a couple of reasons, we have moved the opening bed count to about 50 beds. We previously had a prototype of about 40 beds. We moved it up to 50 beds for two reasons. One is we got more experience with our de novo openings. We found that we were pretty good at ramping those facilities up and so that we were achieving a higher level of occupancy sooner than we had previously anticipated. It was also a way to combat some of the increase in construction costs that we saw really beginning on the back end of 2020. If you go back as far as 2019, our average cost to bed was somewhere between $600,000 and

$700,000 for a new facility. We've now stabilized it at about $1.2 million. But by starting with a plan of 50 beds versus 40 beds, we get more economies of scale.

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

We've also had significant growth in states like Florida where the CON no longer exists there that would have otherwise possibly had a limitation on the available beds in that given marketplace. So, that's another contributing factor why we edge more towards 50 than 40 beds.

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

But to your point, Andrew, when we are opening up a new facility, whether it's 40 beds or 50 beds, and occasionally it's larger than that, we are buying enough land and constructing the core facility in a way that lends itself to future period bed expansions. And those bed expansions really turbo boost the financial returns. You're building into a market where you've already established insurance contracts, referral sources. The demand is there because you're only adding beds when the occupancy dictates such, and you're able to leverage portions of the administrative staff and key components of the physical infrastructure, such as the therapy gym and the dining facility and so forth. So, the returns on bed expansions are really very high.

Andrew Mok
Analyst, Barclays Capital, Inc.
Q

Great. And as good at that 6% same-store discharge growth number is, those volumes are not automatic, right? What are some of the things that you do to compete in the market every day that may not be obvious to us to secure that outcome?

Douglas E. Coltharp
Chief Financial Officer & Executive Vice President, Encompass Health Corp.
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Yeah. Well, first, I'll talk about the clinical programs. And if you think about whether it's neuro or our stroke program as the program we've spent a lot of time developing over the past number of years, we've got a critical state of excellence in terms of our clinicians, best practices, our physician component there. So, we like to lead with our patient outcomes in any given marketplace. And we go in and talk to potential referral sources and we can talk about the fact that we get 84% of our patients go back home at the time of discharge, we have a very low return back to acute care or very low percentage of our patients end up in a nursing home at the time of discharge, those are all critical elements that we lead into a marketplace that helps to identify us IRF versus SNF and even us versus other IRFs in the marketplace. We'd like to leave it for our patient outcomes.

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.
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The provision of inpatient rehabilitative care is a highly specialized service, and it's all we do, and we are by far the largest provider of those services in the US. When you look at the spectrum of patient conditions that we treat as compared to an acute care facility, it's relatively narrow. So, we go very deep on a relatively narrow set of patient conditions. To take the top four conditions we treat with stroke and neurological being the top two, they comprise almost 60% of all of the patients that we're seeing. And so we have developed a very deep database on patients with those kinds of conditions and how they respond to various treatment protocols. And the key decision makers in terms of referring patients into an IRF setting or to another post-acute setting respond very well to data. So, when we're meeting with hospital discharge planners, referring physicians, when we're dealing with managed

care companies, we are presenting them with data about the patient outcomes that we generate for patients that present with those types of conditions.

Andrew Mok
Analyst, Barclays Capital, Inc.

Q

Great. And your guidance assumes salaries, wages, and benefits per FTE is increasing about 3.5%, which is down about 90 basis points from 2024 unit cost increases. What's driving that lower SWB assumption year-over-year? And is core wage inflation also tracking lower?

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

A

Yeah. So, there are a number of things that we think we're going to benefit from with regard to the SWB inflation in 2025 versus 2024. One is we've really done a good job reining in our premium labor expense. And when we say premium labor, we're referring to the utilization of sign on and shift bonuses and then also the utilization of contract labor. Our core assumption in the guidance is that our expenditures for those premium labor categories are going to be relatively constant in nominal dollar terms from 2024 to 2025. And with our business growing, that's going to create leverage on that kind of spend. We dipped down below 1.5% of total FTEs being contract labor FTEs in fourth quarter of 2024 and that's the lowest we've been for quite some time.

Beyond that, we have kind of systematically and proactively, over the last several years, continued to make market adjustments to make sure that the wages for our clinical workforce, both nurses and therapists, were competitive. And so, we don't have to make these catch-up adjustments that some other firms are experiencing right now.

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

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I think we've seen, when we stay at market, make sure that we're, as Doug noted, aggressive about it. It actually saves you money in the long run, because once you get behind the marketplace and you have to catch up, you're fighting a reputation in the community in terms of being a low payer, we think that the fact that we've stayed at market helps our retention. We've seen it reduced turnover, particularly with nurses. So, we think there's a lot of benefits of being aggressive in the marketplace. We provide our hospitals with market data so they can make sure that they are at the marketplace.

Andrew Mok
Analyst, Barclays Capital, Inc.

Q

Right. I remember you guys paying up for premium labor during the pandemic, citing kind of the long-term benefits from referral sources. Do you feel like you're reaping the benefits of that now?

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

A

Absolutely. We told our CEOs and HR directors to go out – if you've got the potential to get the volume, go out and find the labor to do it, and we'll figure out the cost of that labor in the long run. And that has absolutely paid off for us.

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

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And it's much less of a factor right now in terms of, again, the utilization of that contract labor, but we still issue the same instructions to our field operators, which is, at any point in time you have to make a decision between taking volume or increasing labor expense, take the volume.

Andrew Mok
Analyst, Barclays Capital, Inc.

Q

Great. And the group benefits, medical cost is also something that flows through the SWB line. You called that out on the last earnings call. I think that's interesting in the context of broader kind of healthcare trends. In 2024, you did experience higher incidence of high-dollar claimants. You commented that those experiences tend to be mean reverting, but sounds like there's a little bit more caution on what's embedded in your guide. What's different about the recent experience on some of these group medical costs that you're not as willing to say these claims might mean revert this year?

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

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Yeah. Just provide some specifics around that. So, for all of 2024, our year-over-year increase in benefits cost, which makes up about 10% of our total SWB line, was a little over 12%. I think it was 12.4%. It was up more than 30% in the fourth quarter. Some of that was attributable to the fact that the fourth quarter of 2023 was down 9.5%. So, there was a little bit of a catch up based on some adjustments to accruals. We really started to see the increase in benefits cost in the second half of 2024 that was attributable to two things, one of which you've already mentioned, which was we saw an increased frequency and dollar amount of high-dollar claims. We haven't made any changes to our benefits program and there haven't been any significant shifts to the underlying beneficiary population. So, logic would kind of dictate that that's going to be mean reverting. There's no reason why those should continue. We'll have to continue to observe that because that was something that we saw in the second half of last year.

The other piece of that was, like many other employee-sponsored plans across US, we saw a very substantial increase in the cost and the utilization of prescription drugs. And it fell into three primary categories. The largest by far was the utilization of GLP-1s, and we anticipate that that is going to continue in 2025. Ultimately, there are going to be or we anticipate there are going to be some population health benefits that come along with that increased utilization. But, right now, we're just seeing the cost. That will be elevated for at least the first half of this year. And I say only the first half because we're going to anniversary the increase that we saw in the second half. So, GLP-1 utilization was one. There were a number of what we believe are going to be highly effective but also high-cost cancer treatment drugs that have come onto the market as well. So, we've seen an increase there. And then the third would fall into the dermatology category as well, SKYRIZI and some of those that we all are subjected to a great deal of advertising.

Andrew Mok
Analyst, Barclays Capital, Inc.

Q

Understood. A year ago at this conference, I think we were talking about the prospects of a more meaningful share repurchase program given your lower leverage and better cash flow. You then authorized a $500 million share repurchase program in July, but we saw a relatively modest usage of that in the back half of the year. What's the appetite to step up the level of buybacks this year, and what are the other uses of discretionary cash, given your leverage is approaching 2 times?

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

A

Yeah. So, 2024 was another really strong year for us in terms of free cash flow generation and the leverage is getting very close to 2 times, and we recognized that, just given the profile of our company, if we're at 2 times or below, there's some inefficiency that's potentially creeping into the weighted average cost of capital. So, as we think about balance sheet leverage and the utilization of free cash flow going forward, the number one priority is going to continue to be growth CapEx because we do think that the market for inpatient rehabilitation services remains vastly underserved and because we are getting very nice returns on those capital investments. But we're going to have capacity beyond that. We do not need you – because of the leverage level that you've just identified, we don't need to apply that excess cash towards further debt reduction.

And so, shareholder distributions are going to be the most likely recipient of those funds. The board has historically taken approach of modest periodic increases to the dividend. That'll be a decision that they make, but I think it's a reasonable expectation for that to continue. And then the balance is really going to be available for increased share repurchase activity. Our understanding from the board is that that authorization was put in place to be utilized.

Andrew Mok
Analyst, Barclays Capital, Inc.

Q

Understood. Maybe on that growth CapEx point, you're expecting to open seven de novos this year and incur about $20 million of startup costs. Can help us understand how much of that startup cost number would fall into the first half of the year versus the second?

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

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Yeah. So, if you look at our openings this year, they are more heavily weighted towards the latter part of the year. And so that's going to skew some of those expenses more towards probably the third and fourth quarter.

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

A

So, we're actually opening eight hospitals this year, seven de novos and then the eighth hospital is what we refer to as a satellite. It's classified as a satellite, but it's still eight hospitals that we're very happy to be opening this year, five in the state of Florida.

Andrew Mok
Analyst, Barclays Capital, Inc.

Q

Got it. And most of those de novos, they're not JVs, right? So, can you remind us what the key differences are in terms of preopening and ramp up between the JVs and the standalone de novos?

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

A

Yeah. So, what we typically find is that a joint venture has the potential to ramp up more quickly. And the reason for that is our most common method of putting together a joint venture is we will look at a market that we think has a lot of potential for IRF services, and frequently, we can identify within that market a hospital that has an existing IRF unit within its four walls that is under productive.

And so, we can approach that acute care hospital with what we believe is a win-win proposition, which is to say we would like to come into this market. We can build a freestanding inpatient rehabilitation hospital proximate to your existing hospital. If you will sign a non-compete for IRF services and convert your CON unit into something

else that's more profitable for you, typically, general, medical and surgical services, we can give you an in-kind equity contribution into that new freestanding hospital. If you'd like to contribute cash as well to buy up your percentage of ownership, you can do that.

Once that is accomplished, you will have the opportunity to still represent to your key constituencies and the community that you're still in the IRF service. But you will now have enhanced profitability within your four walls, plus a profit contribution from our hospital. There cannot be a contractual arrangement with that JV partner for them to refer patients to us, but what we typically see is that we pick up a large amount of the ADC that had been in that unit in the new hospital. And so, you kind of get a jump start on the ramp up.

Douglas E. Coltharp
Chief Financial Officer & Executive Vice President, Encompass Health Corp.
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So, 40% of our portfolio hospitals, of our 166 hospitals at the end of 2024, are joint venture partnerships. Some of those partnerships have led to more than one hospital within the partnership, such as Piedmont Health in the state of Georgia, right now, has been a great growing partnership for us. So, if we find the right partner out there, it can be really beneficial, and this is something we first started that business model back almost 35 years ago now with Vanderbilt in Nashville. So, it's been a great part of our overall strategy.

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.
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Yeah. A further benefit there is Georgia is a CON state. Historically, it had been difficult for us to get CONs approved to expand our services in the state. When you have a partner that has the kind of standing in the state like Piedmont Health does, it has helped us through the joint venture get CONs for incremental capacity.

Andrew Mok
Analyst, Barclays Capital, Inc.
Q

Great. And then when we look at the payer mix for Encompass, I think it's the Medicare payer mix specifically that's held steady at 65% over the last four years despite continued penetration of Medicare Advantage. Why hasn't Medicare Advantage payer mix increased with the broader industry and what are the implications if we do see that increase?

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

Well, it has increased. If you go back and look at 2019, Medicare Advantage, in terms of our total payer mix, was less than 9% and now it's about 17%. If we look just at last year, total Medicare Advantage discharges were up 12.5%, fee-for-service was up 8.6%, so we were seeing nice growth in both of those. I believe our five-year CAGR for Medicare Advantage discharges is north of 14%. So, we have seen it move up as a percentage of our overall payer mix, and it's moving up roughly in conjunction with the mix change between Medicare Advantage and fee-for-service in the counties in which we are represented with the hospitals. So, I think we're tracking pretty well.

I think the fact that we have been able to convert more than 90% of our Medicare Advantage contracts from a per diem to an episodic basis, and tie those to the fee-for-service rate schedule, has also – is strong evidence of the value proposition we bring to all payer classes. And if you look specifically at 2024, for the full year, the payment differential between fee-for-service and Medicare Advantage for us was just over 3%.

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

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And if you look at the program mix of those patients, they're heavily skewed towards stroke. So, that is one of the programs we talked about, our outcomes. And our ability to use that in our value proposition, it's clearly been seen with our stroke programs as part of the MA program.

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

A

Yeah. For Medicare Advantage patient mix, more than 30% is stroke rehabilitation. For fee-for-service, it's just under 15%. So, almost twice that level.

Andrew Mok
Analyst, Barclays Capital, Inc.

Q

Got it. Moving on to bad debt and the Palmetto audits. That caused some fluctuations in the accrued level of bad debt expense last year. Are there any considerations to keep in mind related to the audits for this year? And [ph] relatably (00:20:16), where are your affirmation rates tracking at this program or when would you expect this to potentially see less frequent audits related to this program?

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

A

Yeah. So, there are really two primary types of audits that are taking place right now. One of them is TPE, the Targeted Probe and Educate, which has been in place since I think 2018. That is the program that caused some fluctuation in the bad debt between quarters of last year, and the third-party contractors who conduct these audits, the largest of which for us is a company called Palmetto, have arrangements with CMS that allows them to request a certain number of claims per hospital under their jurisdiction to review during the course of the year.

For a number of reasons, some of which is related to RCD, which we're going to talk about in a moment, Palmetto chose to request all of those claims for all of the hospitals that we operate under their jurisdiction at one point in time, and they did so late in the second quarter of last year. That is significant in terms of late in the quarter because our historical practice has been to reserve at 25% any claim once it is selected for review, even if no decision has been rendered. And so, we had those claims get selected for review. We hung up the reserve. There wasn't enough time within that quarter for any of those to get processed. And so, we had no results, and so we carried that reserve over into the third quarter. Ultimately, as those claims were reviewed by Palmetto, we had a very high affirmation rate and that reserve came down during Q3 and Q4.

It's hard to say what's going to happen under TPE this year. We would hope that, as was the case prior to 2024, the selection of those claims for audit was more evenly distributed throughout the quarter so it didn't cause that lumpiness, but it remains a risk. If it happens in the same way as it did during 2024, we'll have an internal discussion about whether or not we need to change our reserve methodology in light of the experience that we had.

The second program is Review Choice Demonstration, which right now is being piloted for us. It's more than being piloted. It's been implemented in the state of Alabama where we operate seven hospitals. That has been very frustrating because it's, again, Palmetto reviewing similar claims, where the targeted affirmation rate under RCD is 90%. We're below that level right now, and we continue to see claims being non-affirmed for reasons that we have never been provided in any audit program before by Palmetto or any other reviewer. So, it's an ongoing

battle. It's more of an administrative headache than it is a financial burden. And we'll continue to provide updates periodically on our experience under RCD.

Andrew Mok
Analyst, Barclays Capital, Inc.

Q

Great. Maybe in the last minute here, I'll touch on some of the items in DC. There's obviously been a lot of uncertainty with the new administration, particularly around Medicaid and the exchanges. Your business seems largely insulated from the targeted policy risk right now. Is there anything that you're monitoring on the policy front that might be more impactful to your business?

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

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Well, first of all, we stay very active in DC. We have full-time staff there in addition to working with other lobbyist and trade associations. So, we have a good front-line view, we feel, in terms of what's going on there. We also have ongoing dialogues with CMS and others. We don't see anything immediately that has been discussed to impact our sector, but it's something that we continue to track and, like I said, [indiscernible] (00:24:03) with our members of Congress as well as those in administration.

Andrew Mok
Analyst, Barclays Capital, Inc.

Q

Great. And then we're just a few weeks away from seeing the preliminary airfreight notice for 2026. Any early expectations for that notice?

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

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Well, it's been pretty tight lipped in DC, but we hope to – as you know, hope to see it another three or four weeks. That's our understanding, has been since [ph] our Line-B (00:24:26) for review. So, we would expect that to be out in the fairly near future.

Andrew Mok
Analyst, Barclays Capital, Inc.

Great. Well, we're just about up on time here. So, thank you so much for joining us here today, and please enjoy the rest of the conference.

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

Thank you, Andrew.

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

Thank you.