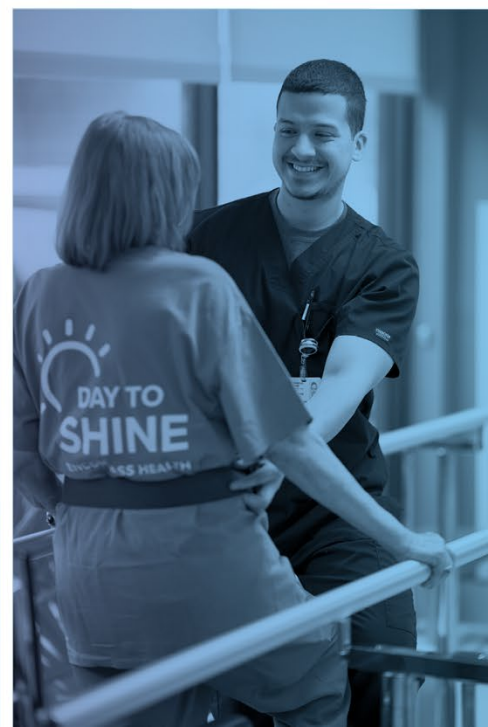




**Encompass
Health®**

2020 Investor Day



Encompass Health



Mark J. Tarr
President and Chief
Executive Officer



Doug Coltharp
Executive Vice President and
Chief Financial Officer



Barb Jacobsmeyer
Executive Vice President,
President Inpatient Hospitals



April Anthony
Chief Executive Officer,
Home Health and Hospice



Luke James
President,
Home Health & Hospice



Rusty Yeager
Senior Vice President,
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Encompass Health Investor Relations Team



Crissy Carlisle

Chief Investor Relations Officer



Amy Rayborn

Administrative Coordinator



Brittany Jager

Investor Relations Manager

Forward-looking statements

The information contained in this presentation includes certain estimates, projections and other forward-looking information that reflect Encompass Health's current outlook, views and plans with respect to future events, including legislative and regulatory developments, strategy, capital expenditures, acquisition and other development activities, cyber security, dividend strategies, repurchases of securities, effective tax rates, financial performance, financial assumptions, business model, balance sheet and cash flow plans, market share, development of new information tools and models, and shareholder value-enhancing transactions. These estimates, projections and other forward-looking information are based on assumptions the Company believes, as of the date hereof, are reasonable. Inevitably, there will be differences between such estimates and actual events or results, and those differences may be material.

There can be no assurance any estimates, projections or forward-looking information will be realized.

All such estimates, projections and forward-looking information speak only as of the date hereof. Encompass Health undertakes no duty to publicly update or revise the information contained herein.

You are cautioned not to place undue reliance on the estimates, projections and other forward-looking information in this presentation as they are based on current expectations and general assumptions and are subject to various risks, uncertainties and other factors, including those set forth in the Form 10-K for the year ended December 31, 2019 and in other documents Encompass Health previously filed with the SEC, many of which are beyond Encompass Health's control, that may cause actual events or results to differ materially from the views, beliefs, and estimates expressed herein.

Note regarding presentation of non-GAAP financial measures

The following presentation includes certain “non-GAAP financial measures” as defined in Regulation G under the Securities Exchange Act of 1934, including Adjusted EBITDA, leverage ratios and adjusted free cash flow. The Company's Form 8-K, dated March 4, 2020, to which the following presentation is attached as Exhibit 99.1, provides further explanation and disclosure regarding Encompass Health's use of non-GAAP financial measures and should be read in conjunction with this presentation.

Company Overview, Strategy and Outlook

Presented by Mark Tarr



Primary elements of our strategy



Quality

Enhance clinical expertise and deliver high-quality outcomes



Workforce

Serve as an engaged and productive workforce



Financial resources

Maintain a strong financial foundation



Sustained growth

Expand our footprint to reach more in need of our high-quality, connected care



Advanced technology

Implement technology to improve patient-centered care and efficiency



Post-acute innovation

Lead the nation in patient-focused, evidenced-based models that improve outcomes and efficiencies

Key takeaways



Our **integrated care model** produces the high-quality, cost-effective care desired by providers, payors, and patients.



We use **technology** to leverage and enhance our clinical and business processes.



We are executing our **growth strategy** to meet the needs of an aging population.

#1 Owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues and number of hospitals

4th Largest provider of Medicare-certified skilled home health services

11th Largest provider of Medicare-certified hospice services

Number of states in which we operate

37

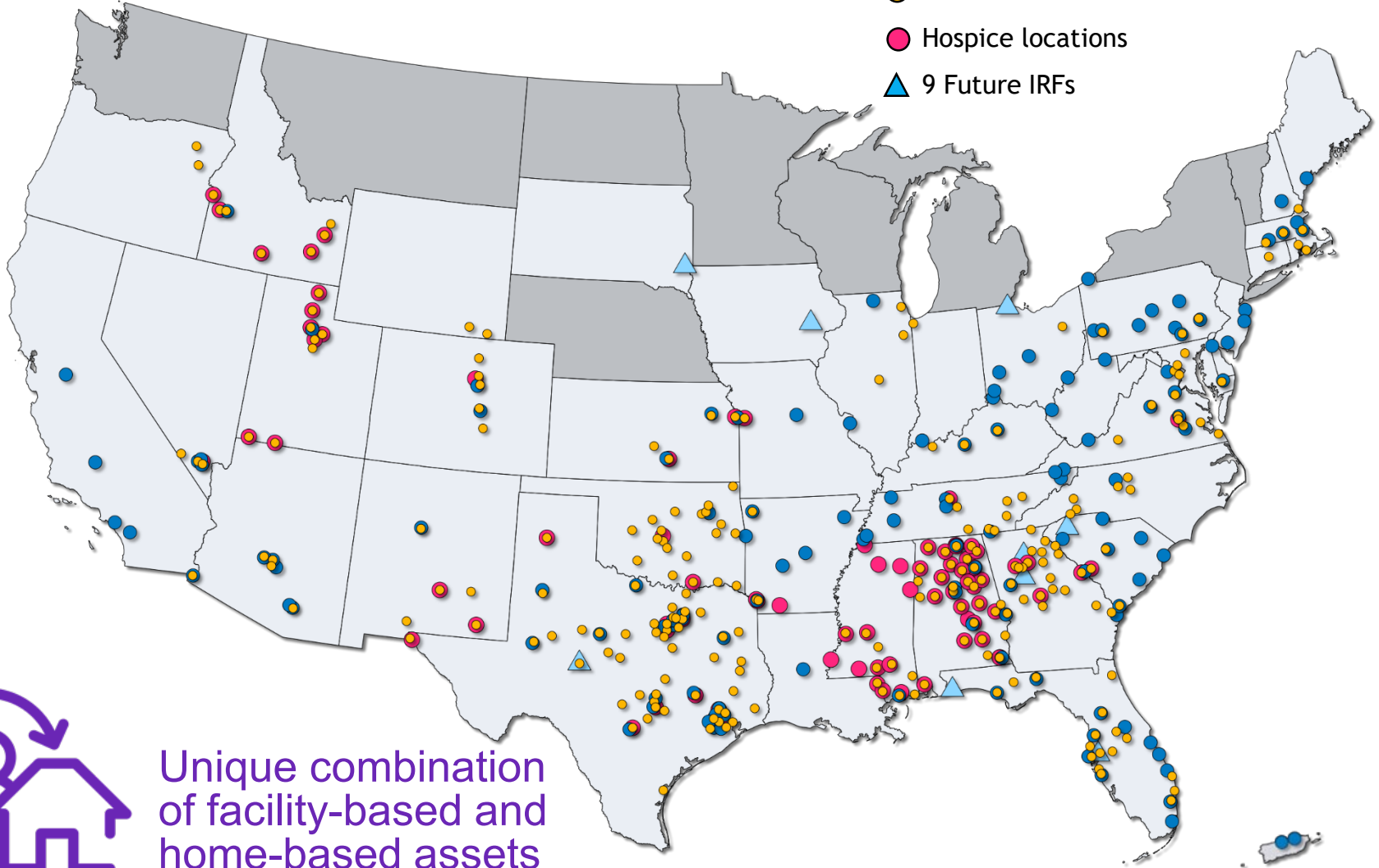
and Puerto Rico

~ 31%

Share of Medicare patients receiving inpatient rehabilitation services from Encompass Health

Strength in our unique position

- Inpatient rehabilitation hospitals (“IRFs”)
- Home health locations
- Hospice locations
- ▲ 9 Future IRFs



Unique combination
of facility-based and
home-based assets

National scale across all service lines

EHC strategic plan - summary

STRATEGY

To be the leading integrated provider of post-acute services, providing facility-based and home-based services

GOALS

Expand Network of Freestanding IRFs

Expand Network of HHAs

Build Scale in Hospice

Invest in Operational Excellence

Complementary Financial Strategy

KEY INITIATIVES

- Add new inpatient rehabilitation hospitals with a focus on de novos
- Expand existing hospitals via bed additions

- Expand home health geography and density via acquisitions

- Continue to build hospice scale via acquisitions
- Develop de novo strategy

- Increase clinical collaboration
- Utilize data analytics
- Develop post-acute care solutions
- Build stroke market share

- Moderate leverage and excess liquidity
- Prioritize free cash flow to growth
- Augment with shareholder distributions

TREND ASSUMPTIONS

- Demographic and utilization trends will drive continued demand for post-acute services
- The progression to value-based and episodic payments will continue and accelerate
- The patient criteria and requirements specific to each PAC facility will erode, allowing for a broader spectrum of conditions to be treated in PAC facilities
- Value-based payments will require financial risk arrangements

Our competitive strengths



Unique combination of assets



Quality of our clinical outcomes



Cost effectiveness

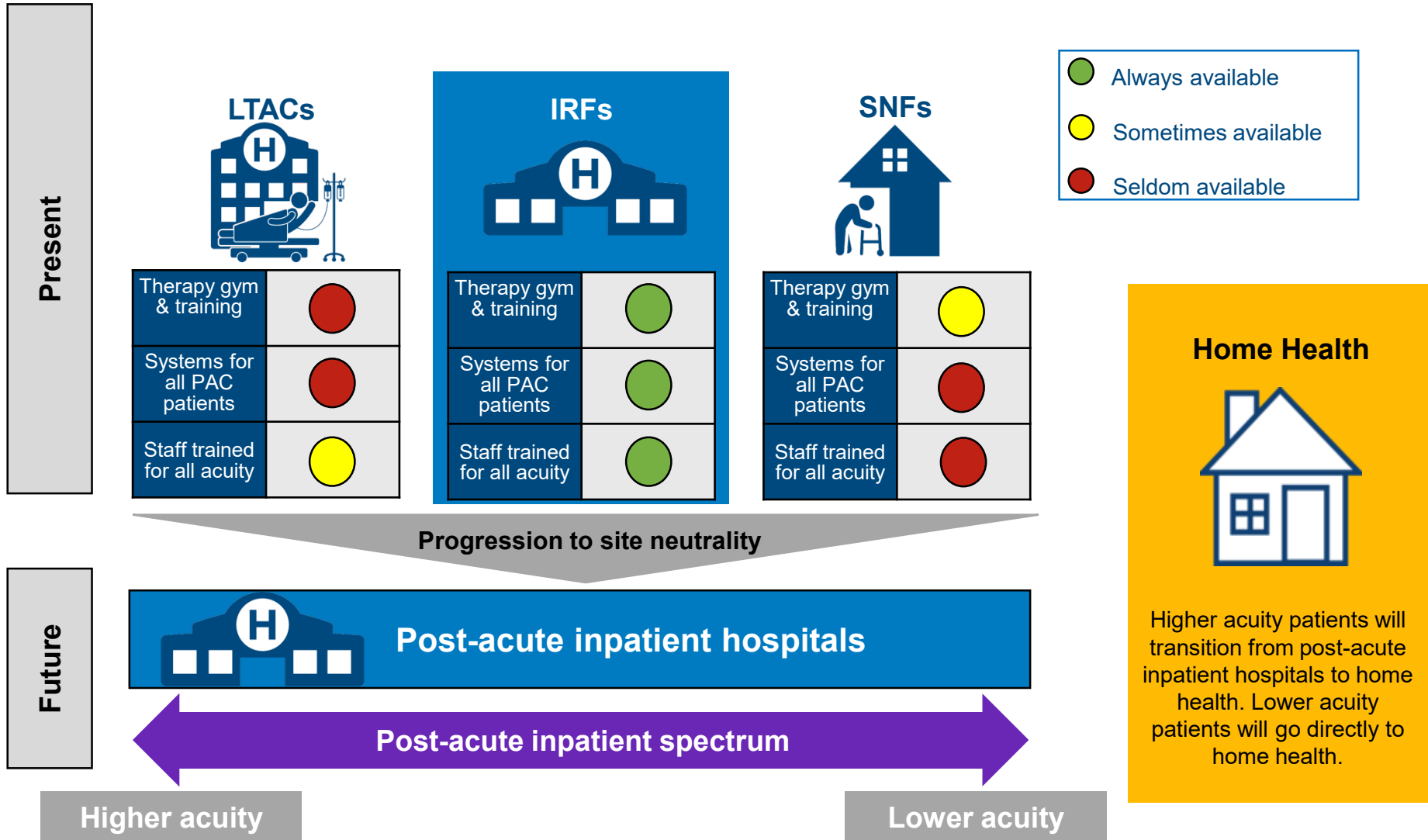


Extensive application of technology



Financial strength

The Company's IRFs have the physical construct, clinical staffing, and operating expertise to address the full spectrum of inpatient post-acute needs in a site neutral environment.



Demographic tailwind

CAGR (population growth by age)				
Age	2014 to 2018	2018 to 2022	2022 to 2026	2026 to 2030
65-69	2.8%	2.6%	1.6%	(0.1)%
70-74	4.9%	3.7%	2.5%	2.1%
75-79	4.0%	5.0%	4.9%	2.0%
80+	1.5%	2.4%	3.6%	5.2%
Total	3.2%	3.3%	2.9%	2.2%

The average age of our Medicare patients:

Inpatient rehabilitation = 76

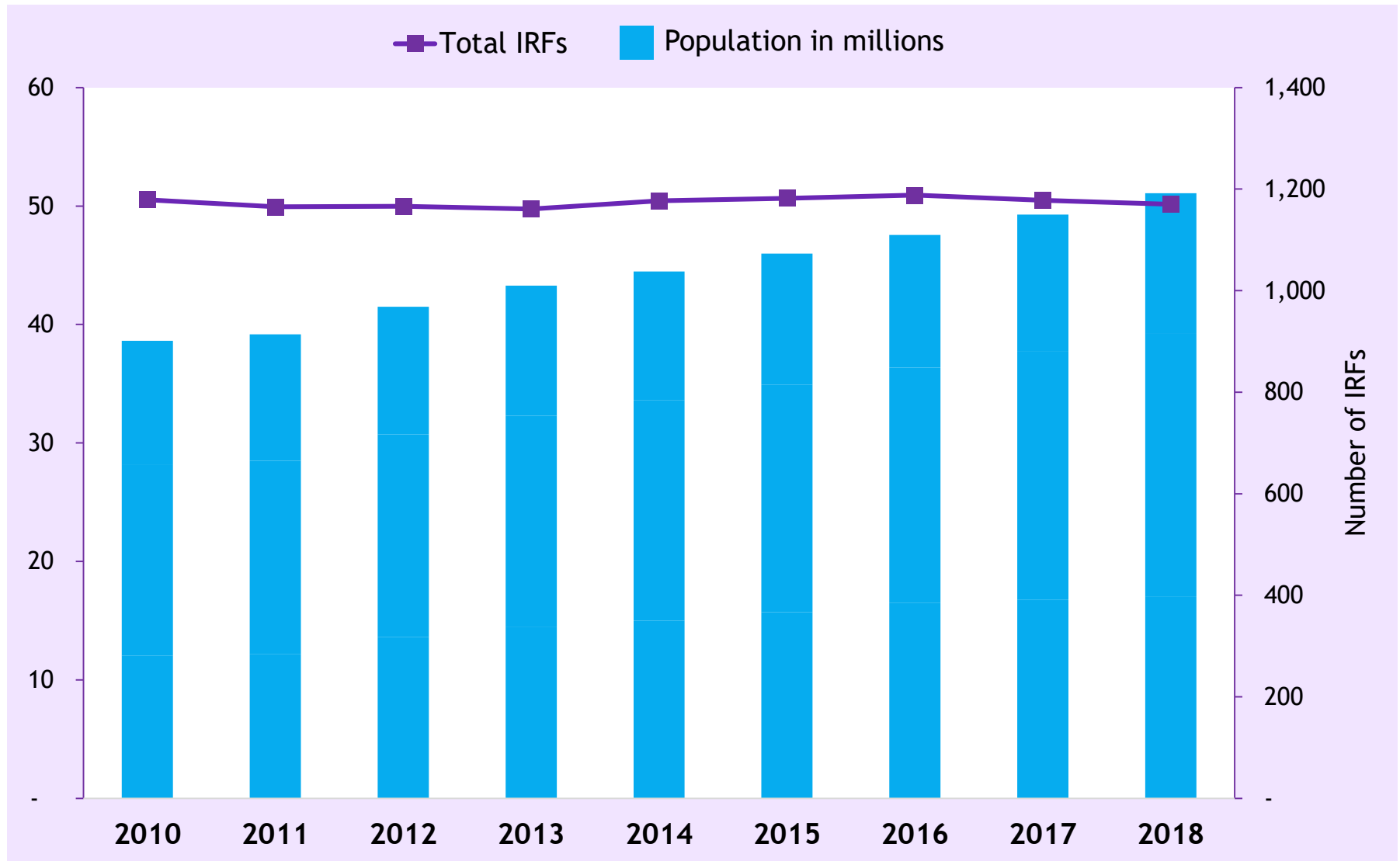
home health = 77

hospice = 83

Sustained growth



Supply of IRFs remains relatively stable while the age 65+ population continues to grow



Proven ability to enter new markets and boost returns with subsequent bed additions

Location	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Mesa, AZ	40	40	60	60	60	60	60	60	60	60	70	70
Aldie, VA		40	40	40	40	55	55	60	60	60	60	60
Bristol, VA		25	25	25	25	25	25	25	25	25	25	25
Houston, TX			40	40	40	60	60	60	60	60	60	60
Ocala, FL				40	40	50	50	60	60	60	70	80
Littleton, CO					40	40	40	40	40	40	40	60
Stuart, FL					34	34	44	44	54	54	64	80
Altamonte Springs, FL						50	50	50	50	60	60	80
Newnan, GA						50	50	50	50	50	50	60
Middletown, DE						34	34	34	37	37	37	37
Franklin, TN							40	40	40	40	40	40
Modesto, CA								50	50	50	50	50
Westerville, OH									60	60	60	60
Pearland, TX									40	40	40	60
Pelham, AL										34	34	34
Bluffton, SC										38	38	38
Murrells Inlet, SC										29	29	29
Winston- Salem, NC										68	68	68

We have built **18** hospitals since 2009.

By the end of 2020, we will have **added beds to 56%** of these hospitals.

By the end of 2020, we will have added beds to **28%** of these hospitals **more than once**.

Encompass Health has more joint ventures than competitors have freestanding IRFs

47* IRF joint venture hospitals in place with major healthcare systems such as:

Barnes-Jewish

Cleveland Clinic Martin Health

Mercy Health System

Geisinger Health System

Maine Health System

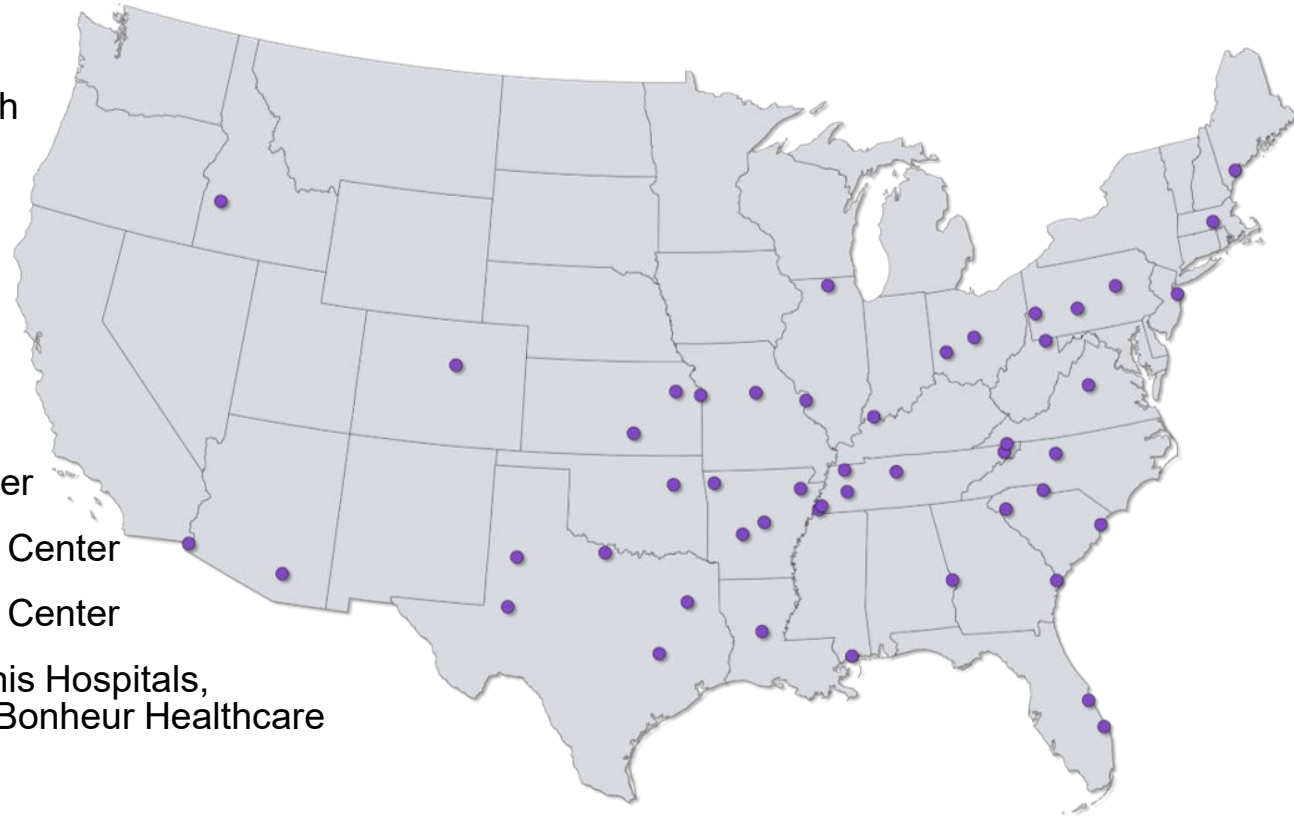
Monmouth Medical Center
(RWJBarnabas Health)

Yuma Regional Medical Center

University of Virginia Medical Center

Vanderbilt University Medical Center

Methodist Healthcare-Memphis Hospitals,
a subsidiary of Methodist Le Bonheur Healthcare

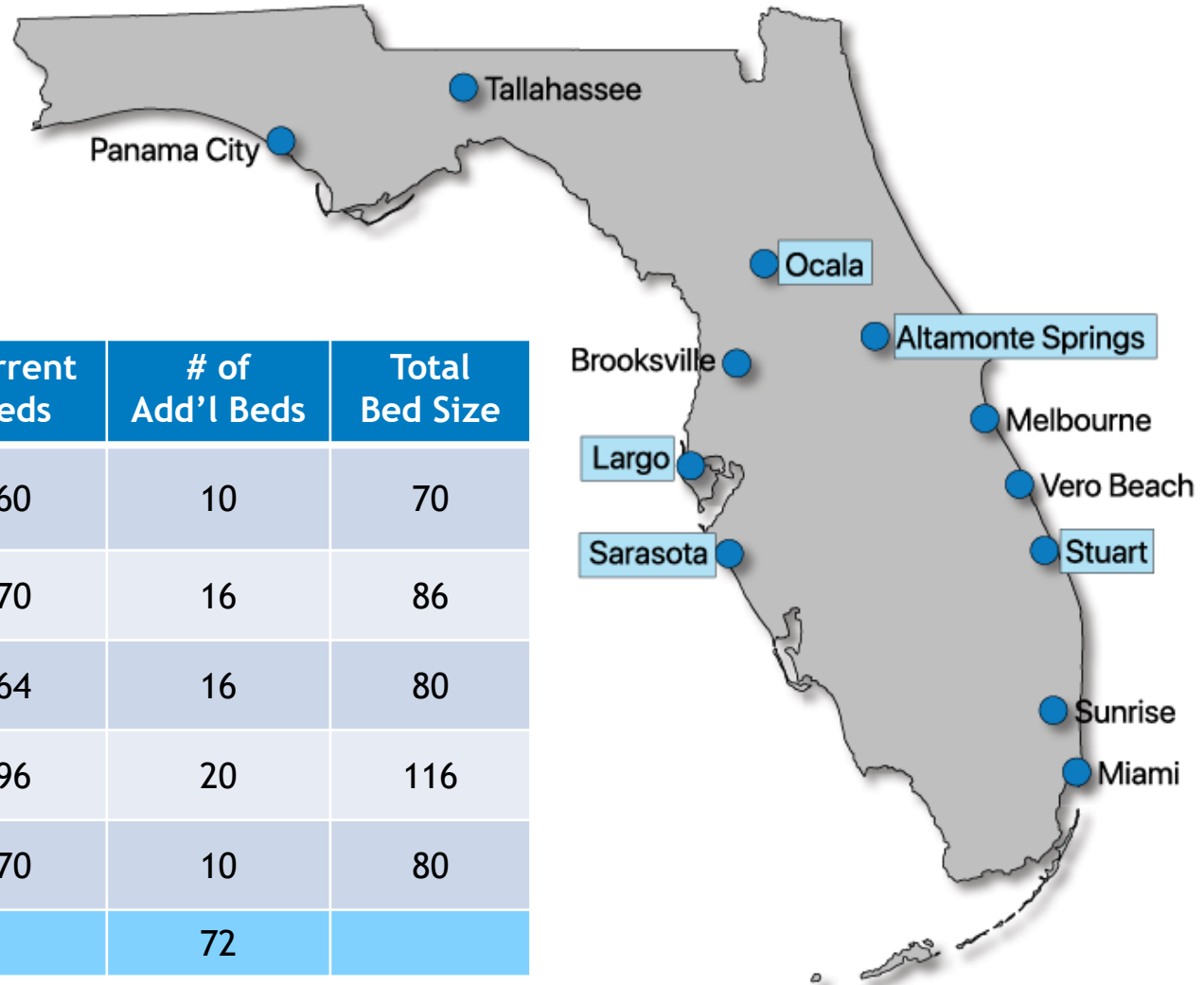


Joint ventures with acute care hospitals establish a solid foundation for integrated delivery and alternative payment models.

Encompass Health has more certificate of need beds and IRFs than any single competitor has total beds or locations

	Total Licensed Beds	Total Provider Numbers
Ernest	726	18
Kindred	1,080	21
Post Acute Medical	786	18
HCA Healthcare	1,643	62
Select Medical	1,821	30
Vibra	445	9
Grand Total	6,501	158
	CON Beds	CON Provider Numbers
Encompass Health	4,750	68

Repeal of CON laws creates accelerated growth opportunity in Florida – bed additions



Location	Est. Completion	Current Beds	# of Add'l Beds	Total Bed Size
Altamonte Springs	Q3 2020	60	10	70
Largo	TBD	70	16	86
Stuart	Q4 2020	64	16	80
Sarasota	Q1 2021	96	20	116
Ocala	Q3 2020	70	10	80
Total			72	

Repeal of CON laws creates accelerated growth opportunity in Florida – new markets



Inpatient Rehabilitation growth targets



Sustained
growth

BEGINNING IN 2021

De novos per year

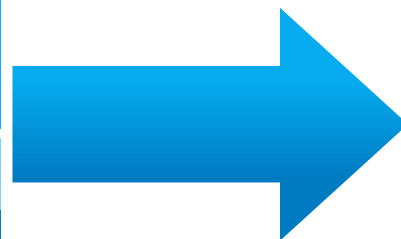
6 to 10

(25% JVs)

BEGINNING IN 2021

Bed additions
per year

100 to 150



Discharge CAGR

4% to 6%

for 2020

through 2025

Home-Based Care: Demand is growing / efficacy is undeniable

Patient Preference for Home Health Care

9 in 10 American seniors want to age at home

Cost Efficiency of Home Health Care

Post-Acute Service Sector	Annual Medicare Spending	Medicare Cost Per Day
Skilled Nursing Facilities (SNF)	\$28.4 billion	\$490
Hospice	\$17.9 billion	\$168
Home Health	\$17.7 billion	\$47

Multi-faceted home health growth strategy



Average organic admissions growth of 8.2% over the last 12 quarters

Organic Growth

- Geographic coverage for 70% of total Medicare home care spend
- Cost effective solution for a growing number of patients with multiple chronic conditions
- Focused specialty programs (heart and vascular; ortho; community care)
- Diversified referral sources
- Strong sales structure to support continued growth and expansion
- Use of Care Transition Coordinators
- Plan of care coordination with EHC's IRFs

Acquisitions and de novos

Focused acquisition strategy

- Increase IRF overlap markets
- Increase hospice overlap markets
- Build scale and density across markets

Proven success

- Proven ability to acquire and integrate
- Dedicated integration team
- Strong technology enable process
- Sustainable and replicable culture

Hospice growth drivers



11th largest provider of Medicare-certified hospice services

83

Hospice locations

18

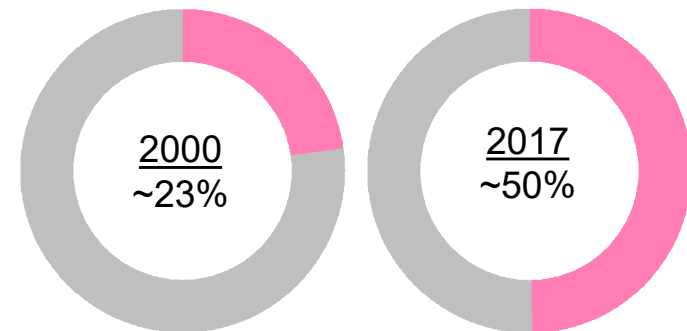
States



Hospice acquisitions and de novos

- Medicare focused
- Located in markets with significant Medicare spend
- Growing societal preference
- Build scale in existing markets
- Increase overlap with home health locations
- Leverage infrastructure and reputation

% of Medicare decedents using hospice



Home Health and Hospice growth targets



Home Health
admissions CAGR

10%+

for 2020 through
2025

Hospice
admissions CAGR

10% to 15%

for 2020 through
2025

Acquisitions

\$50 million to
\$100 million

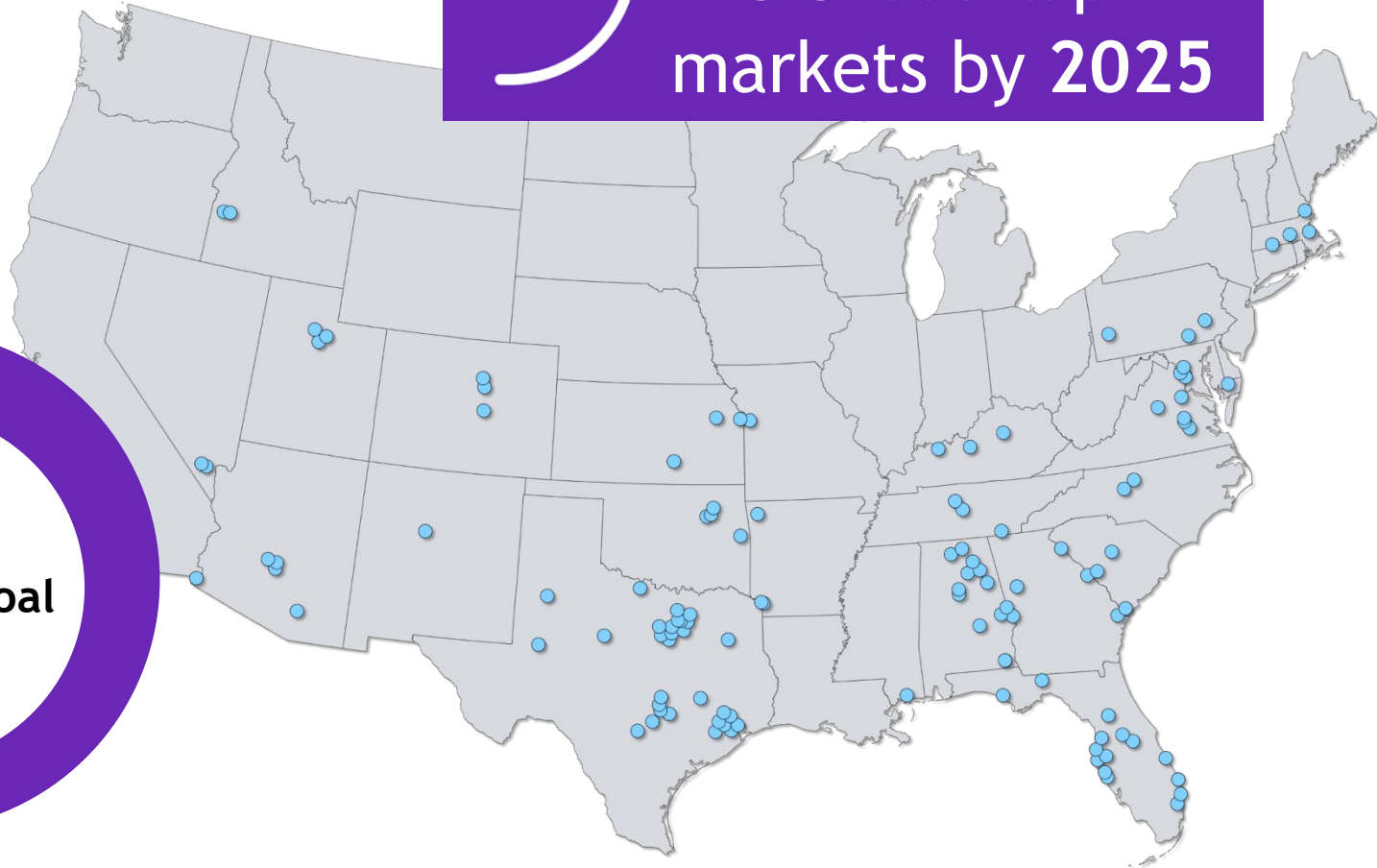
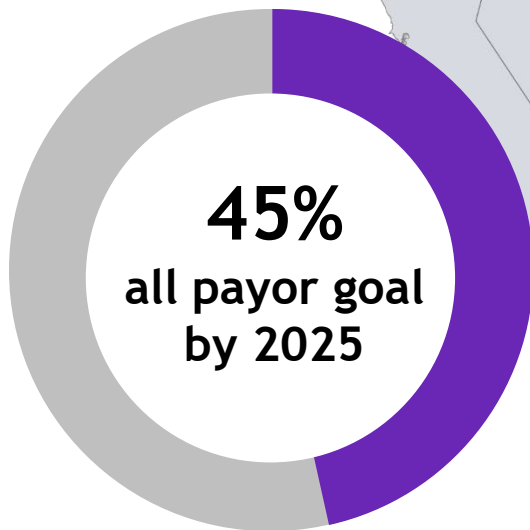
per year

Not inclusive of larger scale acquisitions

Clinical collaboration growth targets



 **100 overlap
markets by 2025**



Consolidated CAGR targets



Sustained
growth

Consolidated
net operating
revenues

7% to 9%

Consolidated
adjusted
EBITDA

7% to 9%

Adjusted
free cash
flow

8% to 10%

2020 through 2025



Patient Journey Video

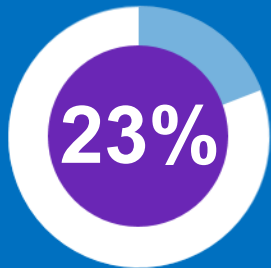
Inpatient Rehabilitation

Presented by Barb Jacobsmeyer

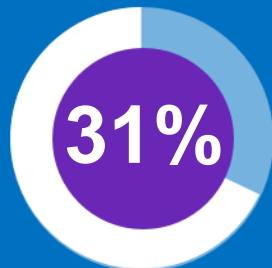


Overview - Inpatient Rehabilitation

Largest owner and operator of IRFs



of Licensed beds



of Medicare patients served

33

States & Puerto Rico

134

Inpatient Rehabilitation Hospitals

47

Operate as joint ventures with acute care hospitals

123

Hospitals hold one or more disease-specific certifications

~31,600

employees

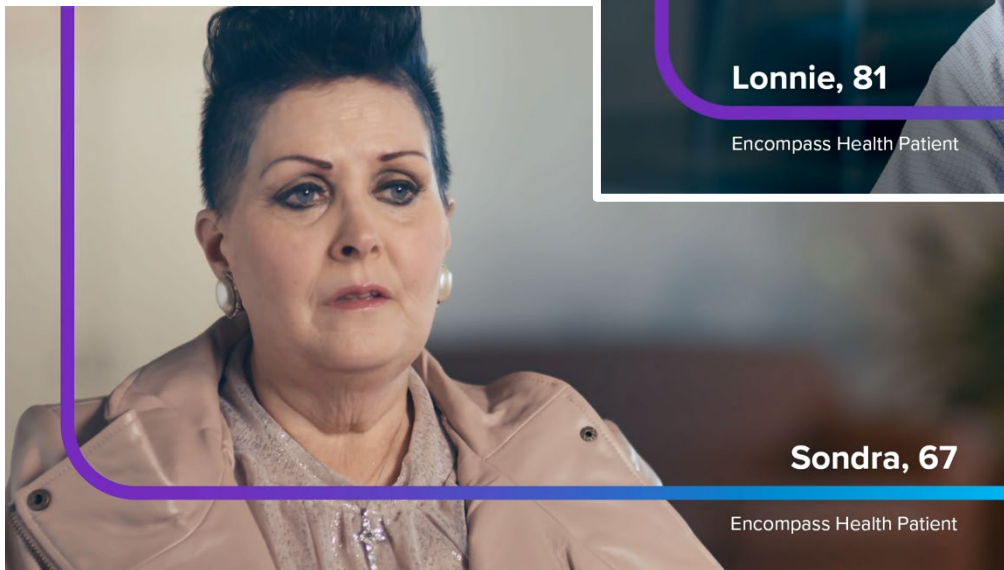
~186,800

patients

~\$3.5 billion

revenues

Who are these patients, and why did they come our way?



Hospital level care





Physician Engagement



Full Care Team



On-Site Pharmacy

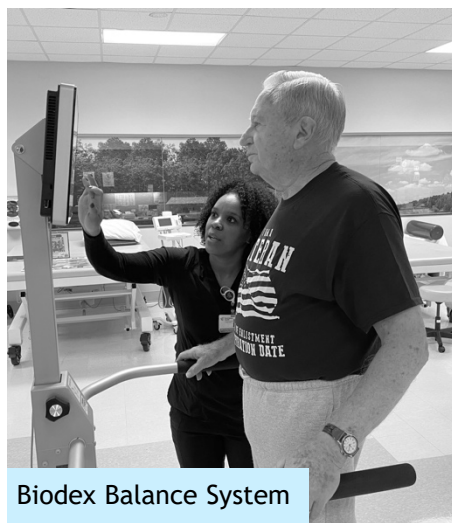


Specialized and Intensive Therapy



Minimum of
3 hours of therapy
5 days a week

We invest significantly in rehabilitation technologies to further improve patient outcomes



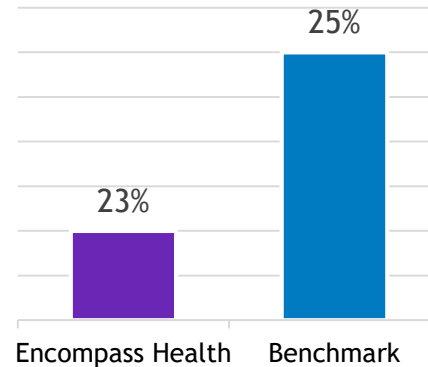


Activities of Daily Living Suite

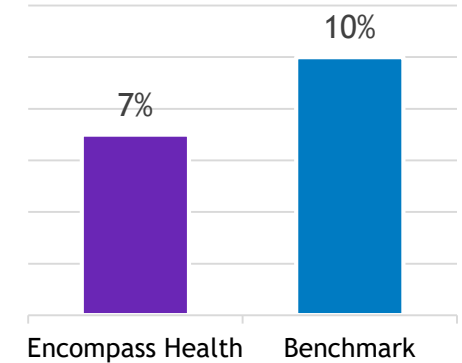
Who provides this great care?

Clinical teams of nurses, physical therapists, occupational therapists, speech language pathologists, respiratory therapists, physicians, case managers, pharmacists, and dieticians

Nurse turnover



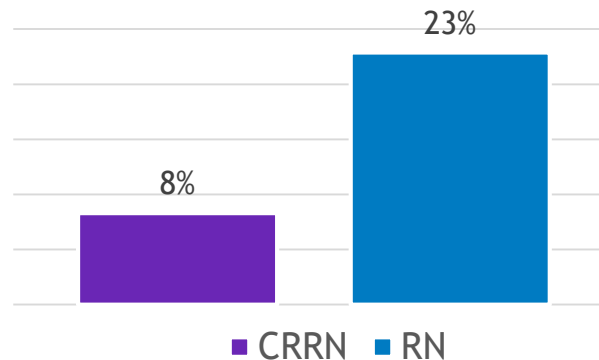
Therapist turnover



Therapy clinical career ladders



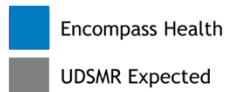
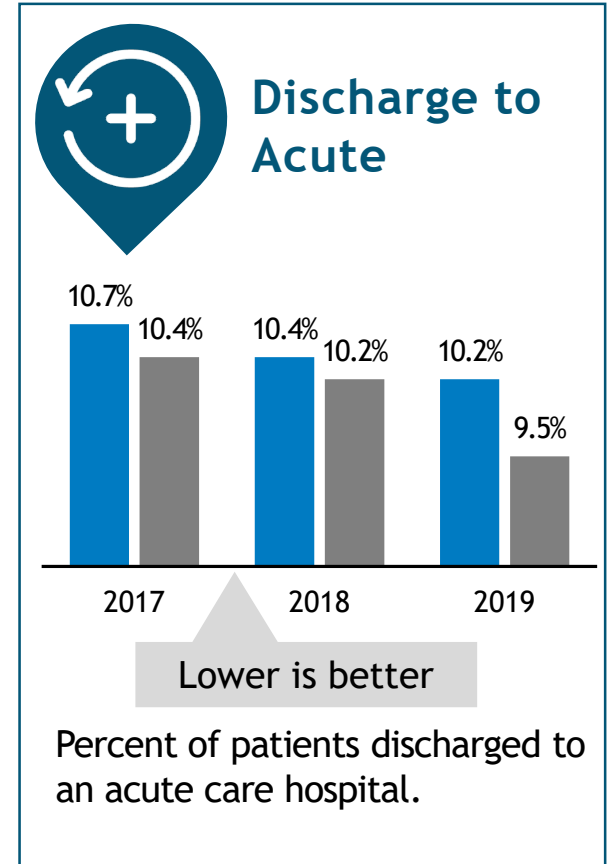
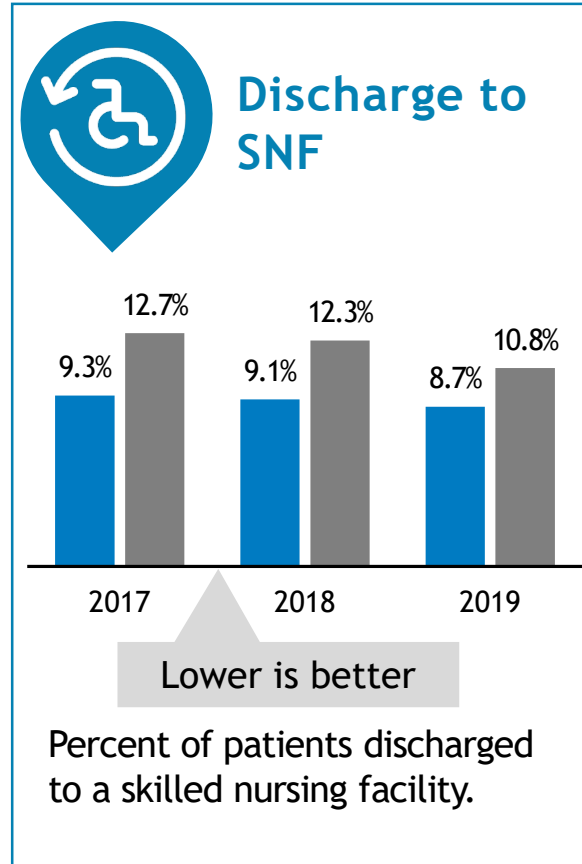
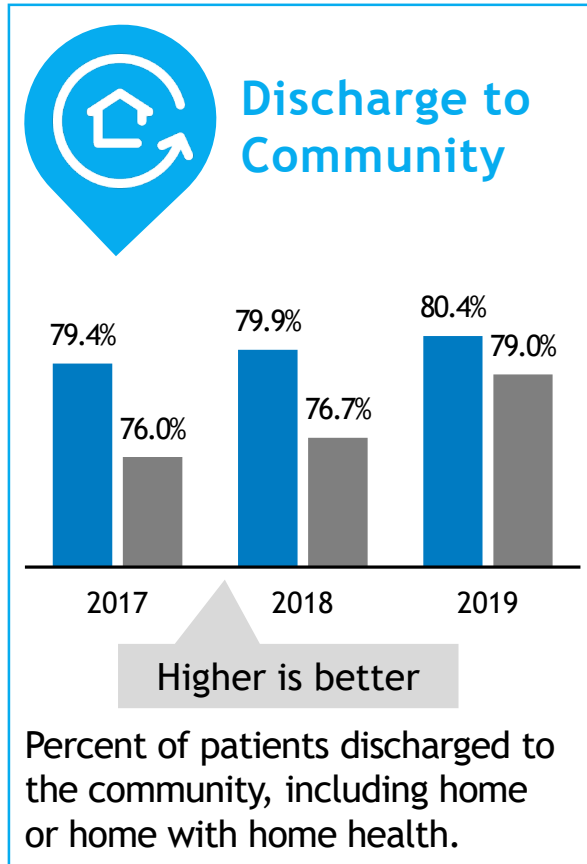
CRRN turnover



Leadership Development
Developing Future CEOs
ENCOMPASS HEALTH

CRRN
CERTIFIED REHABILITATION REGISTERED NURSE
EARN IT. USE IT. KEEP IT.

Encompass Health's patient-focused approach leads to quality clinical results



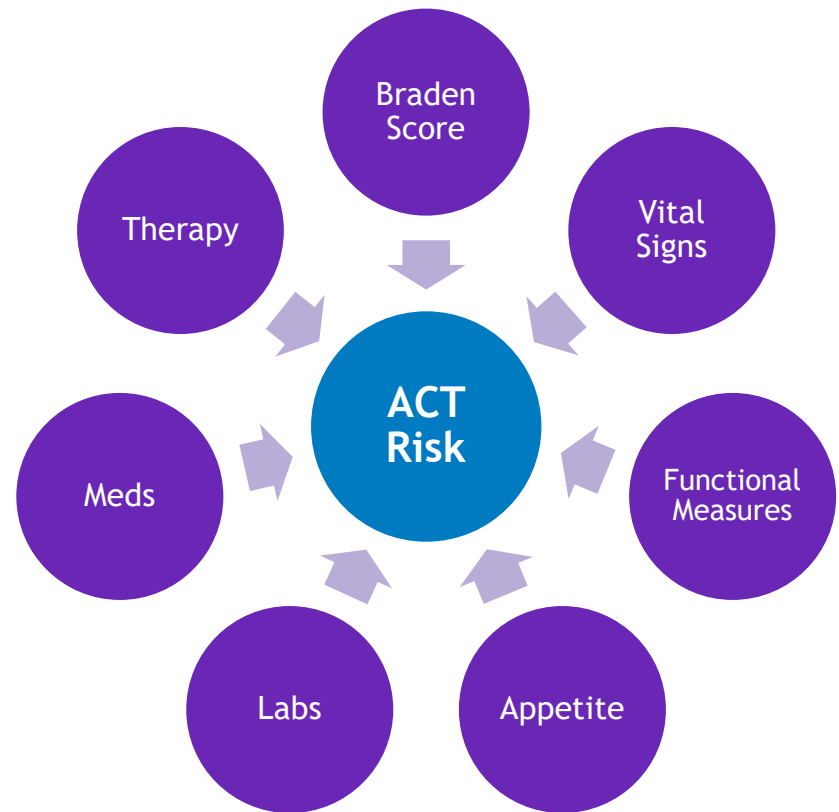


Technology Supports Our Staff

EHC's readmission program, ReACT, is integrated into the clinicians workflow to identify risk of acute care transfer (ACT) and promote early intervention

BACKGROUND

- Clinical tool designed in EHC's proprietary EMR to identify a patient's risk of acute care transfer
- Initial model formulated from **90,000+ encounters** over two years of EHC data
- **28 clinical variables** selected based on significance criteria, clinical relevance and proactive feasibility
- Partnered with Cerner to build

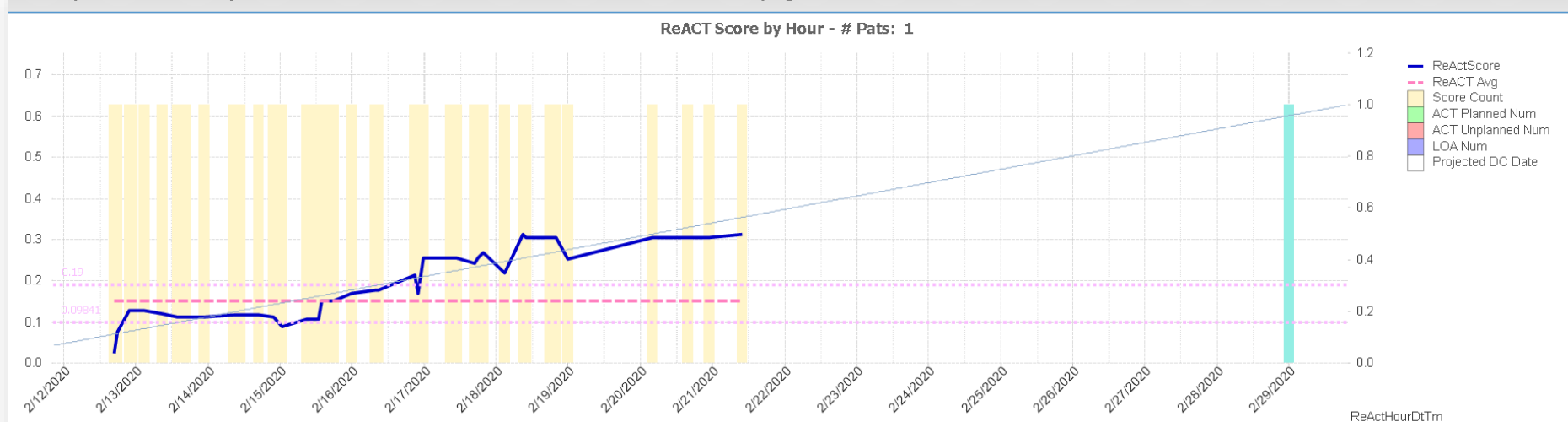


ReACT

Details on the variables contributing to the risk throughout the stay

ncNameFinNbr	L O S	N Station	Room Bed	AttendPhysician	Curr ReACT	12 Hr Trend	24 Hr Trend	48 Hr Trend
	8	R-1	201-A		0.4224			
	25	R-1	212-A		0.3411	-		
	6	R-3	245-B		0.2043			
	16	R-3	237-B		0.1688			
	3	R-2	214-A		0.1181			
	10	R-3	235-A		0.0877			
	7	R-3	230-B		0.0760			
	10	R-3	248-A		0.0592			
	3	R-3	242-B		0.0556			
	10	R-1	205-A		0.0523	-		
	14	R-3	244-A		0.0480			
	14	R-1	209-B		0.0478			
	7	R-3	243-A		0.0404			
	6	R-2	218-B		0.0360			
	3	R-1	204-B		0.0347			
	11	R-1	206-B		0.0300			
	3	R-1	210-A		0.0300			
	8	R-3	246-B		0.0299			
	6	R-2	219-A		0.0287			
	10	R-3	244-B		0.0144			

ReACT By Execution Time - If you see colored bars the Info is in the "ACT Order Details" chart in the top right.



What is the Encompass Health Readmission Prevention Program?

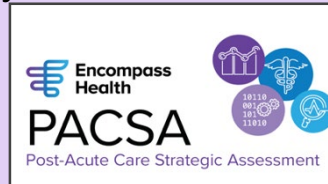
The Readmission Prevention Program is an established, proven set of tools and standards to mitigate the risk a patient will readmit to an acute hospital within 30 days

PREDICTIVE MODEL

- Co-developed with Cerner through the Innovation Center
- Initial model built on 400,000+ patients moving through IRF and Home Health over a 90-day period
- Currently monitors and reports on over 40 *clinical features* (case managers assess non-clinical risk factors)
- Model utilizes artificial intelligence to continue to “learn” and improve over time
- Readmission risk updates daily and is viewable in ACE IT and Clinical Collaboration Beacon Application

Our IRF value proposition

Encompass Health developed the proprietary Post-Acute Care Strategic Assessment (PACSA) tool to identify specific areas of opportunity for EHC with an acute care hospital.



60%+

of stroke rehabilitation disease-specific certifications belong to Encompass Health IRFs

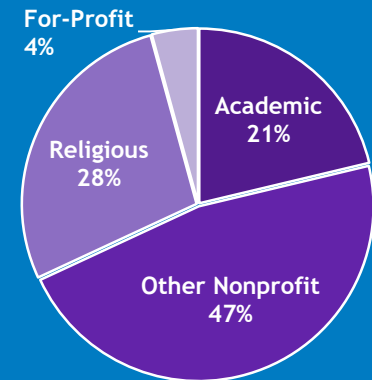


Leveraging our:

- Strategic sponsorship of the AHA/ASA
- Clinical collaboration
- Joint commission certifications

Joint ventures began in 1991

- 47 IRFs are joint ventures



- Joint ventures are an important aspect of Encompass Health's strategy and the Company is actively establishing new partnerships across the country
- Joint venture partners own equity that ranges from 2.5% to 50%

The picture may look different when you examine the data at the diagnosis level

First Post-Acute 30-Day Readmission

Total Post-Acute 30-Day Readmission

Post Acute Provider	Type	First PAC 30 day readmission rate
EHC Albuquerque	IRF	19.8%
Lovelace (#1 based on volume)	IRF	19.6%
Advanced (#2 based on volume)	SNF	17.4%
Avamere (#3 based on volume)	SNF	21.8%

Stroke Post-Acute 30-Day Readmission

Post Acute Provider	Type	Fist PAC 30 day readmission rate
EHC Albuquerque	IRF	16.5%
Lovelace (#1 based on volume)	IRF	26.6%
Advanced (#2 based on volume)	SNF	26.1%
Spanish Trails (#3 based on volume)	SNF	41.7%

Readmissions add significant costs to the 90-day average spend

When analyzed by DRG for the right patient, IRF is the right setting for quality outcomes and cost

DRG	90-Day Avg. Total Spend EHC IRF	90-Day Avg. Total Spend SNF	EHC Spend vs. SNF
61 Acute ischemic stroke w MCC	\$59,086	\$93,449	-37%
62 Acute ischemic stroke w CC	\$40,981	\$55,512	-26%
65 Intracranial hemorrhage or cerebral infarction w CC	\$24,854	\$48,569	-49%
220 Cardiac Valve w CC	\$72,903	\$100,180	-27%
470 Major Joint Replacement of Lower Extremity w/o MCC	\$34,737	\$41,894	-17%
871 Sepsis or Septicemia w/ MCC	\$34,304	\$43,749	-22%

Independent research concludes IRFs are a better rehabilitation option for stroke patients than SNFs

AHA/ASA Stroke Guidelines

"Whenever possible, the American Stroke Association strongly recommends that stroke patients be treated at an inpatient rehabilitation facility rather than a skilled nursing facility."

White et al. *Guidelines for Adult Stroke Rehabilitation and Recovery*
 Conclusion—As systems of care evolve in response to healthcare reform efforts, poststroke care and rehabilitation are critical aspects of the stroke care continuum. The goal of this guideline is to provide a comprehensive review of the current evidence on stroke rehabilitation and recovery, and to provide a framework for the development of a stroke rehabilitation and recovery program. The guideline is intended for use by healthcare providers, including physicians, nurses, therapists, and other healthcare professionals, as well as patients and their families. The guideline is based on a systematic review of the literature, and it is intended to be updated as new evidence becomes available.

AHA/ASA Guideline

Guidelines for Adult Stroke Rehabilitation and Recovery A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association

Endorsed by the American Academy of Physical Medicine and Rehabilitation and the American Society of Neurorehabilitation

The American Academy of Neurology affirms the value of this guideline as an educational tool for neurologists and the American Congress of Rehabilitation Medicine affirms the educational value of these guidelines for its members

Chair,
 Cheryl, PhD,
 Josh Fisher, PhD, PT,
 BSC, MSSP, PT, PhD,
 JSC, CNRN, FAHA,
 & Sires, PhD, ABPP (RP);
 Stroke Council, Council
 & Council on

rehabilitative care of adults

Method—Writing group members were nominated by the committee chair on the basis of their previous work in relevant topic areas and were approved by the American Heart Association (AHA) Stroke Council's Scientific Statement Oversight Committee and the AHA/American Stroke Association's Scientific Statement Oversight Committee. The panel reviewed relevant articles on adult stroke rehabilitation and recovery, and it developed a guideline for healthcare professionals. The guideline is based on a systematic review of the literature, and it is intended to be updated as new evidence becomes available.

Results—Stroke rehabilitation requires a sustained and coordinated effort from a large team, including the patient and his or her goals, family and friends, other caregivers (eg, personal care attendants), physicians, nurses, physical and occupational therapists, speech-language pathologists, recreation therapists, psychologists, nutritionists, social workers, and others. Communication and coordination among these team members are paramount in maximizing the effectiveness and efficiency of rehabilitation and underlie this entire guideline. Without communication and coordination, isolated efforts to rehabilitate the stroke survivor are unlikely to achieve their full potential.

Annals of Internal Medicine

The Management of Stroke Rehabilitation: A Synopsis of the 2019 U.S. Department of Veterans Affairs and U.S. Department of Defense Clinical Practice Guideline

James S. Park, PhD; Melissa C. Eapen, MD; Johanna Elizabeth Tran, MD; Amy O. Bowles, MD; Andrew Burrows, MD; and M. Eric Rodriguez, PhD

Description: In June 2019, the U.S. Department of Veterans Affairs (VA) and U.S. Department of Defense (DoD) approved an update of the joint clinical practice guideline for rehabilitation after stroke. This synopsis summarizes the key recommendations from this guideline.

Methods: In February 2018, the VA/DoD Evidence-Based Practice Work Group convened a joint VA/DoD guideline development effort that included clinical stakeholders and stroke survivors and conformed to the National Academy of Medicine (formerly the Institute of Medicine) tenets for trustworthy clinical practice guidelines. The guideline panel identified key questions, systematically searched and evaluated the literature, and developed 2 algorithms and 42 key recommendations across the

management and evaluation systems. Stroke survivors and their family members were invited to share their perspectives to further inform guideline development.

Recommendations: The guideline recommendations provide evidence-based guidance for the rehabilitation care of patients after stroke. The recommendations are organized into 6 areas: timing and approach; motor therapy; dysphagia; cognitive, speech, and sensory therapy; mental health therapy; and other functions; such as returning to work and driving.

Ann Intern Med. doi:10.7326/M1901051
 Published online before print January 10, 2019.

Veterans Affairs Stroke Guidelines

Stroke is the leading cause of death in the United States and is a leading cause of long-term disability (1). While younger patients may be more physically capable of recovering from stroke than older patients, poor functional outcomes are commonplace. Approximately 44% of individuals aged 18 to 50 years experience moderate disability after stroke, requiring at least some assistance with activities of daily living (ADLs) or mobility (modified Rankin Scale >2) (2). In a group of patients with ischemic stroke who were deemed as having "mild" or "improving" deficits and, therefore, not candidates for recombinant tissue-type plasminogen activator therapy, only 28% were discharged to home, whereas 16% required admission to acute rehabilitation facilities and 11% were admitted to skilled nursing facilities (3).

Disability from stroke can present in myriad ways, depending on the affected area of the brain or spinal cord. The most common types of disability include motor, sensory, and cognitive impairments, such as memory loss, personality changes, and difficulties in the form of attention, concentration, and decision-making deficits (4).

Annals of Internal Medicine

CLINICAL GUIDELINE

JAMA Network

JAMA Network Open

Original Investigation | Geriatrics

Comparison of Functional Status Improvements Among Patients With Stroke Receiving Postacute Care in Inpatient Rehabilitation vs Skilled Nursing Facilities

Keppeler MG, PhD; O'Rourke, James S, MD; Timothy A. Rodin, PhD; O'Rourke, Hong-Kun, PhD; Todd M. Hays, PhD; O'Rourke, Anantharaman, PhD; Yoo, Li, MS; Karmali, S. Omer, PhD; O'Rourke

Abstract

IMPORTANCE: Health care reform legislation and Medicare plans for unified payment for postacute care highlight the need for research examining service delivery and outcomes.

OBJECTIVE: To compare functional outcomes in patients with stroke after postacute care in inpatient rehabilitation facilities (IRF) vs skilled nursing facilities (SNF).

DESIGN, SETTING, AND PARTICIPANTS: This cohort study included patients with stroke who were discharged from acute care hospital to IRF or SNF from January 1, 2013, to November 30, 2014. Medicare claims were used to link IRF and SNF assessments. Data analyses were conducted from January 17, 2017, through April 25, 2019.

EXPOSURES: Inpatient rehabilitation received in IRF vs SNF.

MEASUREMENTS AND MAIN RESULTS:

We measured during an IRF or SNF stay the proportion of patients who were discharged to IRF or SNF (33.4%) vs SNF (21.6%) (46.8%).

In patients admitted to IRF, the proportion of patients who were discharged to IRF or SNF was higher than in patients admitted to SNF (44.2% [95% CI 44.4-44.3] points vs 40.8% [95% CI 40.7-40.9] points) and at discharge (58.6% [95% CI 58.5-58.7] points vs 44.4% [95% CI 44.3-44.5] points), and the risk of care on admission (44.2% [95% CI 44.3-44.3] points) and at discharge (58.6% [95% CI 58.5-58.7] points) vs 45.5% [95% CI 45.0-45.2] points). Additionally, patients in IRF compared with those in SNF had larger improvements for mobility score (16.5 [95% CI 16.1-17] points vs 15.5 [95% CI 15.4-16] points) and for self-care score (13.6 [95% CI 13.2-14] points vs 12.7 [95% CI 12.6-12.8] points). Multivariate, propensity score, and instrumental variable analyses showed a similar magnitude of better improvements in patients admitted to IRF vs those admitted to SNF. The differences between SNF and IRF in odds of 30- to 365-day mortality (adjusted odds ratio, 0.48 [95% CI 0.46-0.50]) were reduced but not eliminated in multivariate analysis (adjusted odds ratio, 0.72 [95% CI 0.69-0.74]) and propensity score analysis (adjusted odds ratio, 0.72 [95% CI 0.69-0.74]).

Key Points

Question: Is change in physical function associated with receiving postacute care after a stroke in inpatient rehabilitation vs skilled nursing facilities?

Findings: This cohort study included 99 185 patients who received postacute care in inpatient rehabilitation or skilled nursing facilities after a stroke. Care in an inpatient rehabilitation facility was associated with greater improvement in mobility and self-care compared with care in a skilled nursing facility, and a significant difference in functional improvement remained after accounting for patient, clinical, and facility characteristics at admission.

Meaning: These findings suggest that there is room for payment reform in postacute care and highlight the need to target decision-making regarding discharge to postacute facilities based on patient needs and potential for recovery.

Supplemental content

Author disclosures and article information are found at the end of this article.

Patients "who received services at an IRF after a stroke demonstrated greater improvement in mobility and self care compared with patients who received inpatient rehabilitation at a SNF."

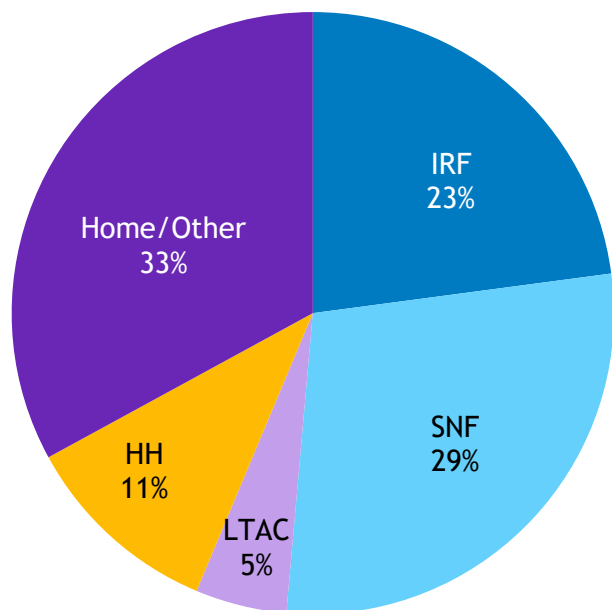
There is strong evidence to endorse the AHA/ASA Guidelines and the need for an organized, multidisciplinary approach found at an Inpatient Rehabilitation Facility.

* "Guidelines for Adult Stroke Rehabilitation and Recovery," issued May 2016 (stroke.ahajournals.org)

** "Comparison of Functional Status Improvements Among Patients With Stroke Receiving Postacute Care in Inpatient Rehabilitation vs Skilled Nursing Facilities," issued December 2019 (jamanetwork.com)

For this acute care hospital's stroke patients, outcomes are superior and acute length of stay is shorter when discharged to an EHC hospital

Stroke Patients' Discharge Destination



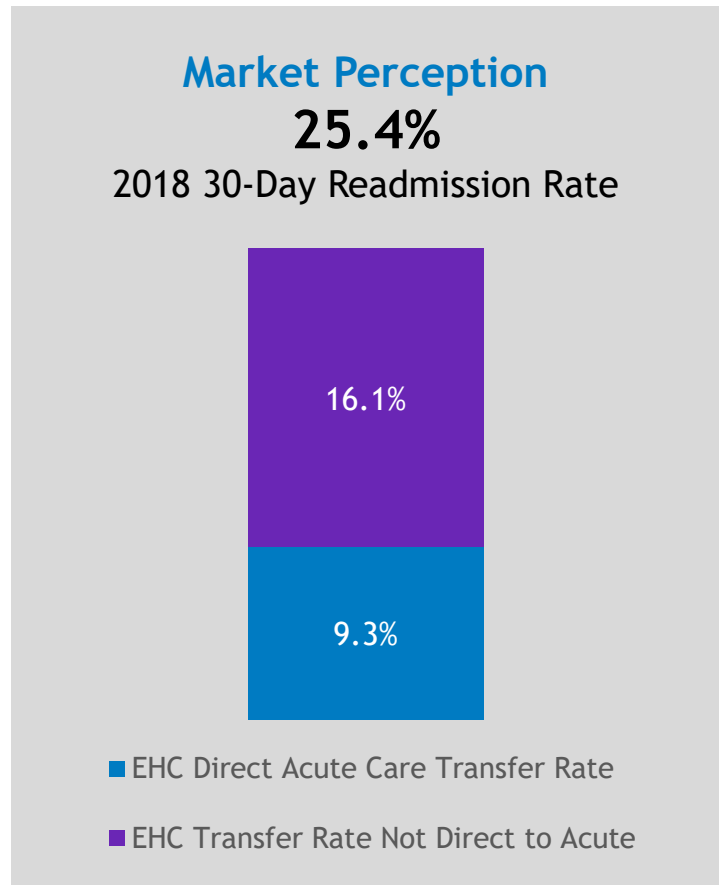
Source: Dixon Hughes Group Q2 2017 - Q1 2018 Medicare FFS claims, analyzed for stroke patients most likely to be candidates for rehab level of care

Stroke Results

	# (%) of Discharges	Acute Avg. Length of Stay	Readmission Rate 30-Days Post-Discharge PAC
SNF	122 (29%)	7.2	20.5%
Home/Other	141 (33%)	4.4	21.3%
EHC	95 (22%)	5.0	16.8%

Source: Dixon Hughes Group CY 2017 Medicare FFS claims, analyzed for stroke patients most likely to be candidates for rehab level of care

Encompass Health developed the proprietary Post Acute Care Strategic Assessment (PACSA) to address opportunities with a specific acute care hospital



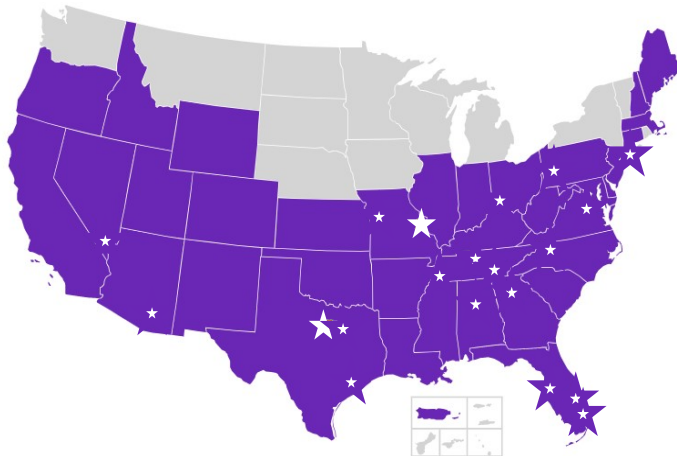
- 31% of patients referred to home health did not receive care within 3 days
- 24% of patients referred to home health never received care

Readmission Rate: Discharged from IRF and readmitted within 30 days (PEPPER method)

AHA/ASA strategic sponsorship - by the numbers



9,460 Life After Stroke guide downloads from the AHA/ASA website



42 hospitals included in the 20 Go Red sponsored luncheons

11,000 Number of guests reached through 20 Go Red for Women Luncheons

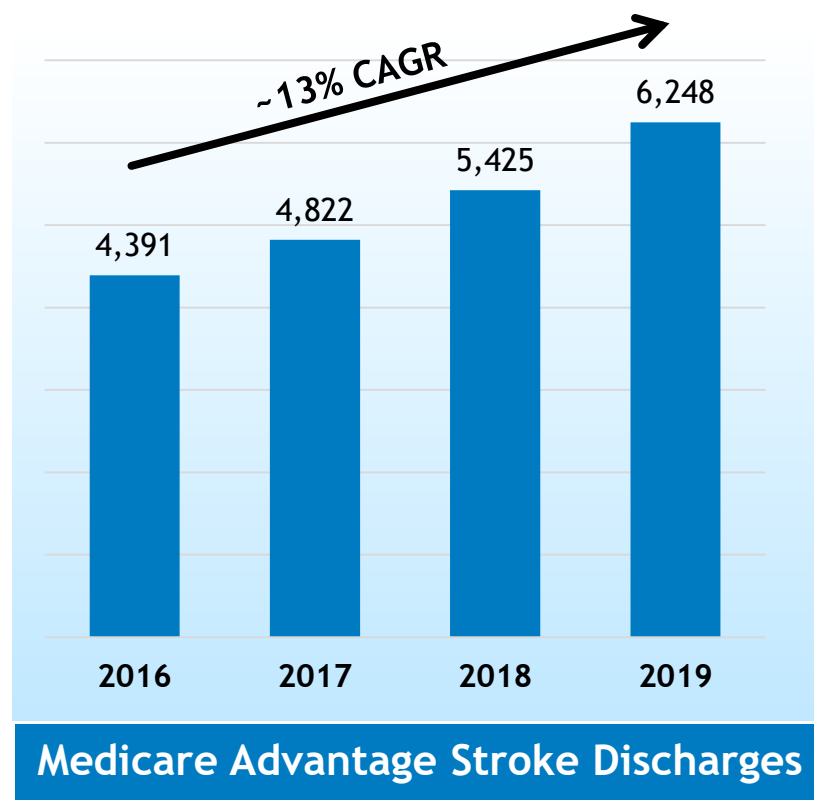
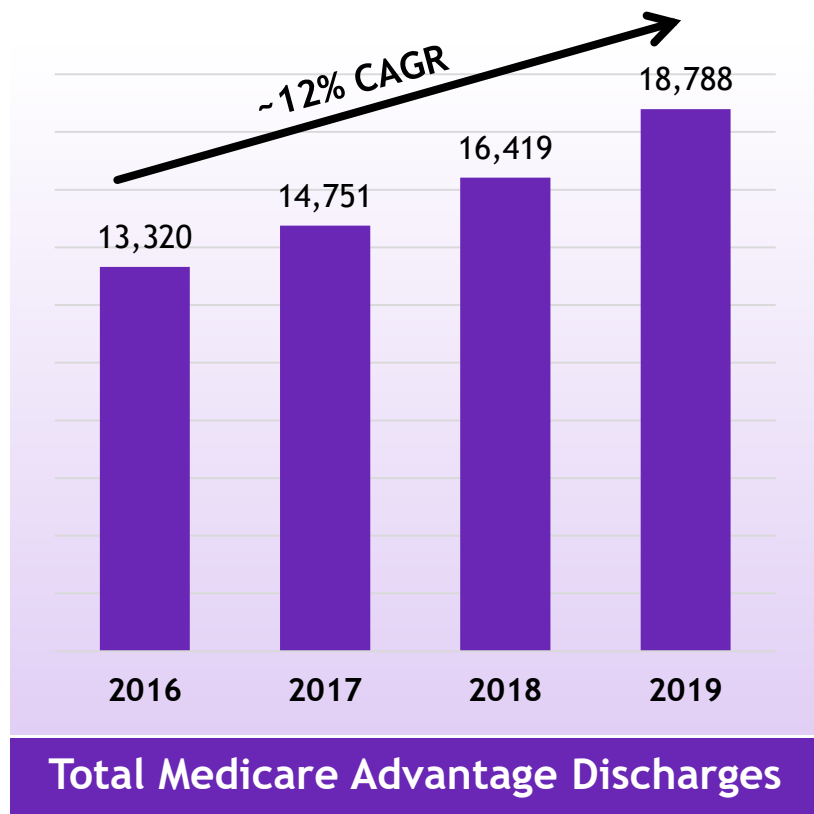


11.2M+ Reach on AHA/ASA-owned channels (e.g. blog, e-newsletters, AHA home page)



51,777 Life After Stroke guides distributed by Encompass Health hospitals

Encompass Health's hospital volume trends in Medicare Advantage are outpacing beneficiary enrollment



From 2016 thru 2019, the Medicare Advantage enrollment CAGR was ~7% for Medicare eligibles in counties where Encompass Health has inpatient rehabilitation hospitals.

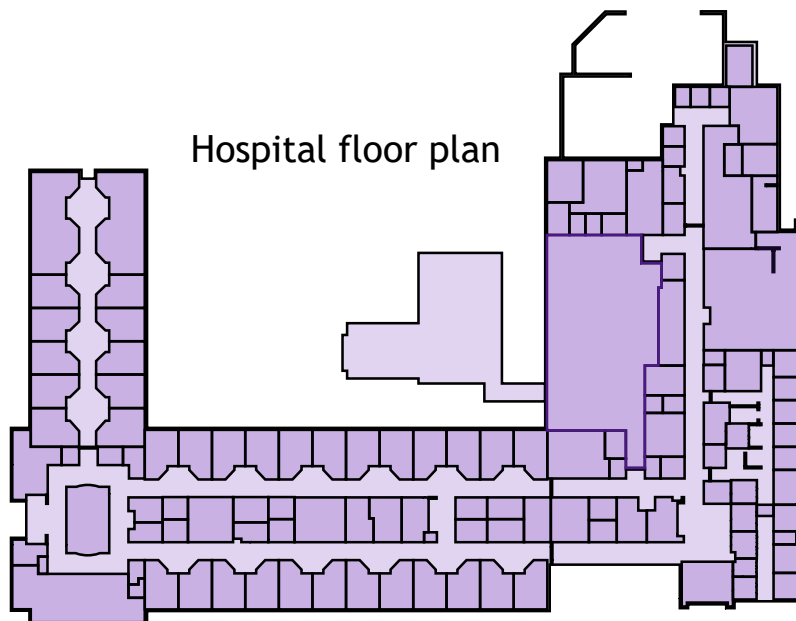
Stuart, Florida IRF - opened June 2013 with 34 beds



50/50 Joint Venture with
Cleveland Clinic Martin Health

365 acute care beds in the market

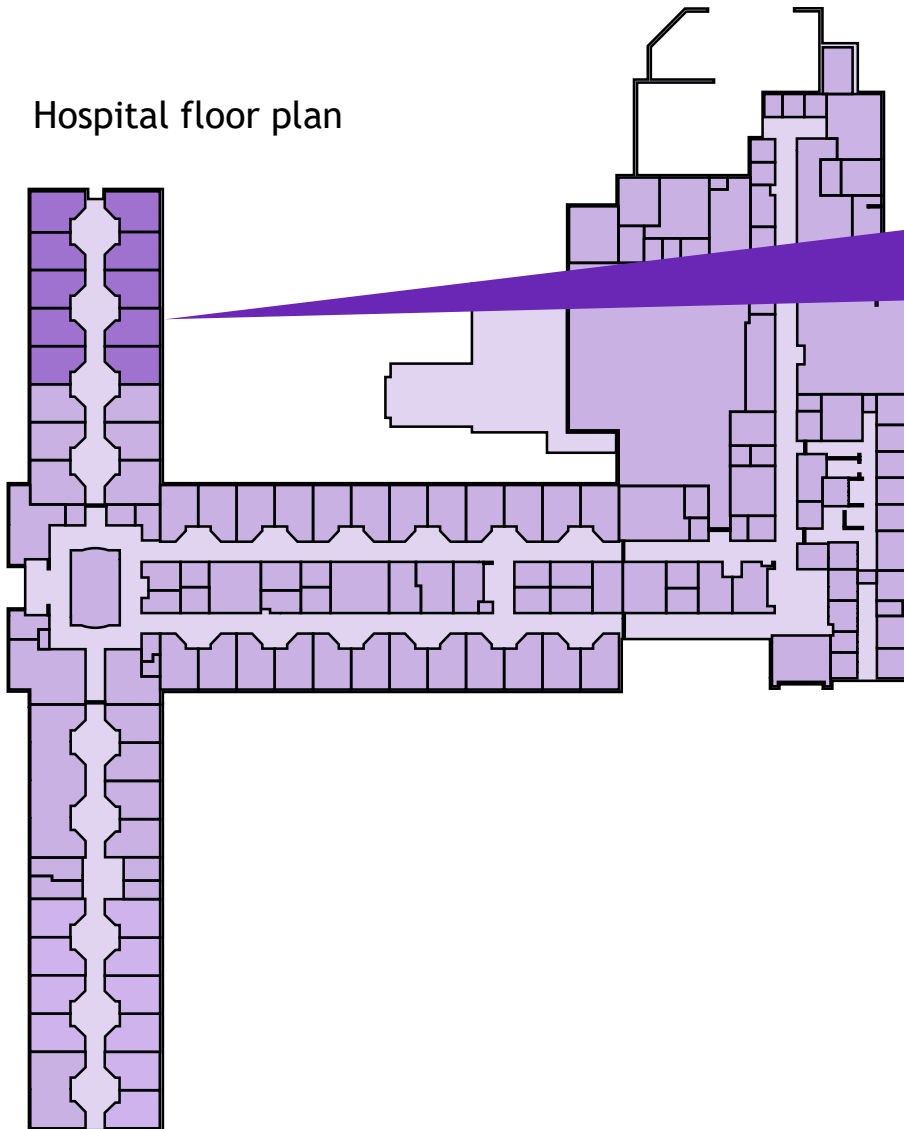
193,000 65+ population in
primary and secondary service area



	2013	2014
Licensed Beds	34	34
Avg. Daily Census	16	33
Occupancy	46.9%	96.0%
Revenue (millions)	\$7.1	\$16.1
EBITDA (millions)	\$0.5	\$3.7
FTEs	68	110

Stuart, Florida IRF - expanded in August 2015

Hospital floor plan



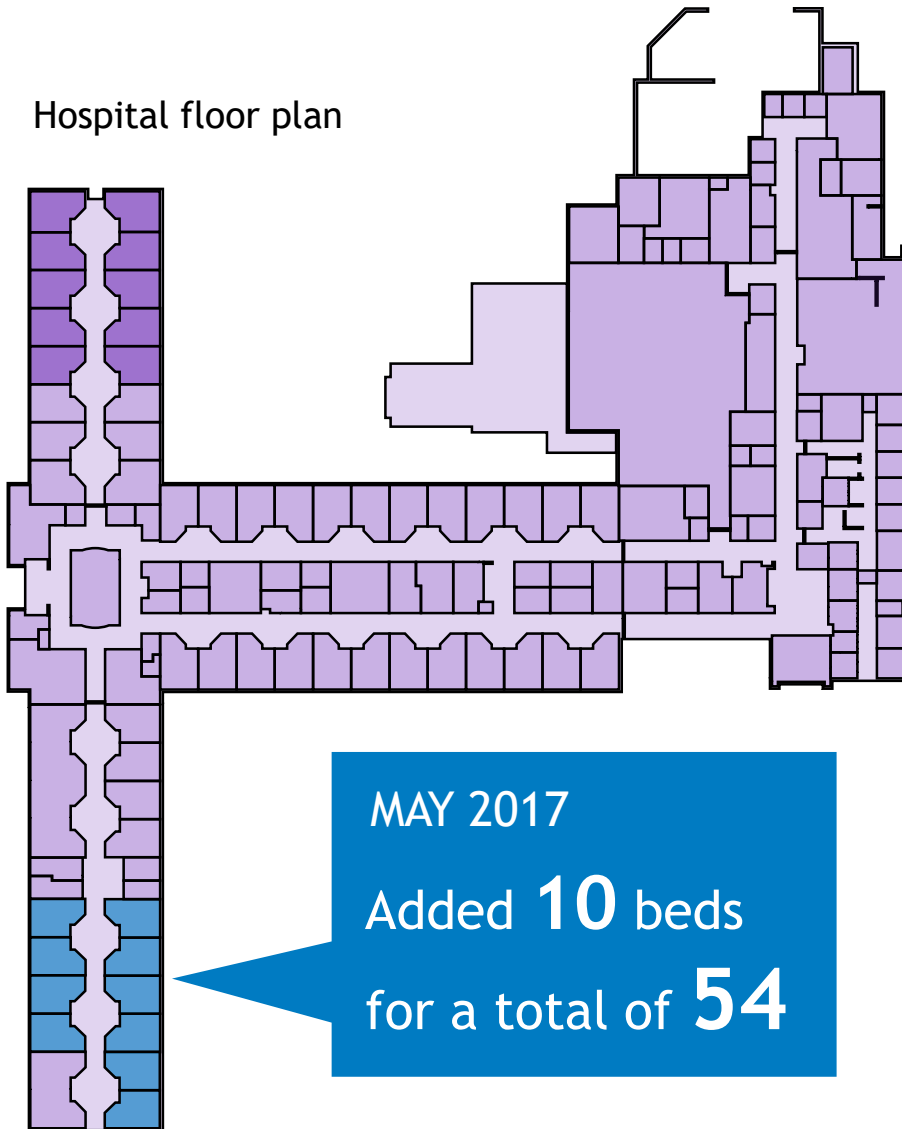
AUGUST 2015

Added **10** beds
for a total of **44**

	2015	2016
Licensed Beds	44	44
Avg. Daily Census	37	43
Occupancy	84.8%	98.5%
Revenue (millions)	\$20.5	\$23.5
EBITDA (millions)	\$5.2	\$6.0
FTEs	121	140

Stuart, Florida IRF - further expanded in May 2017

Hospital floor plan



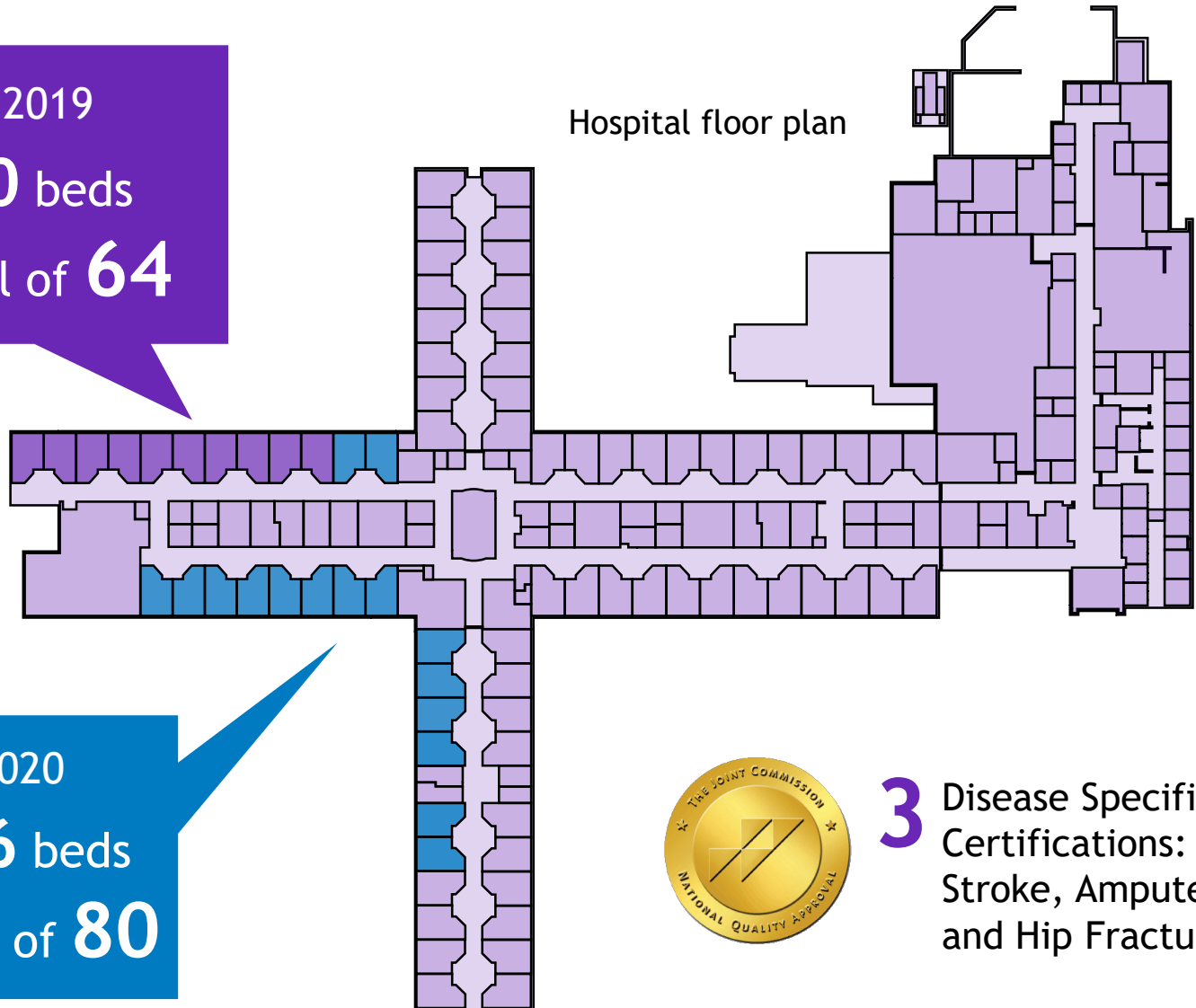
	2017	2018
Licensed Beds	54	54
Avg. Daily Census	48	53
Occupancy	89.7%	97.3%
Revenue (millions)	\$26.5	\$29.7
EBITDA (millions)	\$6.7	\$7.6
FTEs	152	166

Stuart, Florida IRF - further expanded in 2019 and 2020

DECEMBER 2019

Added **10** beds
for a total of **64**

Hospital floor plan



OCTOBER 2020

Adding **16** beds
for a total of **80**



3 Disease Specific
Certifications:
Stroke, Amputee,
and Hip Fracture

Leading position in cost effectiveness

	#	Avg. beds per IRF	Avg. Medicare discharges per IRF	Case mix index	Avg. est. total cost per discharge for FY 2019	Avg. est. total payment per discharge for FY 2019
Encompass Health=	126	67	951	1.28	\$13,622	\$20,315
Free-standing = (Non-Encompass Health)	154	58	589	1.27	\$18,107	\$21,400
Hospital units =	846	24	228	1.22	\$21,483	\$21,569
Total	1,126	34	358	1.25	\$18,388	\$21,159

Medicare pays *Encompass Health less per discharge, on average, and Encompass Health treats a higher acuity patient.*

Patient-centered technology allows for benchmarking and continual improvement

Standardize the process, then automate it

Enterprise scalability



Proprietary large patient datasets



Clinical and business knowledge



Continuous improvement



Proprietary Management System

BEACON

- Proprietary operations management system that provides real-time data
- Benchmarking to promote best practices
- Capabilities include:
 - Clinical collaboration
 - Physician quality reporting
 - Readmission risk
 - Therapy outcomes
 - Quality and patient satisfaction reporting
 - Workforce and labor productivity
 - Sales and marketing analysis
 - Care management
 - Food and drug spend analysis
 - Market-by-market analysis
 - Claims analysis

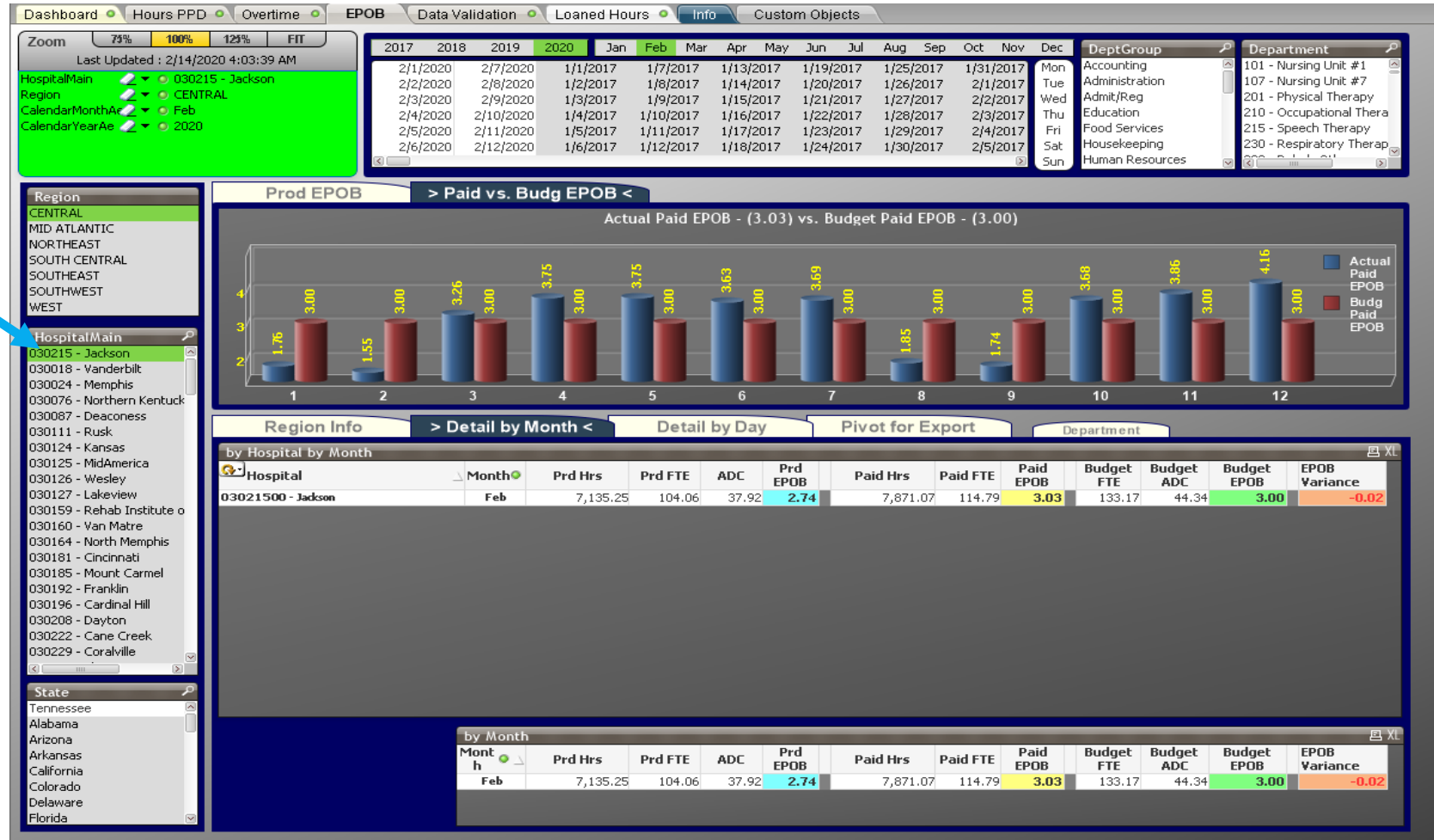
Labor productivity

Select date range



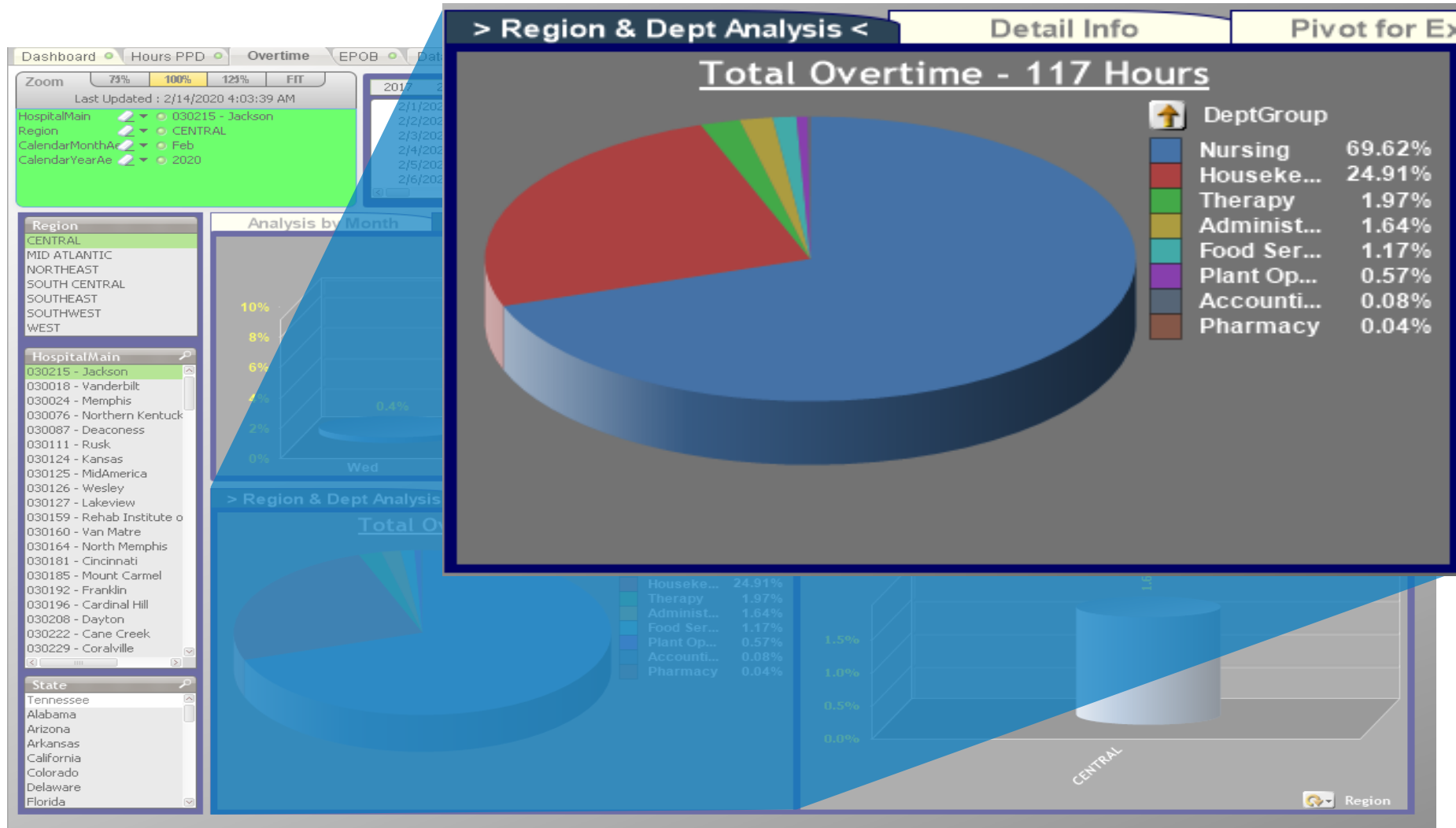
Combines time & attendance system with patient accounting system to show labor metrics

Labor productivity

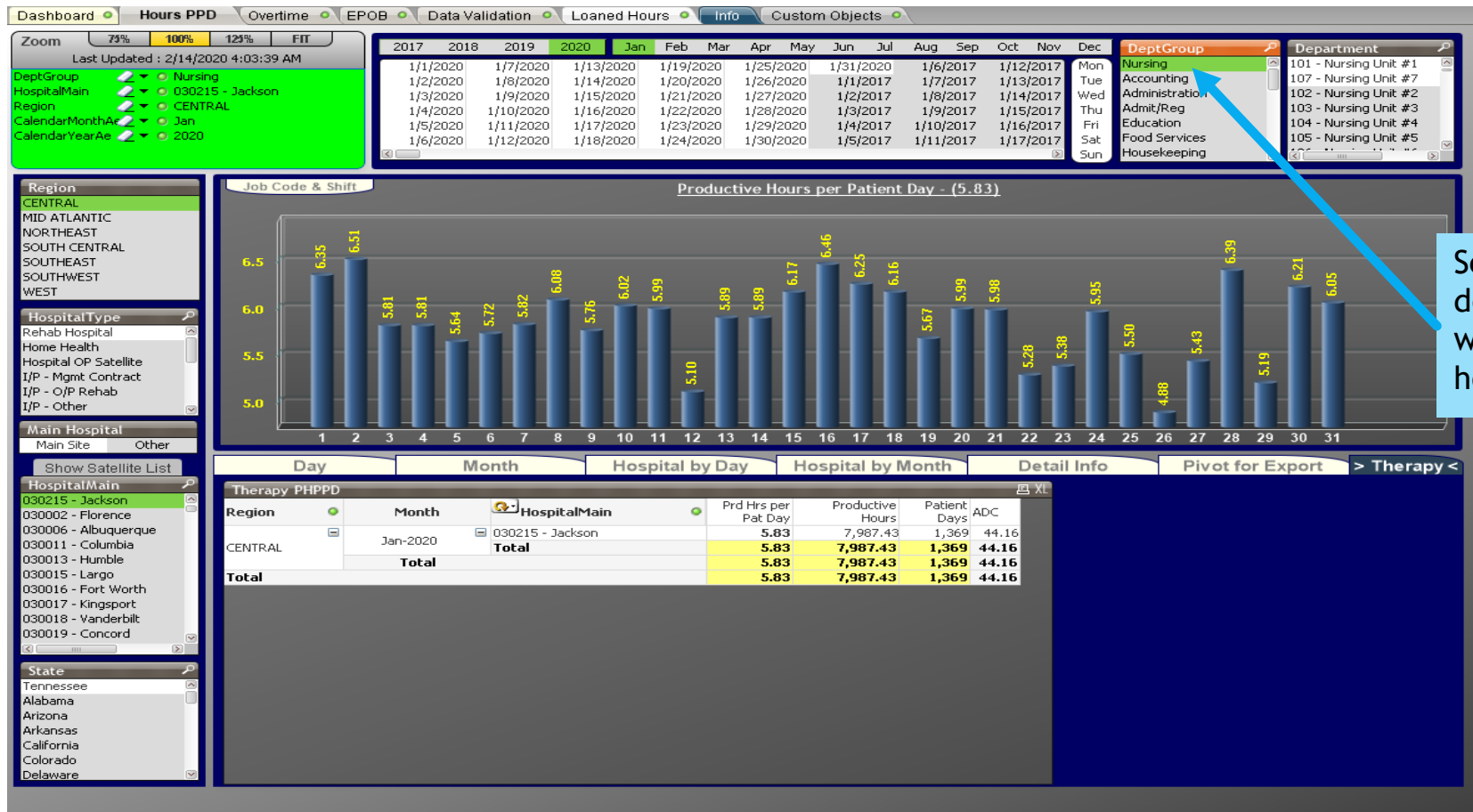


Select
by
hospital
within a
region

Labor productivity



Labor productivity



Care management

Patient level outcomes combined into one report for easy of comparison by hospital

KCI Analysis Modifications - Updated 10/1/2019

Current Selections

Fields Values
 CalendarMonth Jan, Feb
 CalendarQuarter Q1
 CalendarYear 2020

Last Updated : 2/14/2020 4:56:02 AM

Zoom: 75% 100% 125% FIT

Region
 CENTRAL
 MID ATLANTIC
 NORTHEAST
 SOUTH CENTRAL
 SOUTHEAST
 SOUTHWEST
 WEST

Hospital
 030002 - Florence
 030006 - Albuquerque...
 030011 - Columbia
 030013 - Humble
 030015 - Largo
 030016 - Fort Worth
 030017 - Kingsport
 030018 - Vanderbilt

FinClass
 BC/BS
 Comm Ins
 Mangd Care
 Med Adv
 Medicaid
 Medicare
 Other
 Self Pay
 Wrks Comp

RIC
 Neurological conditi
 Stroke
 Other disabling imp
 Orthopedic - other
 Hip fracture

RefHospital
 Home
 University Hospital
 Upmc Altoona Hosp
 Huntsville Hospital
 Maine Medical Cent

CaseManager

ImpairmentCode
ImpairmentDesc

2017 2018 2019 2020 Q1 Q2 Q3 Q4 Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Year/Month

Key Care Indicators

	Actuals	Target	Variance	2019	PY Var
# Dschs	22,803			186,432	
DC to Comm	80.47%	78.32%	2.15%	80.27%	0.20%
DC to SNF	8.93%	10.10%	-1.17%	8.78%	0.18%
DC to Acute	9.92%	10.71%	-0.80%	10.31%	-0.40%
Admit Motor	50.17	N/A		51.07	-0.90
Admit GG SelfCare	22.54	N/A		22.80	-0.26
Disch GG SelfCare	34.71	N/A		22.80	11.91
Change GG Self Care	12.17	N/A		12.21	-0.03
Admit GG Mobility	34.40	N/A		34.75	-0.34
Disch GG Mobility	65.39	N/A		65.74	-0.35
Change GG Mobility	30.98	N/A		30.99	-0.00
Admit GG QI	56.94	N/A		57.54	-0.60
Discharge GG QI	100.10	N/A		100.74	-0.64
Change GG QI	43.15	-		43.19	-0.04
LOS Efficiency	3.83	N/A		-	-
PEM Score	-	N/A		-	-
CMI	1.380	N/A		1.37	0.01
# Surveys	2,824			37,523	

Key Care Indicators

FinClassGr oup	#Dschs	DC to Comm	DC to SNF	DC to Acute
Medicare	22803	80.47%	8.93%	9.92%
Non Medicare	15596	79.80%	10.18%	9.43%
	7207	81.92%	6.24%	10.98%

Key Care Indicators

Region	#Dschs	DC to Comm	DC to SNF	DC to Acute	Admit Motor	Admit Self Care	Disch Self Care	Change Self Care	Admit Mobility	Disch Mobility	Change Mobility	A G
CENTRAL	3261	77.58%	10.70%	10.95%	52	23	35	12	36	66	30	
MID ATLANTIC	3258	83.58%	7.43%	8.75%	51	23	35	12	34	68	34	
NORTHEAST	3555	79.58%	9.62%	10.44%	50	22	35	12	35	68	31	
SOUTH CENTRAL	2804	82.31%	6.70%	10.45%	49	22	35	12	34	65	31	
SOUTHEAST	3505	80.31%	9.10%	10.13%	48	22	34	12	32	63	31	
SOUTHWEST	3894	81.18%	8.37%	9.35%	48	22	35	13	33	65	32	
WEST	2526	78.50%	10.73%	9.34%	54	24	35	10	38	65	27	

Care management

KCI Analysis Modifications - Updated 10/1/2019

Current Selections

Fields Values

Region MID ATLANTIC

CMG Stroke

CalendarMonth Jan, Feb

Last Updated : 2/14/2020 4:56:02 AM

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Region

CENTRAL

MID ATLANTIC

NORTHEAST

SOUTH CENTRAL

SOUTHEAST

FinClass

BC/BS

Comm Ins

Mangd Care

Med Adv

Medicaid

Medicare

Other

Self Pay

Wrkrs Comp

RIC

Stroke

Amputation, lower e

Amputation, other

Brain dysfunction, r

Brain dysfunction, t

RefHospital

Wvuh

Peninsula Regional

Richland Memorial/I

McLeod Regional Me

Uva Medical Center

CaseManager

030074 - Chattan...

030077 - Hunting...

030088 - Morgan...

ImpairmentCode

ImpairmentDesc

Select by impairment category (diagnosis)

2017 2018 2019 2020 Q1 Q2 Q3 Q4 Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Year/Month

Key Care Indicators

	Actuals	Target	Variance	2019	PY Var
# Dschs	686			5,243	
DC to Comm	81.78%	78.51%	3.27%	79.76%	2.01%
DC to SNF	9.18%	10.12%	-0.94%	10.05%	-0.87%
DC to Acute	8.45%	10.74%	-2.29%	9.75%	-1.29%
Admit Motor	48.71	N/A		49.30	-0.60
Admit GG SelfCare	21.80	N/A		21.78	0.02
Disch GG SelfCare	33.17	N/A		21.78	11.39
Change GG Self Care	11.37	N/A		11.56	-0.19
Admit GG Mobility	33.64	N/A		34.13	-0.49
Disch GG Mobility	64.51	N/A		64.28	0.23
Change GG Mobility	30.87	N/A		30.15	0.72
Admit GG QI	55.43	N/A		55.91	-0.47
Discharge GG QI	97.68	N/A		97.62	0.06
Change GG QI	42.25	-		41.72	0.53
LOS Efficiency	3.34	N/A		-	-
PEM Score	-	N/A		-	-
CMI	1.605	N/A		1.60	0.01
# Surveys	61			1,000	

Key Care Indicators

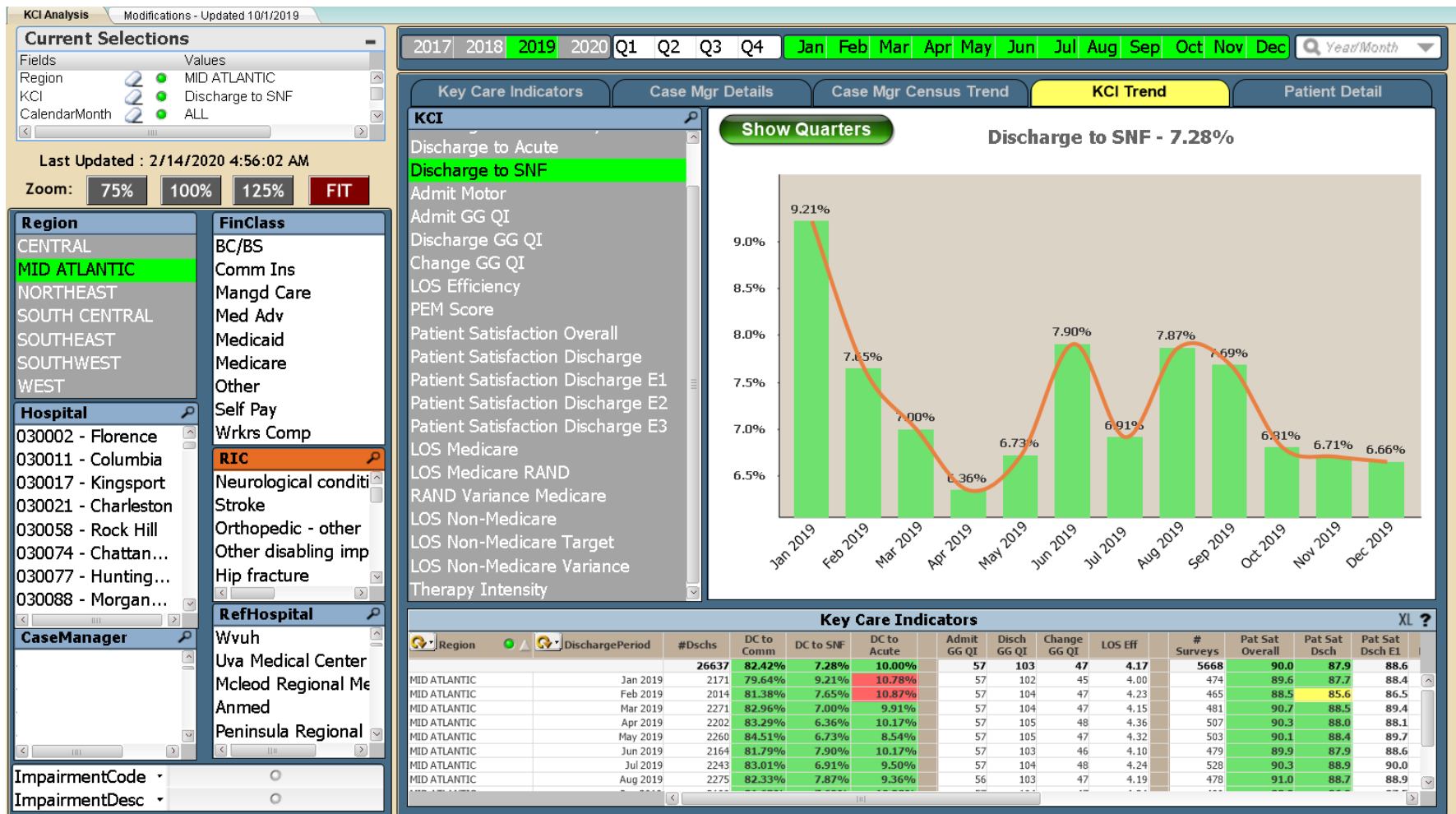
FinClassGroup	#Dschs	DC to Comm	DC to SNF	DC to Acute
	686	81.78%	9.18%	8.45%
Medicare	362	79.56%	11.33%	8.56%
Non Medicare	324	84.26%	6.79%	8.33%

Key Care Indicators

Region	#Dschs	DC to Comm	DC to SNF	DC to Acute	Admit Motor	Admit Self Care	Disch Self Care	Change Self Care	Admit Mobility	Disch Mobility	Change Mobility	Adm GG
	686	81.78%	9.18%	8.45%								
MID ATLANTIC	686	81.78%	9.18%	8.45%	49	22	33	11	34	65	31	

Care management

Trend individual quality metrics by month or quarter



Care management

KCI Analysis Modifications - Updated 10/1/2019

Current Selections

Fields Values

Hospital 030011 - Columbia

Region MID ATLANTIC

CalendarMonth ALL

Last Updated : 2/14/2020 4:56:02 AM

Zoom: 75% 100% 125% FIT

Region

CENTRAL

MID ATLANTIC

NORTHEAST

SOUTH CENTRAL

SOUTHEAST

SOUTHWEST

WEST

Hospital

030011 - Columbia

030002 - Florence

030017 - Kingsport

030021 - Charleston

030058 - Rock Hill

030074 - Chattan...

030077 - Hunting...

030088 - Morgan...

FinClass

BC/BS

Comm Ins

Mangd Care

Med Adv

Medicaid

Medicare

Other

Self Pay

Wrkrs Comp

RIC

Stroke

Neurological conditi

Orthopedic - other

Other disabling imp

Hip fracture

RefHospital

Richland Memorial/I

Lexington Medical

Baptist Medical/Pris

Richland Heart/Pris

Providence

CaseManager

ImpairmentCode

ImpairmentDesc

2017 2018 2019 **2020** Q1 Q2 Q3 Q4 Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Year/Month

Key Care Indicators

	Actuals	Target	Variance	2019	PY Var
# Dschs	246			2,052	
DC to Comm	81.71%	79.00%	2.71%	83.58%	-1.87%
DC to SNF	8.54%	10.00%	-1.46%	8.92%	1.62%
DC to Acute	9.76%	10.50%	-0.74%	9.50%	0.25%
Admit Motor	53.12	N/A		53.81	-0.69
Admit GG SelfCare	23.70	N/A		24.40	-0.70
Disch GG SelfCare	35.51	N/A		24.40	11.11
Change GG Self Care	11.81	N/A		11.26	0.55
Admit GG Mobility	35.80	N/A		34.47	1.33
Disch GG Mobility	66.19	N/A		65.18	1.01
Change GG Mobility	30.39	N/A		30.71	-0.32
Admit GG QI	59.50	N/A		58.87	0.63
Discharge GG QI	101.70	N/A		100.84	0.86
Change GG QI	42.20	-		41.97	0.23
LOS Efficiency	3.75	N/A		-	-
PEM Score	-	N/A		-	-
CMI	1.338	N/A		1.32	0.02
# Surveys	25			363	

Patient Satisfaction by CM

Region	CaseManager	Year	Month	# Surveys	Pat Sat Overall	Pat Sa Dsch
MID ATLANTIC		2020	Jan	3	88.1	84
MID ATLANTIC		2020	Feb	1	98.2	100
MID ATLANTIC		2020	Jan	3	89.7	86
MID ATLANTIC		2020	Jan	1	83.2	75
MID ATLANTIC		2020	Feb	2	96.6	91
MID ATLANTIC		2020	Jan	5	91.4	88
MID ATLANTIC		2020	Jan	5	93.3	81
MID ATLANTIC		2020	Jan	4	86.6	70
MID ATLANTIC		2020	Feb	1	99.5	100

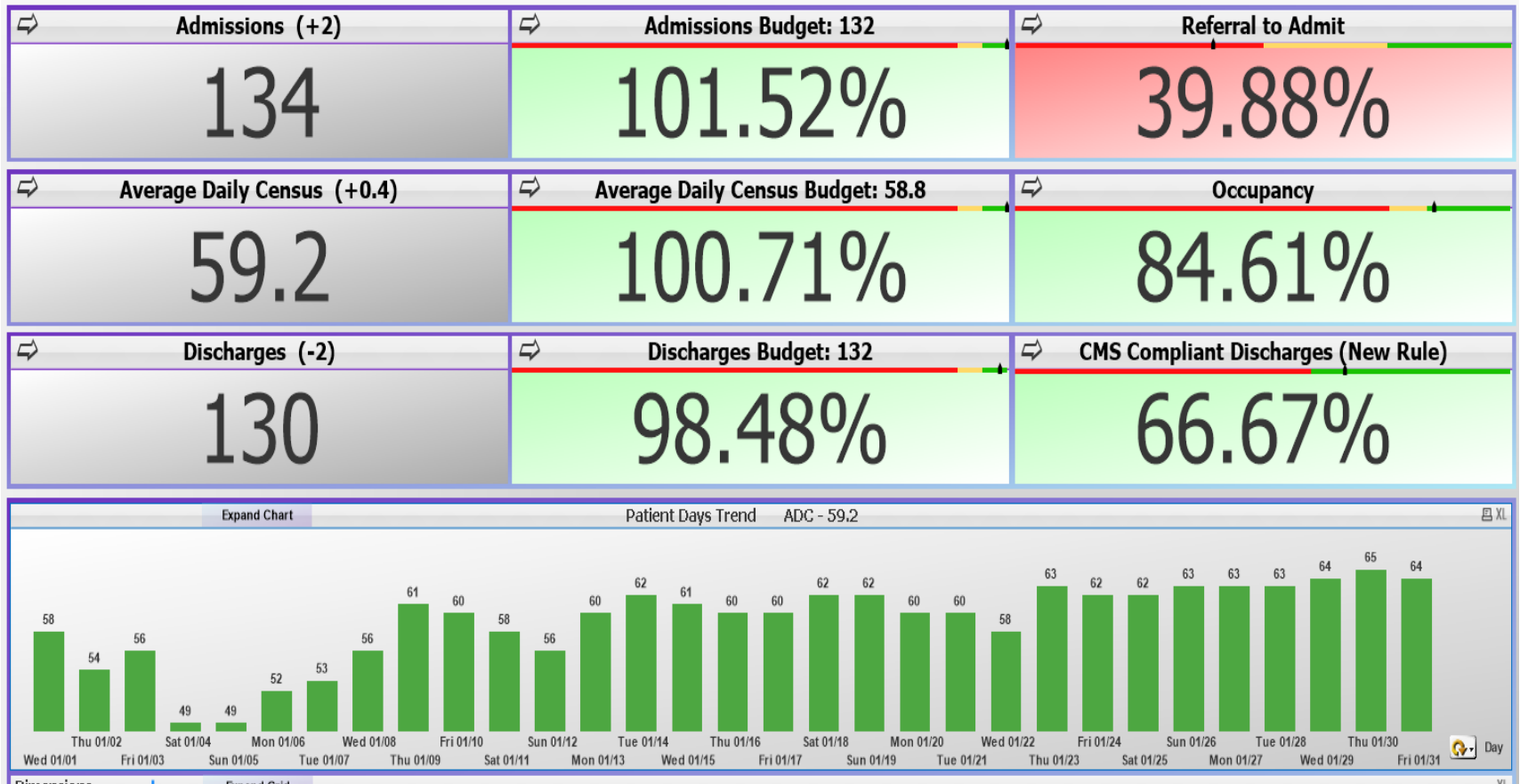
Key Care Indicators by CM

Region	CaseManager	Discharge Period	#Dschs	DC to Comm	DC to SNF	DC to Acute	Admit Motor	Admit Self Care	Disch Self Care	Change Self Care	Admit Mobility	Disch Mobility	Change Mobility
MID ATLANTIC		Jan 2020	32	87.50%	6.25%	6.25%	52	23	35	12	34	62	28
MID ATLANTIC		Feb 2020	17	88.24%	11.76%	0.00%	54	22	34	12	37	67	30
MID ATLANTIC		Jan 2020	29	68.97%	3.45%	27.59%	51	25	35	10	34	62	27
MID ATLANTIC		Feb 2020	8	87.50%	0.00%	12.50%	63	27	41	14	42	79	37
MID ATLANTIC		Jan 2020	34	79.41%	8.82%	11.76%	53	23	36	13	36	67	31
MID ATLANTIC		Feb 2020	15	73.33%	20.00%	6.67%	48	22	35	13	32	65	33
MID ATLANTIC		Jan 2020	29	86.21%	6.90%	6.90%	57	25	37	12	38	68	29
MID ATLANTIC		Feb 2020	11	72.73%	18.18%	9.09%	51	24	36	12	38	67	29
MID ATLANTIC		Jan 2020	28	82.14%	10.71%	7.14%	55	25	35	10	36	67	30
MID ATLANTIC		Feb 2020	6	83.33%	0.00%	16.67%	67	28	40	12	39	76	36

Patient level outcomes combined by case manager

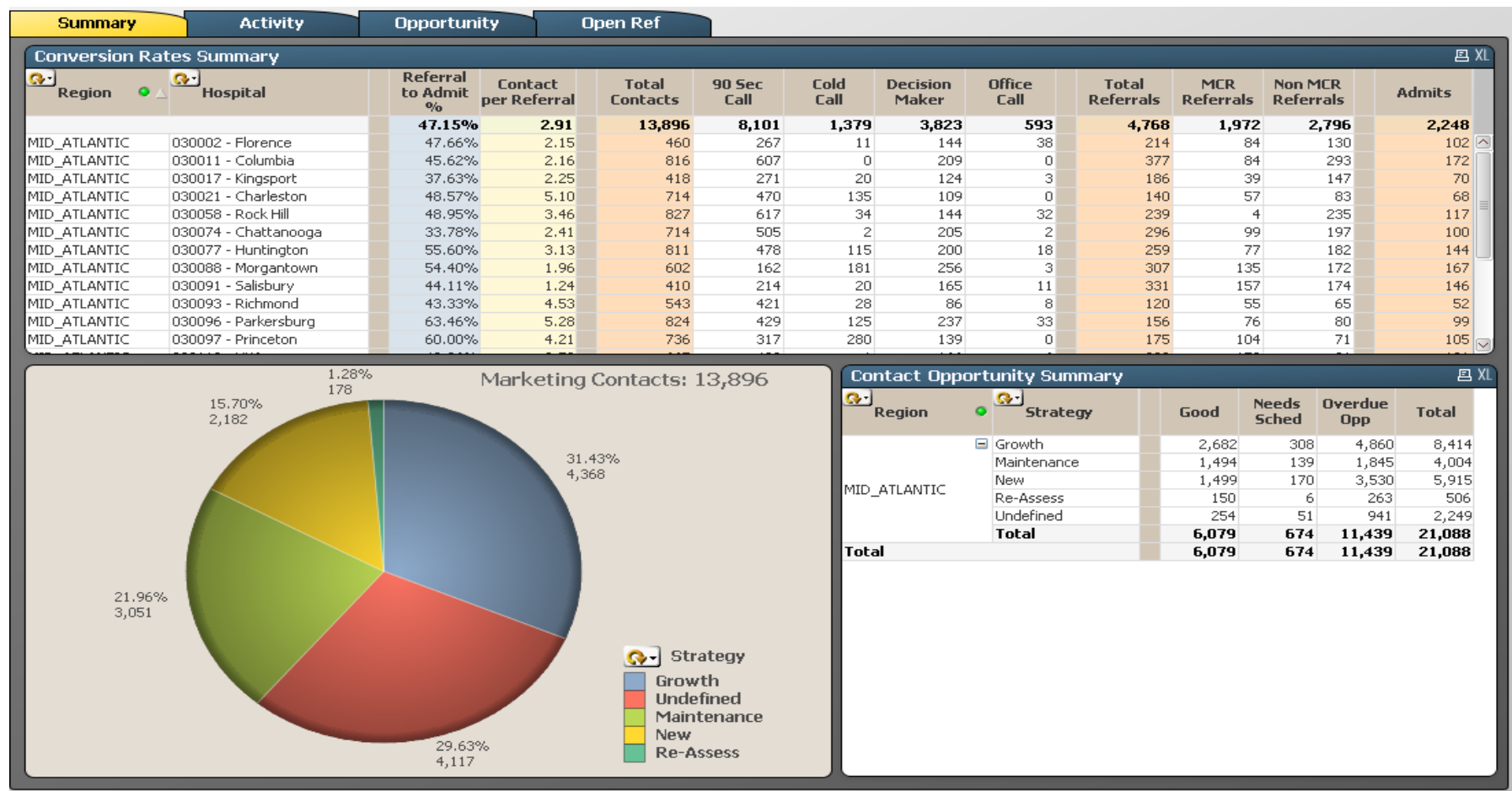
Hospital business development (volume analysis)

High level overview of hospital level volume performance versus budget

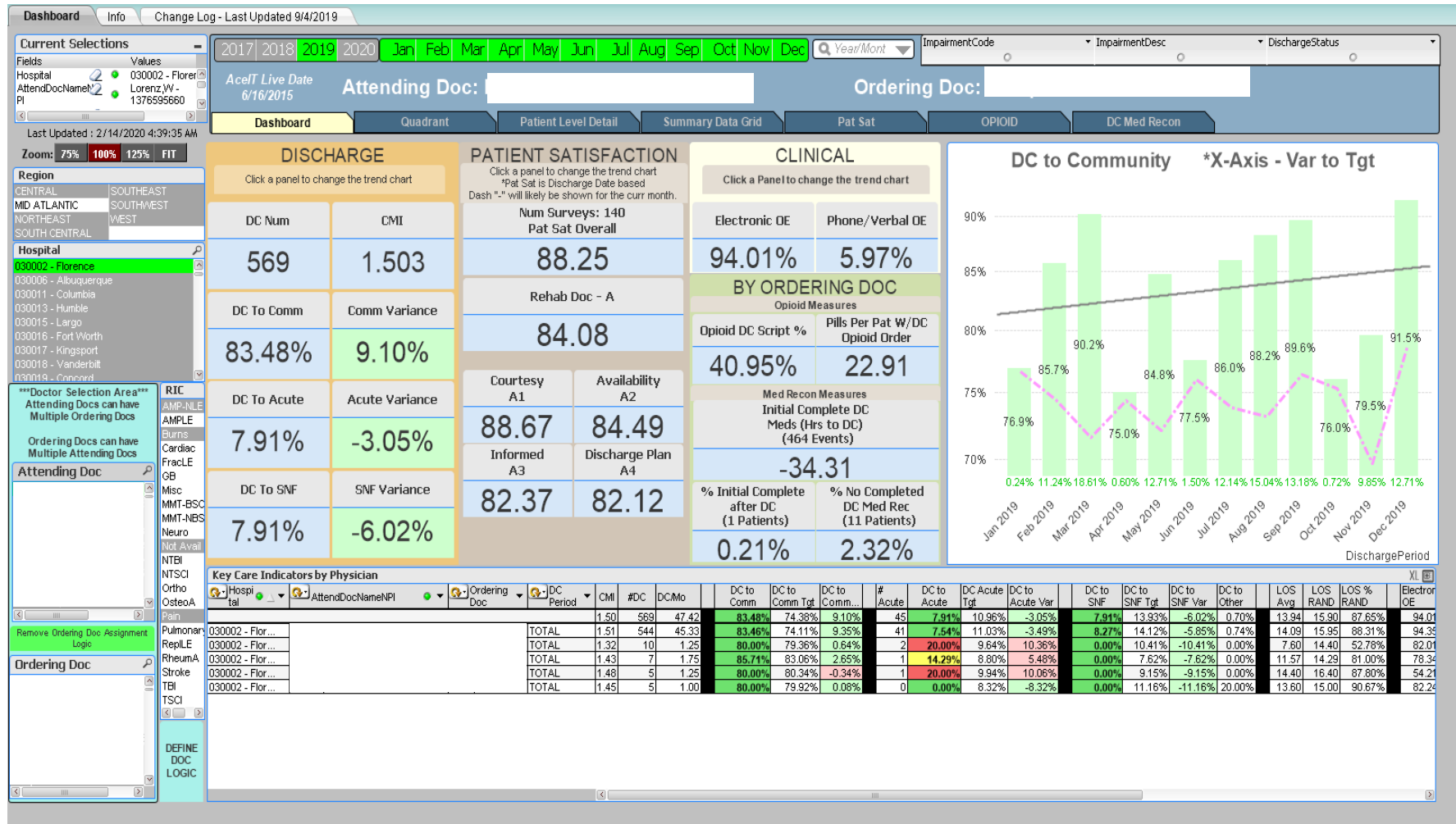


Hospital business development (sales and marketing)

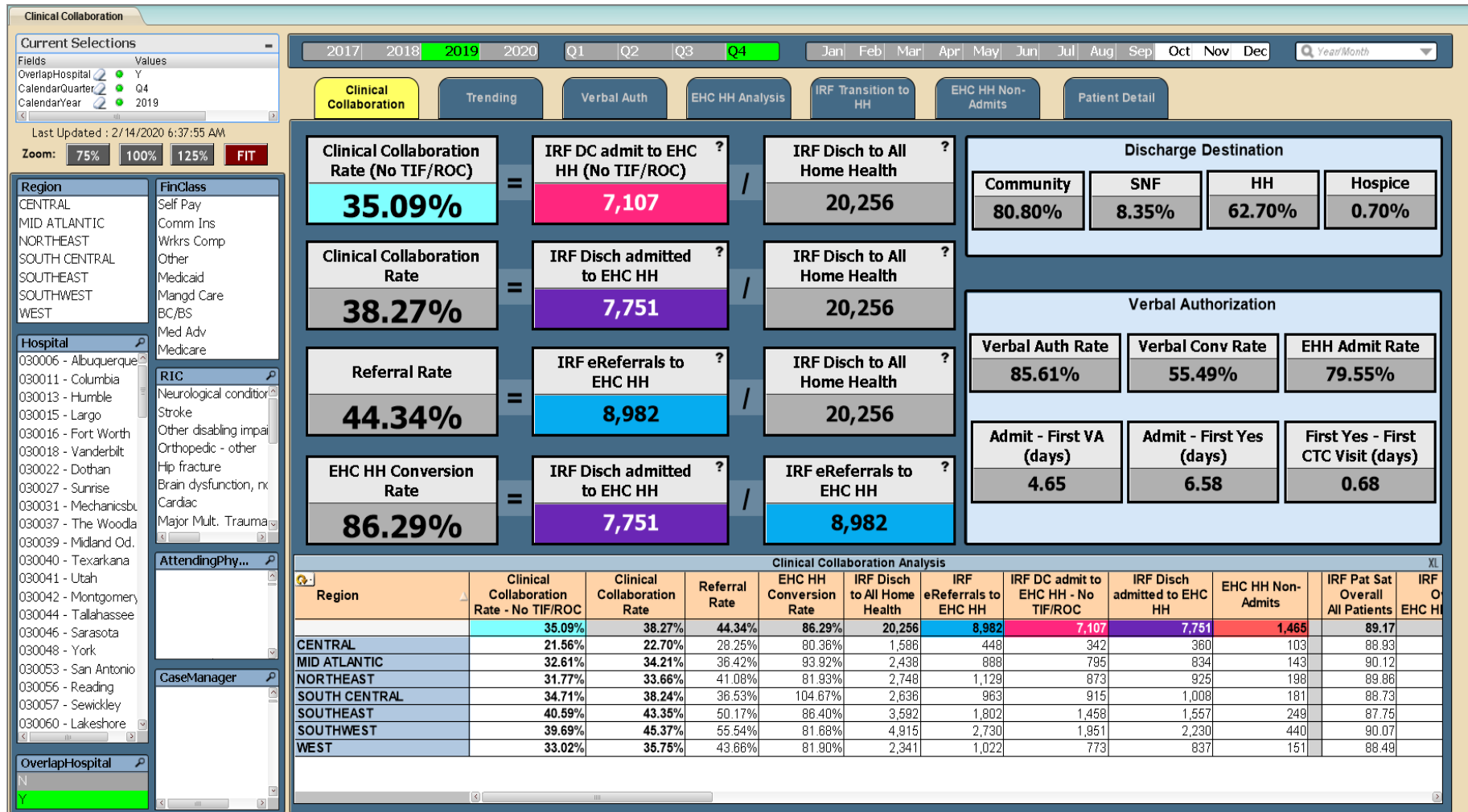
Demonstrates how contacts are impacting referrals and admissions



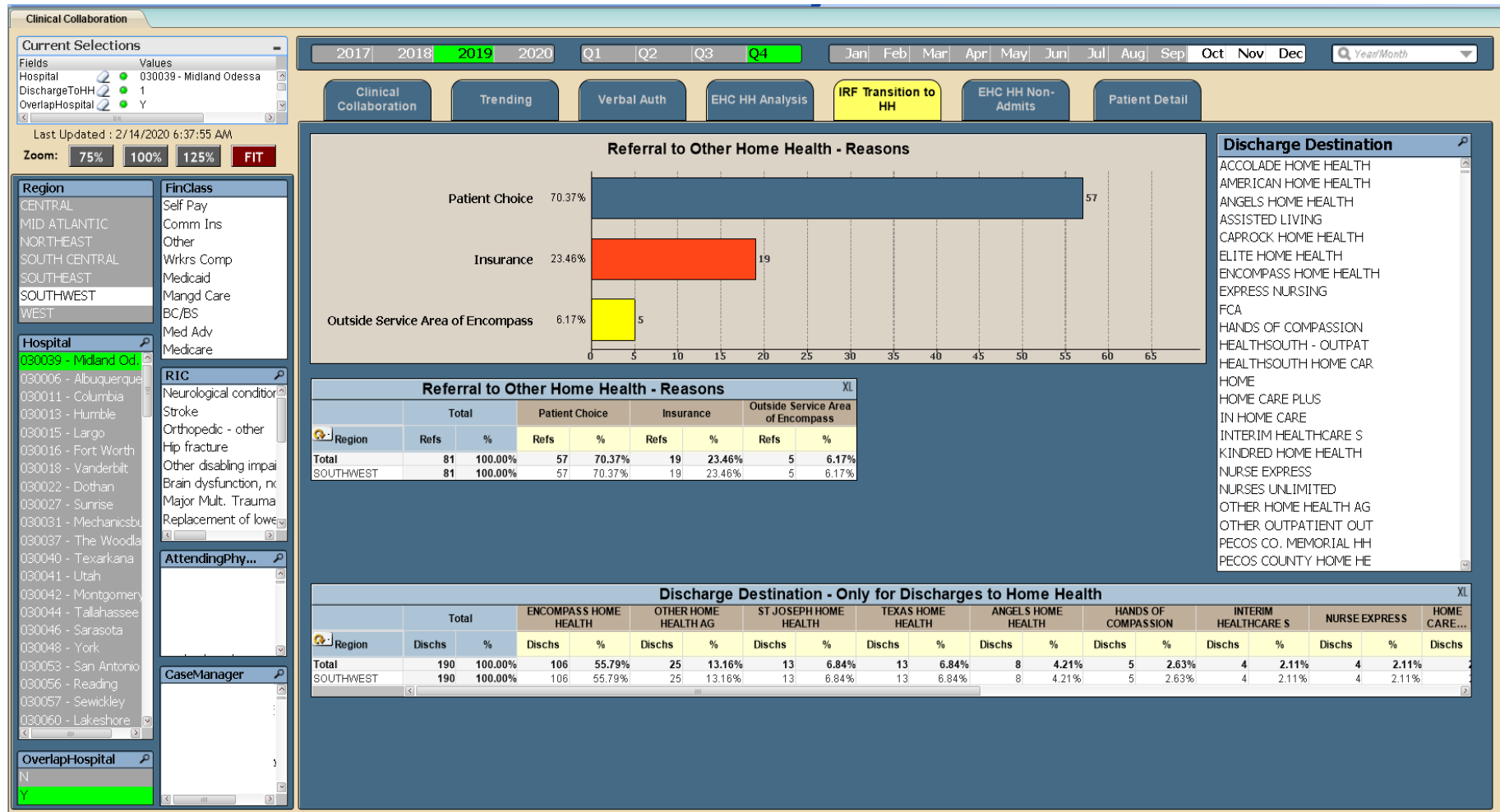
Physician dashboard



Clinical collaboration



Clinical collaboration



Clinical collaboration - integrated care drives quality metrics

Of the **89** overlap markets, **34** are at collaboration rates of **40%** or higher.

Score increases			
	Overall satisfaction	Discharge satisfaction	Discharge to community
Overlap	2.27 pts	2.26 pts	110 bps
Non overlap	0.71 pts	0.67 pts	80 bps



Clinical Collaboration

Home Health

Presented by April Anthony
and Luke James



Overview - Home Health



4th largest provider of Medicare-certified skilled home health services



245

Home Health locations

31

States



89

overlap markets with
Encompass Health
Rehabilitation
Hospitals

82%

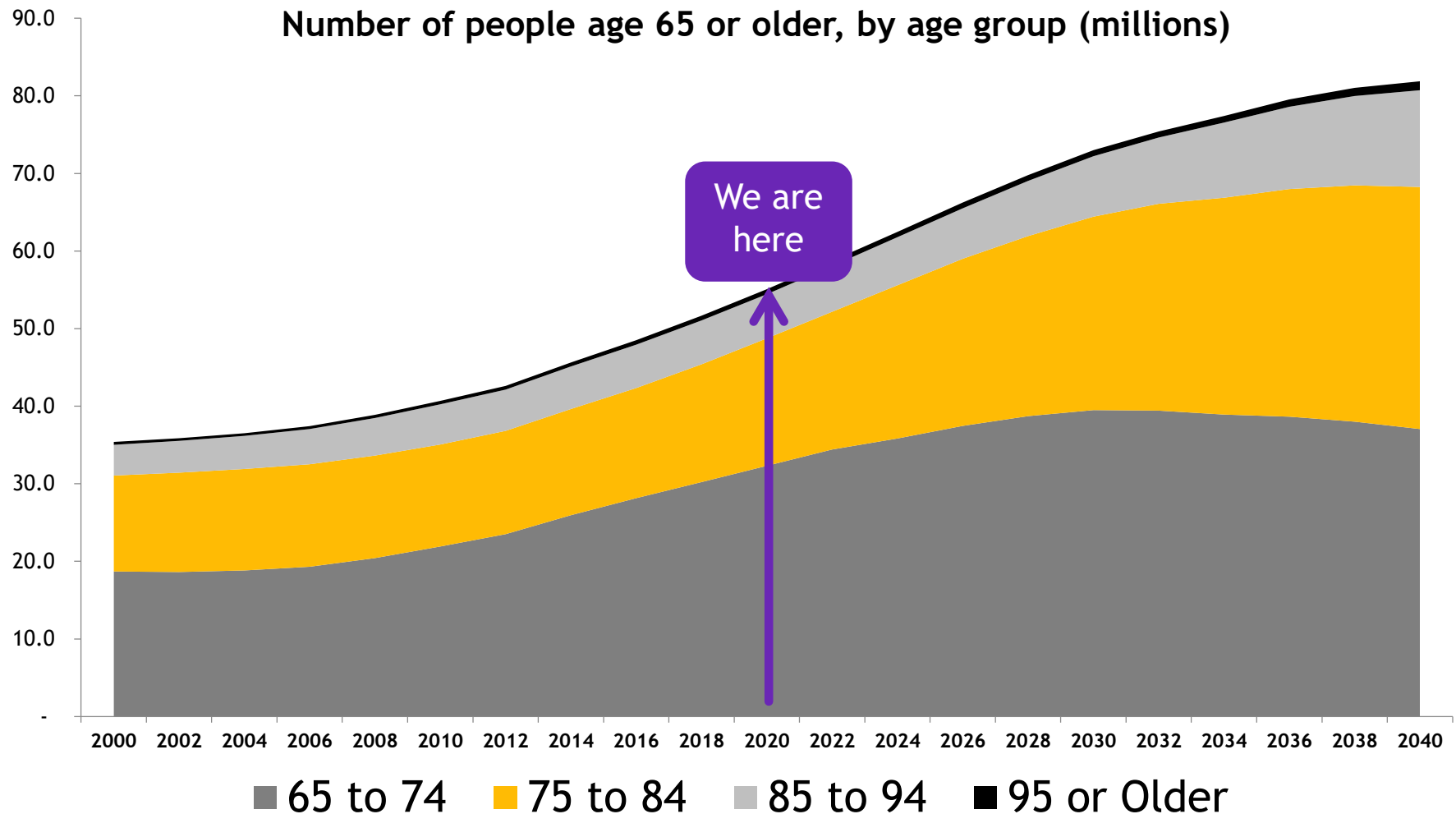
of revenue is Medicare

~9,900
employees

~159,700
home health
admissions

~\$900 million
revenues

Why we are excited about Home Health



Why we are excited about Home Health

Growing % of seniors are experiencing chronic conditions

Currently, **36%** of Medicare beneficiaries have **4+** chronic conditions and consume **75%** of Medicare spending.

Why we are excited about Home Health

Cost Efficiency of Home Health Care

Post-Acute Service Sector	Annual Medicare Spending	Medicare Cost Per Day
Skilled Nursing Facilities (SNF)	\$28.4 billion	\$490
Hospice	\$17.9 billion	\$168
Home Health	\$17.7 billion	\$47

Why we are excited about Home Health

Patient Preference for Home Health Care

9 in 10 American seniors
want to age at home

How we grow



Clinical Collaboration

14% of admits

- Clinical collaboration rate for Medicare is 43%



Care Transitions

34% of admits

- Care Transitions Coordinators
- High-quality outcomes, low re-hospitalization rates



Specialty Programs

32% of admits

- Heart & Vascular
- Joint & Ortho
- Community Care



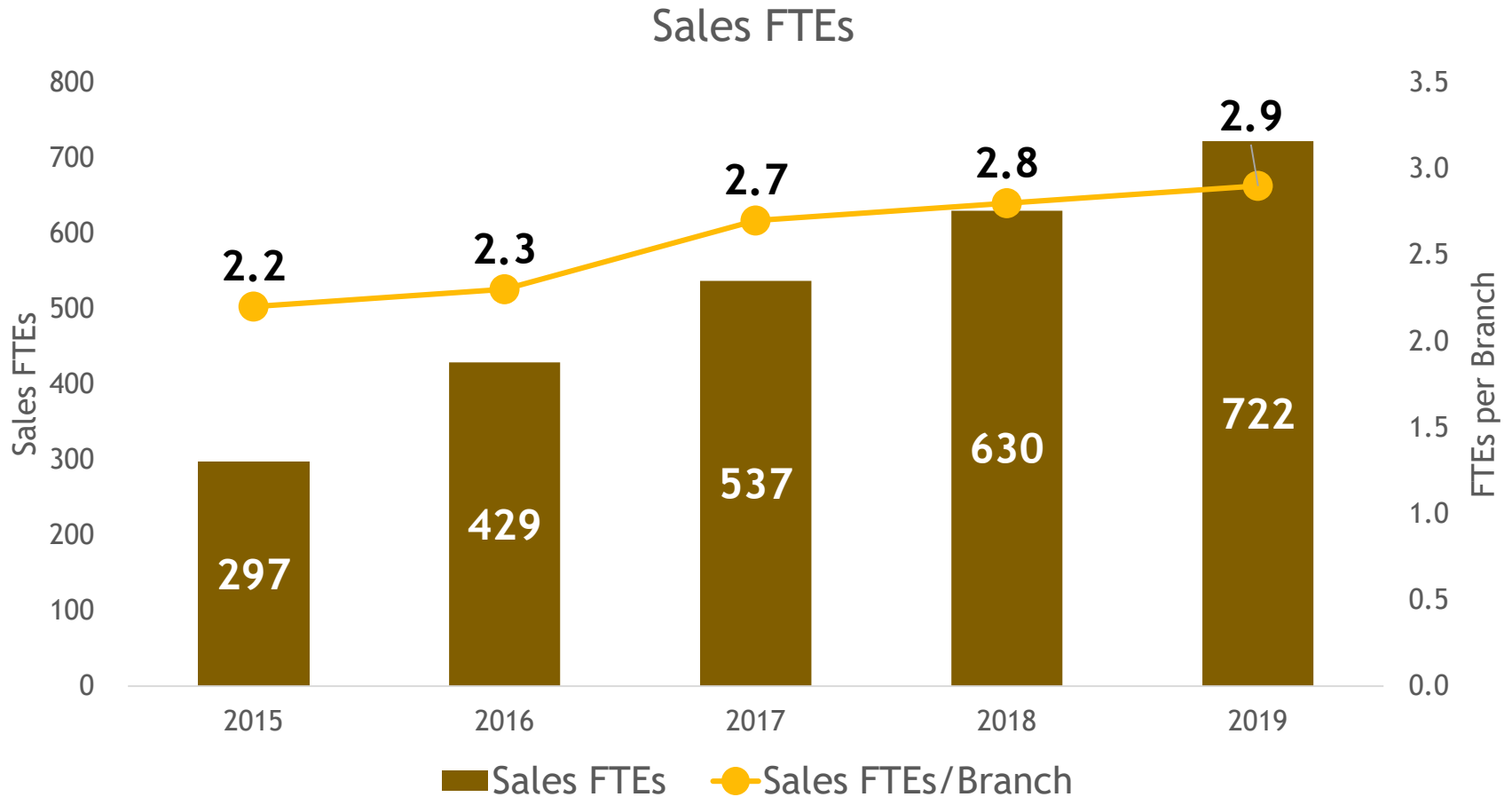
Traditional Referrals

20% of admits

- Internal Medicine
- Family practice
- Gerontology

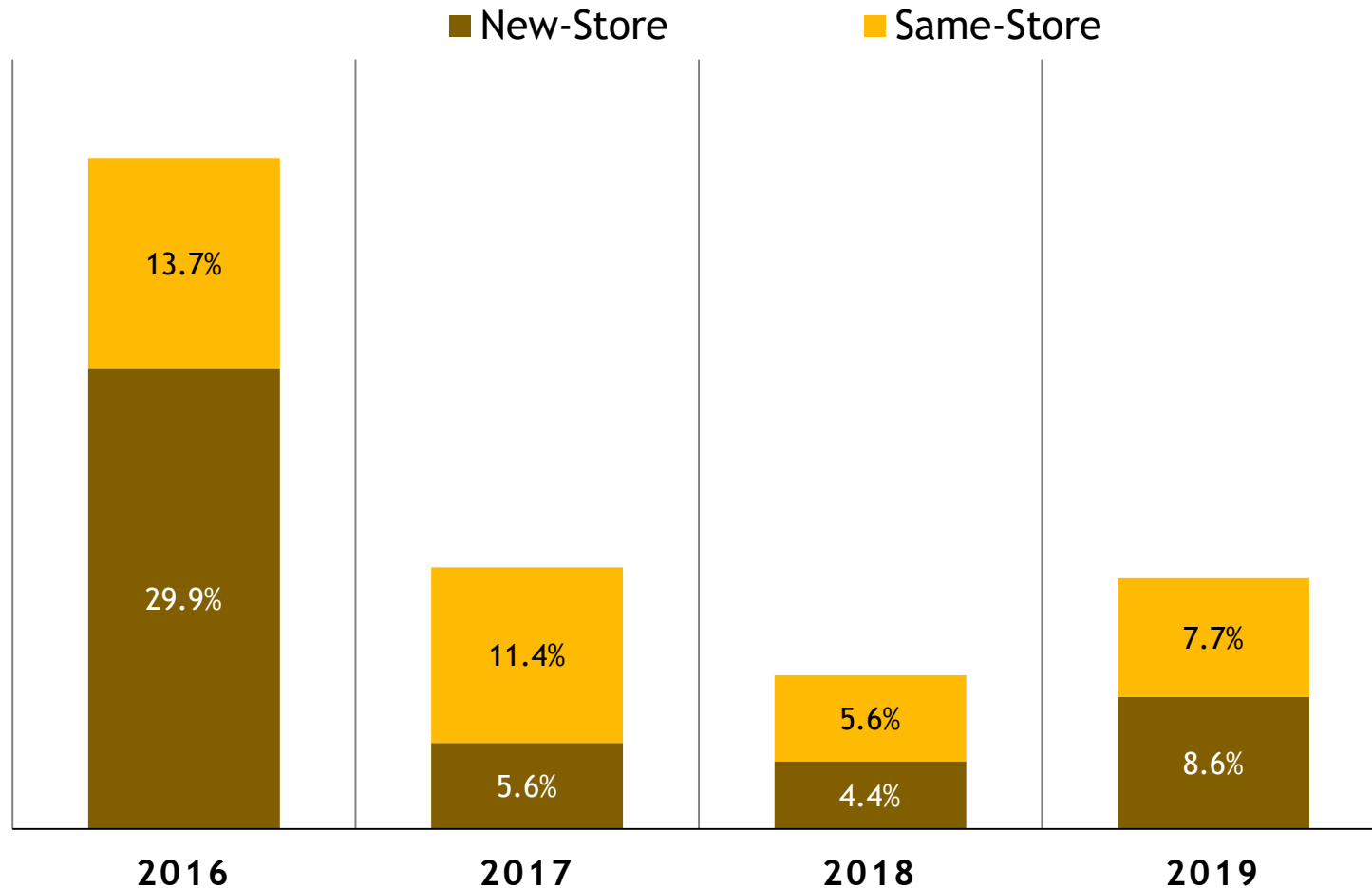
How we grow

Total EHC Home Health Sales Personnel



The results of our efforts

New-Store/Same-Store Growth*



How we expand

Proven Track Record of Successful Acquisitions and Integrations

	As of Date of Acquisition			As of Q4 2019	
Year of Acquisition	Purchase Price (millions)	Annual Revenue (millions)	EBITDA Multiple	Annual Revenue (millions)	EBITDA Multiple
2015	\$200.7	\$145.9	7.9	\$186.7	4.5
2016	\$48.5	\$42.6	6.2	\$52.7	3.3
2017	\$24.5	\$24.6	6.4	\$25.5	4.3
2018	\$147.6	\$87.2	10.0	\$85.7	9.3
Total	\$421.3	\$300.3	8.1	\$350.6	5.2

Expanding sophistication in care management

Clinical decision support tools that ensure better and more consistent outcomes

Prompts continued touch points with discharged patients to identify and prevent post-discharge hospitalizations

Nurture

Proactively identifies home health patients who are potentially better suited and eligible for the hospice benefit

Bridge

Medalogix Modules

Risk stratifies the patient population based on hospitalization risk and utilizes interactive voice response to increase touch points with high risk patients

Touch

Recommends a patient-centered visit utilization plan that optimizes care to promote discharge to community without hospitalization

Care

Dedicated Care Management Team provides support via non-visit based interventions

MRN981712670

Patient Name

71 Years Male

EPISODE DATES

2/16/20 4/15/20

Data processing completed 2/17/20 at 5:00 AM
OASIS update processed on 2/9/2020 at 5:00 AM

Recommendation

24 Visits

11 Therapy - 13 Nursing

Based on the current OASIS assessment, patient should receive a total of 24 visits across all disciplines for this 60 day certification period.

Are you finalizing the visit frequency now?

Yes

No

Current Episode Details

Episode Type	Primary Diagnosis	OASIS Author	Case Manager	Branch	Payor	HHRG	Physician
Start of Care	Z47.1 - Aftercare following joint replacement surgery	PRICE, SHERI		TER - ALEXANDRIA, LA HOME HEALTH (TER)	MEDICARE: PALMETTO-PDGM		Physician Name

Note

- DISCIPLINES INVOLVED:
- DOCUMENT DETAILS RELATED TO EXCEPTION:
- ADDITIONAL COMMENTS REGARDING CARE TEAM COLLABORATION THAT OCCURRED (NOT ALREADY DOCUMENTED):

Note: Medalogix Care is a predictive analytics tool that uses information collected by the assessing clinician during the Start of Care or the Resumption of Care visit to provide a recommended number of visits and discipline mix. It is designed to assist home health clinicians and providers in their decision-making. It is not intended to, and should not, replace the clinical judgment of the agency or the clinician.

☒ Send to HCHB

Cancel

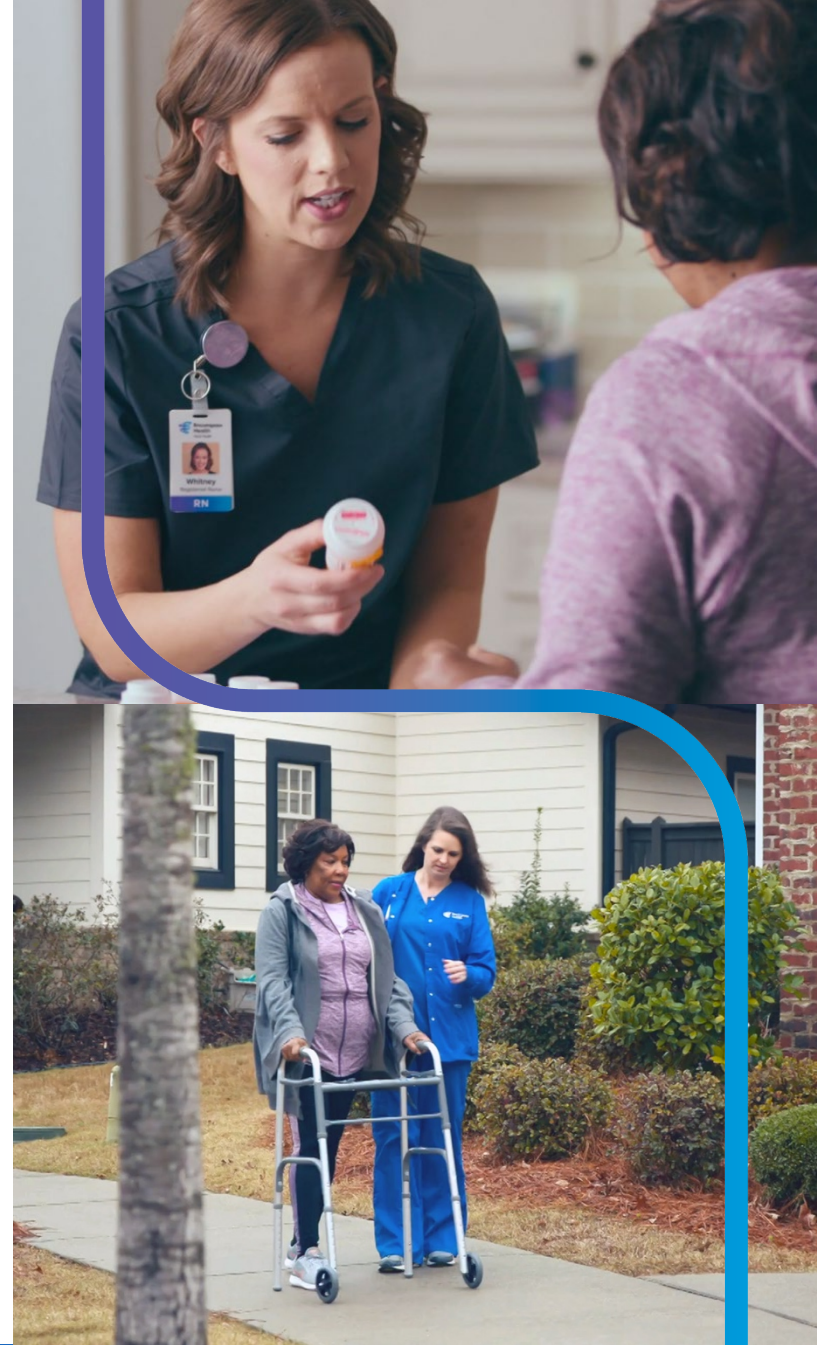
Save

How therapy changes at home

Medicine reconciliation allows us to see what the patient is really taking and train them to take the correct medicines

Therapy is no longer about high-tech equipment but rather about navigating the patient's home and surrounding environment

Teaching and training extends to the caregiver and patient support network



Technology-enabled outcomes

Homecare Homebase is an exceptional tool. We make it more effective by our disciplined use and response to the guidance and information it provides.



Produces
operational
efficiency



Promotes
clinical
consistency



Ensures
compliant
processes

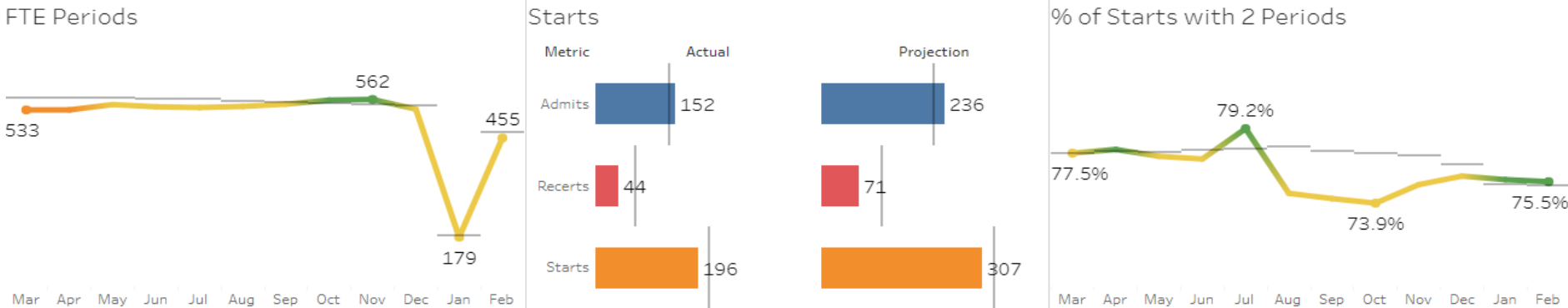


Enhances
financial
opportunity

Real-time dashboard tools in Homecare Homebase

Home Health Medicare Key Metrics (PDGM Preview)

FTE Periods	Starts	Rev per Period	Visits per Period	Rev per Visit	Est. GM per Period	LUPA %
455 -3.3%	307 -6.9%	\$1,819 -4.0%	12.3 -5.9%	\$147 -16.8%	\$878 -10.3%	6.0% +0.3%



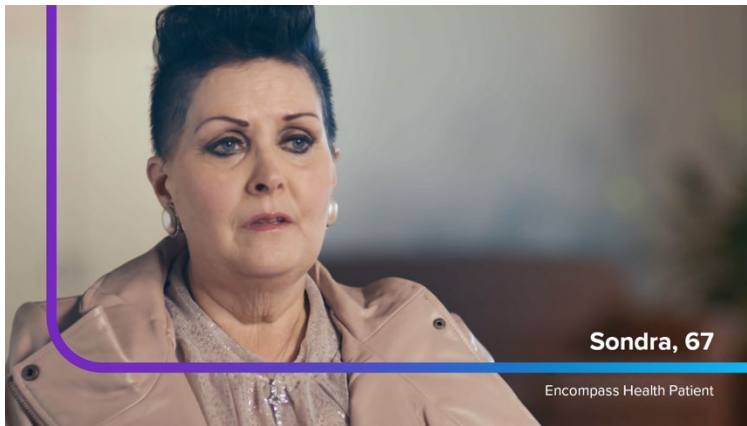
Efficiency (Non-LUPA)

Category	FTE Mix	Revenue per Period	Visits per Period	Revenue per Visit	Est. GM per Period
(All)	94.0%	\$1,916	13.0	\$147	\$929
Community Early	24.7%	\$2,125	13.0	\$163	\$994
Community Late	41.2%	\$1,419	10.4	\$136	\$759
Institutional Early	26.6%	\$2,463	16.8	\$147	\$1,123
Institutional Late	1.5%	\$2,428	18.9	\$128	\$1,070

Efficiency (LUPA)

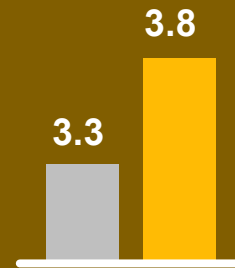
Category	FTE Mix	Revenue per Period	Period 1 %	Period 2 %
(All)	6.0%	\$297	54.6%	45.5%
Community Early	2.4%	\$341	100%	0%
Community Late	2.1%	\$168	27.3%	72.7%
Institutional Early	1.1%	\$483	100%	0%
Institutional Late	0.5%	\$196	0%	100%

Outcomes



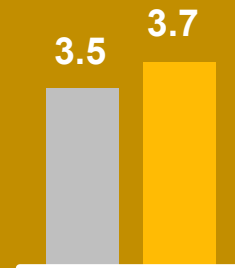
HOME HEALTH QUALITY


Quality of
Care
Star Ratings



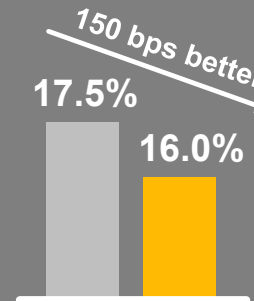
99% of our home health agencies are **3** Stars or higher;
47% are **4** Stars or higher


Patient
Satisfaction
Star Ratings



95% of our home health agencies are **3** Stars or higher;
62% are **4** Stars or higher


30-Day
Readmission
Rate



Percent of patients readmitted to an acute care hospital.
Lower is better.

 National average  Encompass Health

Best place to work culture

FORTUNE
100
BEST
COMPANIES
TO WORK FOR®
===== 2016 =====

FORTUNE
100
BEST
COMPANIES
TO WORK FOR®
===== 2017 =====

FORTUNE
100
BEST
COMPANIES
TO WORK FOR®
===== 2018 =====

FORTUNE
100
BEST
COMPANIES
TO WORK FOR®
===== 2019 =====

FORTUNE
100
BEST
COMPANIES
TO WORK FOR®
===== 2020 =====

Modern Healthcare
BEST PLACES TO WORK™
2012 2013 2014 2015 2016 2017 2018 2019



2020+: Evolving payment models and payor relationships



PDGM requires the combination of accurate coding and assessment, efficient care planning and effective care delivery



RCD will require thorough upfront processes including timely face-to-face and timely document signatures



Expansion in non-Medicare payor relationships



Evolving payment models will benefit providers like EHC and we are already leading the way

Keys to success in Patient-Driven Groupings Model (PDGM)

Focus Area	Need	Result
Referral Documentation	Complete referral information from every referral source	‘Whole picture’ information for better coding & care planning
Coding & Assessment	Precise information collected in the home	Enhanced ability to care plan and bill for correct reimbursement
Care Planning	Proven evidence-based tools in the hands of clinicians	Individualized care plans for every patient, every episode
Care Delivery	Equipped, passionate caregivers	Best-in-class clinical and patient satisfaction outcomes

2020+ Review Claim Demonstration (RCD)

RCD Changes

Potential delays in cash flow as information is collected and submitted

Significantly reduced risk of post-payment audits on affirmed episodes

Strategies for Success

1

Gather robust, timely referral information (face-to-face documentation)

2

Prompt correction of errors in claims and resubmission for full payment

3

Automated workflow ensuring consistency while minimizing administrative burden

2020+ Growth in non-Medicare payor mix

Our Approach

included **value-based** arrangement concepts since 2019

achieve **desired growth rates** with current payors

acceptable rates & terms with all applicable payors

Examples of differentiators



Largest home health participant in the initial BPCI Model 3 & produced **significant savings** in that program



For over 5 years, we have been paid a capitated rate for home health services across multiple markets covering **~70,000 MA lives**



Leading the way in **hospitalization rates** positions us to bring the most value to MA payors by keeping their members safely in their homes.

Hospice

Presented by April Anthony



Overview - Hospice



11th largest provider of Medicare-certified hospice services



83
Hospice
locations

18
States



77

overlap markets with
Encompass Health
Home Health

98%
of revenue is Medicare

~1,900
employees

~10,500
admissions

~\$200 million
revenues

How we grow

Demographics and cost efficiency

Increasing patient and family preference

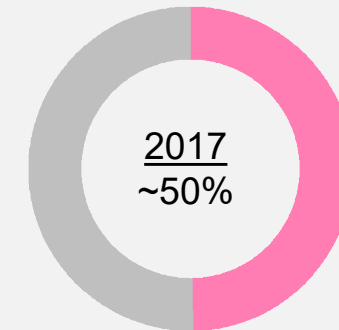
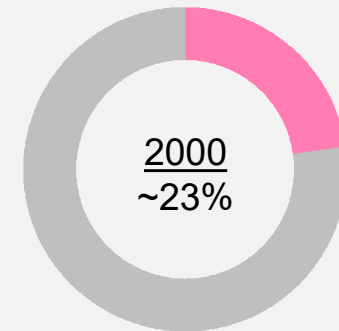
Opportunity to serve a larger percentage of Medicare beneficiaries and begin treatment earlier in their end of life process

Grow the scale of our currently small hospice branches
(average branch census ~45)

Open more de novo locations in our non-overlap markets and leverage infrastructure and reputation

Continue to participate in industry consolidation

% of Medicare beneficiaries using hospice



Of the 50% who utilized hospice services in 2017, approximately 28% died in the first seven days of care.

Financial Strategy

Presented by Doug Coltharp



Growth requires investment.



Investment requires funding.

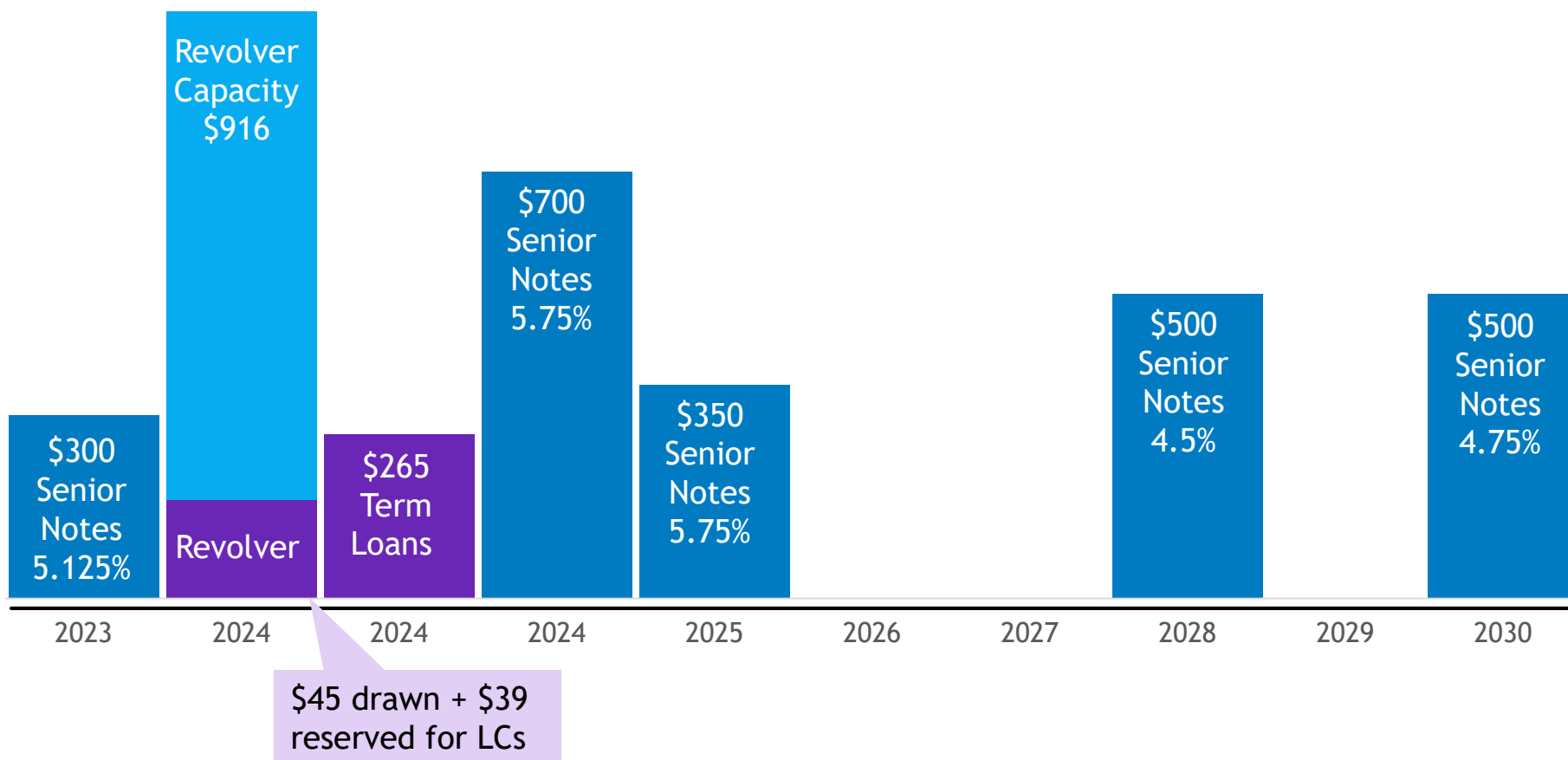
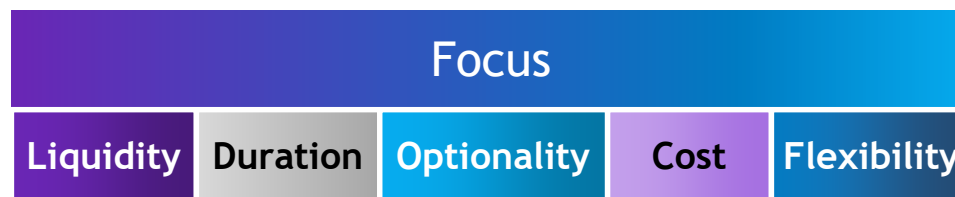
Managing the balance sheet to support our growth

As of December 31, 2019*

Leverage Ratio: 3.2x

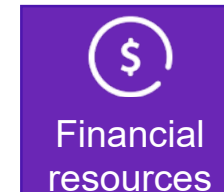
Total Liquidity: \$1.0 billion

(\$ in millions)



Managing the balance sheet to support our growth

Comparison of YE 2018 to YE 2019



Liquidity

- Increased revolving credit facility from \$700M to ~\$1.0B

Duration

- Bank credit facilities extended 2+ years
- Average remaining maturity of senior notes extended from ~6 years to ~7 years

Optionality

- Exercised call on 2024 senior notes to reduce refinancing risk

Cost

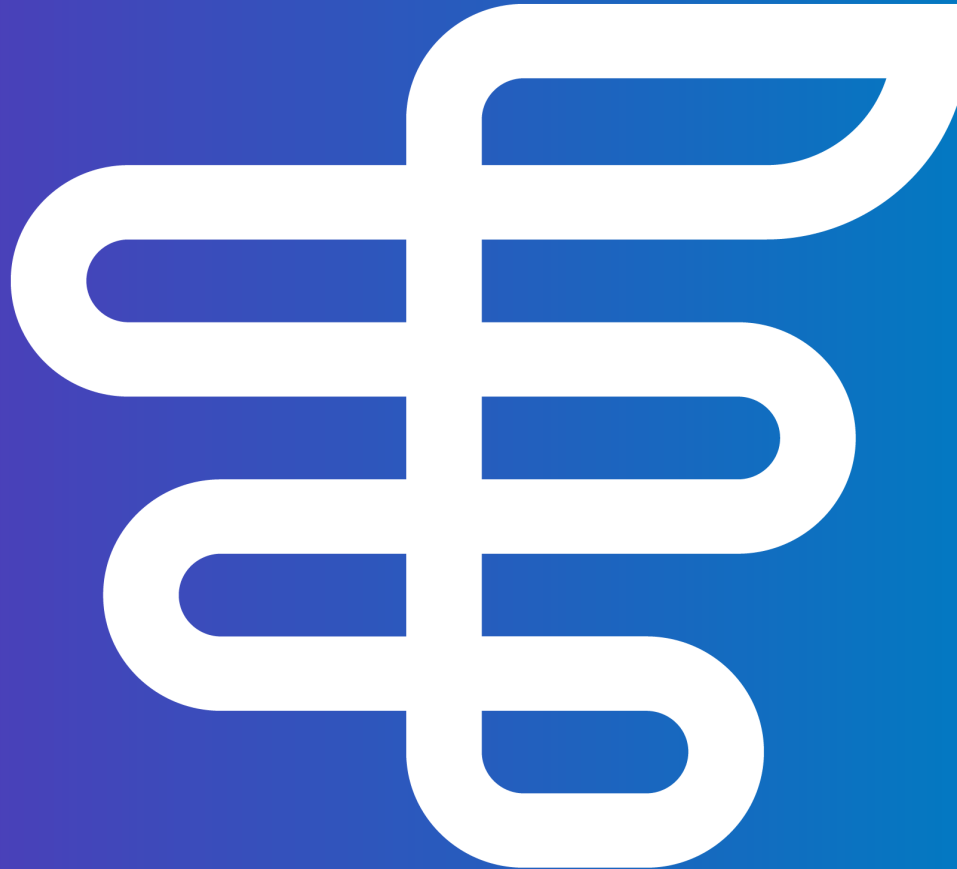
- Both tranches of new senior notes priced below 5.00%
- Favorable rate arbitrage on call of 2024 notes

Flexibility

- Enhanced flexibility of bank credit facility covenants

Summary

Presented by Mark Tarr



Key takeaways



Our **integrated care model** produces the high-quality, cost-effective care desired by providers, payors, and patients.



We use **technology** to leverage and enhance our clinical and business processes.



We are executing our **growth strategy** to meet the needs of an aging population.

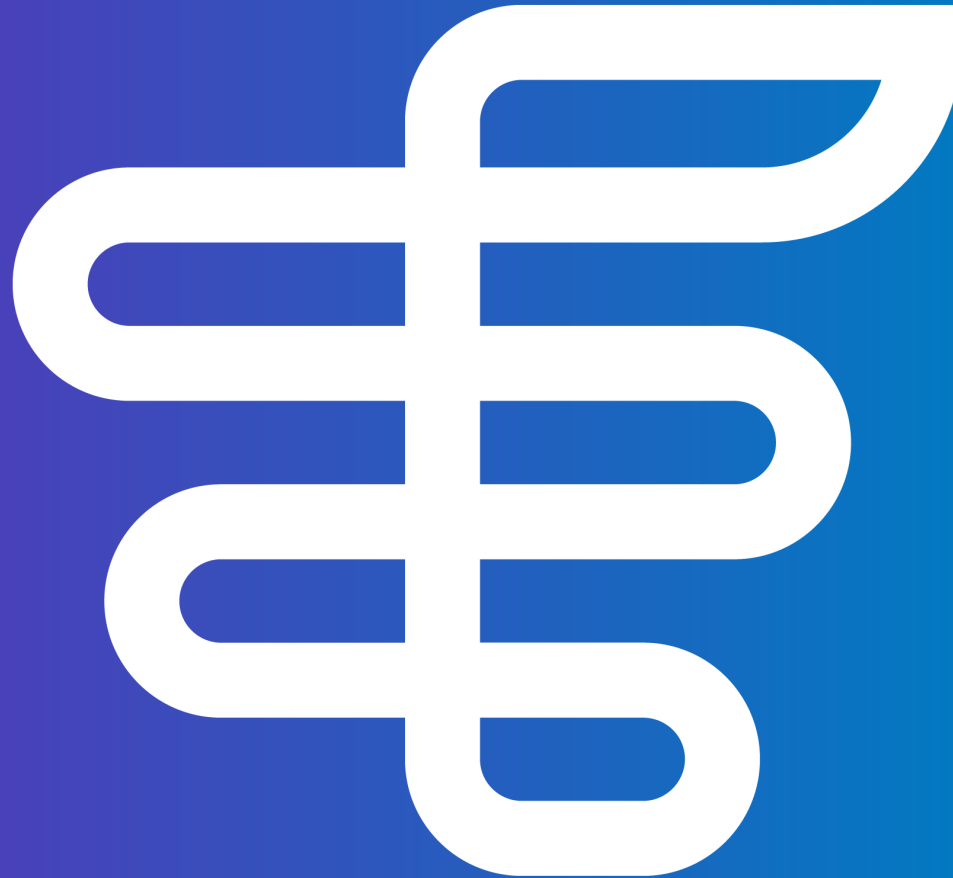
Q&A

Moderated by Crissy Carlisle



Closing Remarks

Presented by Crissy Carlisle





Video



Committed to delivering integrated high-quality, cost-effective care across the healthcare continuum