Company Name: Encompass Health Corporation (EHC)
Event: William Blair 40th Annual Growth Stock Conference
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<<Matthew Larew, Analyst, William Blair & Company LLC>>

Okay. Good afternoon. My name is Matt Larew, and I'm the healthcare delivery and services analyst here at William Blair who covers Encompass Health. The Encompass Health really is the clear market leader in inpatient rehabilitation and is a growing network of home health and hospice agencies built around its rehab hospitals.

I'm joined today by President and CEO, Mark Tarr; CFO, Doug Coltharp. I think many of you know, Crissy Carlisle from Investor Relations as well. A brief compliance note, I'm required to inform you that for a complete list of research disclosures or potential conflicts of interests, please visit our website at williamblair.com.

So Mark, maybe I just wanted to start giving this as a generalist gross stock conference and actually the 40th Annual William Blair Growth Stock Conference. Maybe you could provide us a quick overview of the business as there may be a few folks on the call with us today who are not familiar.

<<Mark J. Tarr, President & Chief Executive Officer>>

Sure, Matt, and thanks all of you for joining us today. Just quick comments on who Encompass Health is and the industries that we're involved with. We are a leading provider of post-acute services. We report out on two operating segments, which contain a total of three different service lines. Our first segment is made up of inpatient rehabilitation hospitals. The second segment is made up of home health and hospice. Each of these industries has the characteristic of being highly fragmented with many small providers. We are one of the few that have scale. We're the largest owner and operator in the IRF space, the fourth largest operator in the home health space and the 11th largest in the hospice space. We have an average age of our patient is 76 in the hospitals and 77 in the home health, and we benefit from the aging population. It's just a matter of fact, as people age, the likelihood that they need the services that we provide increases with each year that passes.

The types of diagnostic categories we typically treat our hospitals include stroke, hip fractures, neurological, post trauma, brain injuries and spinal cord injuries. And then in home health, we have post-surgical care, chronic disease care and fall prevention. It's a strategic priority of ours to create what we call overlap markets where we have both an IRF and a home health agency in the same marketplace, typically within a 30-mile radius that allows us to coordinate the care and collaborate the care or the transition from patients leaving our hospitals going into home health.

Overall, we're the high-quality, most efficient provider in our space, and we are focused on growth going forward, taking advantage of the demographic tailwind. That growth would come in terms of same-store de novos, particularly for our IRFs, acquisitions through home health and hospice and then bed additions for IRFs as well. So Matt, that gives just a few comments in terms of our overall Industry & Company.

<<Matthew Larew, Analyst, William Blair & Company LLC>>

That's helpful, Mark. And your description of your patient type is skewing towards highly acute more nonelective type patients, I think provides, a nice segue sort of to first question I have here around COVID dynamics. And obviously, with a number of states now actively reopening, electric procedures starting to come back online and slightly more normalized office visit patterns and certainly not back to pre-COVID levels with respect to physician offices. Could you just maybe help us understand how things have trended at Encompass Health? And obviously, you released an 8-K last night to that effect. But I think there's also some nuance there in terms of thinking about balancing the return of procedures. With things like recertifications, which may be kind of a lagging indicator because they reflect episodes starts of care from 60 days ago when we were still experiencing a lot of issues. So, Doug and Mark, can you just help us understand that?

<<Mark J. Tarr, President & Chief Executive Officer>>

Yeah. Sure. So Matt, as you said, we released an 8-K and it shows the trading that we've had over a period of time, specifically goes back to the pre-COVID time and then brings us up to our current – we're broken and out by service line, obviously, starting with inpatient rehabilitation hospitals, home health and hospice admissions. And overall, we've been very pleased with our – the trajectory of our ramp up. We're not back to where we were pre-COVID quite yet. We – part of that reason is we just started out the year strong. And all the service lines are running extremely well going into the month of March. So we set the bar pretty high. But we have come back the majority of the way back to it and think that we'll certainly be there in the near term. The metric that we show here for home health includes the starts of episodes, which that is both new admissions and recertifications in our home health. So the timing with regards to recertifications and as it plays out in the overall census for our home health to be able to catch up as we came off a period of extremely low volume during the pandemic period.

But we are starting to see across the majority of our marketplaces ramp up due to the acute care hospital systems, starting with their elective procedures. The vast majority of the types of cases we treat on our IRFs do not directly involve elective procedures, but having elective procedure start back up into acute care hospitals has reestablished the referral patterns that were disrupted during the height of the COVID period where essentially they get sent home, the acute care hospital sent home the majority of their discharge planners and social workers, and those who were the individuals that we were most likely to deal with, with our own staff, our clinical sales and marketing staff. And they too were prohibited from going into the hospitals just due to the no-visitor regulation. So it's not been uniform across all of our markets, we still have probably 10 to 20 markets that seem to have ramped up slower in terms of just where they were. Much of that ties back directly to where we saw the hotspots in New Jersey and Massachusetts, and those are some areas that we've seen the return back to pre-COVID volumes be just a little bit slower than areas and states that are running full force again.

<<Matthew Larew, Analyst, William Blair & Company LLC>>

Okay. Thanks, Mark, that's helpful. And one thing I wanted to follow-up on is a little more specific. To IRF – is there was a kind of a bifurcated dynamic between the Medicare fee-for-service trend and Medicare advantage in terms of COVID volumes. So maybe help us

understand what was driving those discrepancies? And is the way that the different payer classes there handle patient discharges and admissions, maybe an indicator longer-term of some of the more positive interaction you're having with payers?

<<Douglas E. Coltharp, Executive Vice President & Chief Financial Officer>>

Hey, Matt, this is Doug. I'm going to take that one. And as you know, really for the last several years, we've experienced very positive volume trends on the IRF side and Medicare Advantage. And while we've been seeing that growth at a rate faster than fee-for-service, we've also been successful in narrowing the historical reimbursement rate discount between Medicare Advantage and fee-for-service. It was at a high of about 25% of lower than fee-for-service about five years ago and at the end of the first quarter of this year, that differential gained narrowed to 6%. And the sources of the narrowing are really twofold. One is we have been successful over that period of time in converting a higher percentage of our Medicare Advantage contracts from a per diem to a per case basis. And also, we've seen our acuity skew higher in Medicare Advantage. And higher acuity comes with a higher reimbursement rate. You may recall at the end of the first quarter, 36% of the patients that we treated for Medicare Advantage were stroke patients and because of the high acuity of the stroke patient that carries a significant reimbursement.

In response to the COVID-19 pandemic, virtually all of the Medicare Advantage plans removed the preauthorization requirements they had that can sometimes stand in the way of a patient – an eligible patient being discharged from acute care hospital into the IRF setting. And so those were suspended for a period of time, and those facilitated a very substantial increase over the period from about mid-March through the end of May in our Medicare Advantage volumes. And to give you some specifics when we compare the four-week period that ended just prior to the week of Memorial Day, and I choose that period so that it isn't influenced by the holiday and compare that to the weeks two through five of January, again, trying to remove the first week because of the holiday. We saw our Medicare Advantage referrals up 8.7%. But the admissions were up 72%. And that was due to an increase of 58% in the conversion rate.

As we got to the end of May, the Medicare Advantage plans reinstituted the preauthorization requirements. And as we had expected, we're seeing somewhat of a decrease as a result in the conversion rate. It is not going back to the levels that existed at the beginning of the year, but it is down from the peak that we experienced in April and May. We think we'll continue to retain some of the volume increase that we got in response to the pandemic. But as we think specifically about overall volume growth for June, the lower level of growth related to Medicare Advantage is going to offset the continued progress that we're making on fee-for-service as the various acute care markets come back online for the dynamic that Mark just mentioned. And so that we would expect in the month of June, that you'll see our recovery of IRF volumes moderate a little bit and maybe even flatten out. But we view that as really a one-month transition period would expect to see the resumption of that growth recovery beginning in July.

And that ties into the same trajectory that we're seeing on the home health that Mark described, where, to date, we've been benefiting over the last couple of months from both recovery and admissions and recertifications. But because of the low overall level of home health admissions in the month, of April, they won't be recertified and those patients aren't

there to be recertified in June. So both of those volume trajectories will be flat for the month of June and then resume in July.

<<Matthew Larew, Analyst, William Blair & Company LLC>>

Okay. That's helpful because I think the transition from the April numbers to the May numbers, and I think it's helpful to understand that that's not necessarily just going to shoot that same level in June because of the variety of dynamics you spoke about. That's some helpful detail. But I think the – your comments, Doug, around some of the forces shaping referral patterns and then the proportion feeds really into my next question, which is that COVID has created some near-term challenges, but does seem to be opening the door to some perhaps long-term opportunities. We discussed the rule book for post acute care, at least temporarily, has changed a little bit, some of that patient criteria. Some of that is tele health or nonposition referrals.

And more broadly, it does seem like the value proposition on both ends, both for high acuity rehabilitation to occur in specialized stand-alone settings and perhaps lower acuity rehabilitation maintenance care on – in home. Both of those props have, I think, been bolstered. So maybe just give us a sense for what are the near-term changes you think are unlikely to stay versus go? And where your team is really seeing sustainable change and perhaps some opportunities as a result of COVID.

<<Mark J. Tarr, President & Chief Executive Officer>>

Yes, Matt, you mentioned value proposition. I think that the whole period of this pandemic helps to really put an exclamation point on our business and our quality outcomes and how we performed during this last few months. It from a more global standpoint, it has helped to point out the differences and articulate the differences of the post-acute settings and how certain patients have much better outcomes. And in this case, in an IRF versus a skilled nursing facility. And clearly, it's been well documented. The challenges that the nursing homes have had with the COVID patients.

On the other hand, we have been taking COVID patients in our hospitals. We've been taking them through our home health agencies and providing great care with great outcomes. I think that it does and will help to differentiate us going forward. And there will be a lot of goodwill that we have built up with referral sources during this period of time that in the past, may have chosen alternative post-acute providers, but I think that this will give us an opportunity to continue to take market share and build awareness not only in the marketplaces, but among the various payers as well.

<<Douglas E. Coltharp, Executive Vice President & Chief Financial Officer>>

And Matt, we had seen over the last several years was that we were successful in disintermediating from the SNFs with both of our businesses. On the high end of a SNF acuity curve, we were taking market share with the IRF segment, predominantly focused around stroke in neuro, and we think this will accelerate opportunities to do that. And then on the low end of the SNF acuity schedule or spectrum, we have been taking market share in our home health business, specifically by targeting patients who would have had a lower length of stay and developing clinical programs that would allow those patients to bypass and post-acute inpatient stay altogether and receive quality treatment in the home.

And what we've seen during the pandemic is an acceleration of those trends that we believe will be sustainable given the difficulty that many of the SNFs have experienced during this time frame.

<<Matthew Larew, Analyst, William Blair & Company LLC>>

Okay, great. And then something that's a little more challenging for us in the nonclinical role here to understand and maybe a little more nebulous than things like elective procedure return is really patient apprehension and patient theater about interacting with healthcare system. We were surprised to see that there was popular press reporting about things like strokes and heart attacks not showing up in the emergency room.

What has the company Encompass done to address patient apprehension, specifically with your home care team, but maybe more broadly? And what are you hearing from referral sources about patient apprehension, patient theater, and things like that?

<<Mark J. Tarr, President & Chief Executive Officer>>

So we've been proactive on that in both of our segments. And a lot of it deals with education, education with the actual referring discharge planner, it is education of the patient and education of the patient family. And we're educating them in terms of what precautions we are taking to eliminate any risk of exposure in our setting. It could be as simple as doing prescreen calls to the patients in our home health setting. Our home health clinicians have also been very careful to keep a six-foot distance when they're doing their chart work. And then obviously, closing that when they're actually doing the care itself, but anything that can help the patients feel more comfortable that we are being attentive to those types of protocols or precautions that would limit any types of exposure.

Clearly, we are making full use of PPE. That is another part of the education for patients, so that, that didn't create any anxiety. And in some cases, we go through the entire protocol, such as what it takes for a visitor that comes into our hospitals at the time they enter the door threshold, they're screened for their temperature, they have to have a mask on. They are – have a series of questions they have to answer to. It really all goes into education on what we put in place in terms of the structure whether that is in the home setting or the hospital setting and making everyone feel more comfortable that feel more comfortable that we've done everything we can eliminate the exposure or the existence of the virus.

<<Douglas E. Coltharp, Executive Vice President & Chief Financial Officer>>

And Matt, you may be aware that we're getting some help now from both the Medicare program and the Medicare Advantage plans. Who are embarking on a program of education and communication with their beneficiaries about the perils of deferring on required care and maintenance care and also then providing them some assurances about the safety of reengaging with providers and offering instructions and direction about how to safely reengage with providers of care to make sure that they're no longer foregoing what could be very necessary care for them that would result in exacerbated conditions down the road.

<<Matthew Larew, Analyst, William Blair & Company LLC>>

Okay. And that maybe ties into my last COVID-related question, which is acknowledging that you withdrew formal guidance, I'm not asking you to comment on guidance in any way. But just give us a sense for what you're assuming in your internal model in terms of the disease curve? Is there a second wave from the fall? When are you assuming that there's a "return to normal"? And as a part of that, how have you positioned your PPE inventory and thought about workforce safety?

<<Douglas E. Coltharp, Executive Vice President & Chief Financial Officer>>

So one of the things that we've learned through this, and I think almost every business in the country and probably in the world has learned, is the value of scenario planning, scenario analysis planning. And so we don't have just one internal view of what – how things may transpire. We have got a set of assumptions around what the world might look like if the trajectory that we've been experiencing here recently continues, and there isn't a second wave.

And then we've got a couple of scenarios regarding the potential impact of a second wave. I will say or we will say, if there is a second wave, we believe that it will be significantly less disruptive than the initial wave. We believe that the entire infrastructure from the Federal Government down to the regulatory environment, the CBC and the local health authorities to the provider networks and the payers are all better prepared to deal with this now. We know which tools were deployed successfully and which were unnecessary. And so we think it will be much more effective if, in fact, there is a second wave.

We are taking many precautions under the assumption that there will potentially be a second wave. And one of those includes the procurement of excess PPE and the stockpiling of excess inventory of PPE. We're also making sure that we maintain sufficient excess liquidity. I think we've done a good job of reestablishing that and just making sure that we have just from a staffing perspective to meet these changes in volume.

<<Matthew Larew, Analyst, William Blair & Company LLC>>

And Doug, maybe I would just follow-up on your comment about the kind of disintermediation of the normal healthcare ecosystem. Second wave versus the first wave. As we refer to numbers of providers that given the wide availability of PPE at this point and as you move through the better understanding of the virus and some capacity that even if a second wave occurred and there were perhaps local or state lockdowns that the healthcare ecosystem. And again, to your point, of payers trying to educate patients on the danger of referring care, then the healthcare system will not be as disintegrated as the first time around. It sounds like, is that what you're suggesting, Doug?

<<Douglas E. Coltharp, Executive Vice President & Chief Financial Officer>>

Yeah, yeah. And we believe that we've – all providers have learned so much through this process. And many of us spent the first two to three weeks of the pandemic in a scavenger hunt for PPE and trying to educate our clinicians on the appropriate use of PPE so that we were able to appropriately control the burn rate. Those things have all been codified now and are already in place.

<<Mark J. Tarr, President & Chief Executive Officer>>

Matt, just the whole COVID itself, I mean the acute care systems and what we saw on the news every night in New York City was just beyond imagination. But the vast majority of our marketplaces, you had acute care hospitals. They emptied their beds. They cut off any type of elective procedures, discharged many patients as they could, getting ready for this bulbous of patients, for these COVID patients that then, they never came. And so I think that certainly, the next go around, I think that you would see the acute care hospitals manage this process much better. The majority of the hospitals that we have in our marketplaces managed through it quite well. I think that you saw clinical protocols change from every patient has to go on a ventilator to many patients not needing a ventilator. So it all adds to the thought that any second wave would not be near as serious of an interruption on the overall marketplace as this last one was.

<<Douglas E. Coltharp, Executive Vice President & Chief Financial Officer>>

And Matt, also to that point, through much of this first wave of the pandemic, the ability of the provider community to react and to respond to the rolling wave of this disease has been limited by the availability of testing and initially the turnaround time on testing from the labs. And as we move forward, the supply of both the testing equipment, and of the testing kits is increasing rapidly and will be more widely deployed and the turnaround time on the test is much more rapid. So that puts you in a position to really limit exposure to infected caregivers and to infected patients and to not nearly have – not have to reduce the capacity in the system in response nearly as much.

<<Mark J. Tarr, President & Chief Executive Officer>>

With a third of our hospitals being partnered with acute care hospital systems, it gives us pretty good line of sight and pretty good access to kind of what they're thinking, what their mentality is regarding future changes if the same circumstances present themselves.

<<Matthew Larew, Analyst, William Blair & Company LLC>>

Understood. And I think that's an important point. Something you highlighted at the Analyst Day, which feels like ages ago at this point. But was how Encompass IRFs outperformed SNFs from a 60-day, 90-day perspective, by many criteria, despite being a more expensive upfront per diem stay. So particularly, in light of kind of the well-publicized issues with SNFs during COVID, can you help us just size what you think that IRF and SNF overlap market is in terms of number of patients or percentage of patients currently treated and what patient categories when you're rolling in with this data to providers or payers have met the most success when you bring this data on formal diverse doors?

<<Mark J. Tarr, President & Chief Executive Officer>>

Well, I think when – certainly, when we think about the types of patients that do well in an IRF that a lot of them end up in a skilled nursing facility, start thinking about not only strokes, other neurological related categories and hip fractures are three areas that come to mind that we do an extremely good job relative to outcomes that we see, particularly as we enter new marketplaces, and we start generating new referral patterns. Many of the places we go are those referral sources or those acute care hospitals that are sending those types of patients to skilled nursing facilities, where we can see that they have a high returned back to

the acute care after discharge, acute care readmission rate and which drives up the cost and decreases the quality of the outcome.

<<Matthew Larew, Analyst, William Blair & Company LLC>>

And something else you highlighted at the Analyst Day was increased Fed expansion and de novo targets for IRF and a component of that was ramping up your presence in Florida. So obviously, it's been a couple of months. Can you just maybe, update us on how things have progressed with those plans over the last couple of months? And I don't think COVID has anyway changed your long-term expansion plans. But has it any nuances to where or how you plan to grow?

<<Mark J. Tarr, President & Chief Executive Officer>>

It really has, Matt. At the Investor Day, we said we had – we believe we had the ability or the revocation of the CON law in Florida to add 12 to 15 de novos to our existing base of 12 existing hospitals over the next three to five years. And we have continued throughout this pandemic phase to make great progress on the acquisition of land and developing plans for expansion around those target markets that we shared with everyone at Investor Day. We have one hospital that's currently under development. It was – it received a CON prior to the decision by legislature to revoke the CON requirement.

So, Tampa is currently underway. We had mentioned to you previously that we were using Pensacola as a test case around resolving what we believe is an ambiguity in the law about whether you could start construction on a new specialty hospital before July of 2021 when the CON goes away. We believe that we're getting favorable signals there. So we're optimistic that we're going to be able to actually start building here in the near-term, to start bringing some of those hospitals online. And I will say that we have also been very pleased that during the time the pandemic, we've been able to continue to build our business development pipeline outside of the state of Florida as well. And there are a couple of things in this pandemic that may help us actually accelerate those opportunities. First, there's going to be some pressures from – politically, perhaps even regulatory as well on acute care hospitals to increase their capacity of critical care beds. And in order to do that in a cost-effective way, they may choose to convert what have been some underproductive IRF units back to that type of capacity, we may be able to help them in that regard by going into more markets in the typical way that we have entering into a JV giving them an in-kind equity stake in a new de novo in their market in return from converting their IRF beds to another purpose and signing a non-compete. So if anything, we believe that the outcome of the pandemic is going to be to help us further accelerate the IRF de novo pipeline.

<<Matthew Larew, Analyst, William Blair & Company LLC>>

Okay. That's great. Then I think per usual, most of these conversations, we've now got there about half my questions, but we do assume we have one minute left. So maybe, I'd just ask a final one, which would be sort of reimbursement update on the home health side. Obviously, there's a 2021 proposal coming out in July, so maybe just get a sense of what you're hearing from your government affairs, just whether that's going to be a clean update and then how things have tracked from Q1 to Q2 in terms of PDGM.

<<Mark J. Tarr, President & Chief Executive Officer>>

So, I think from an update standpoint from CMS whether it's from home health or from the IRF. Certainly, the proposed rule from IRF was benign. And I think CMS knew that this is just not a great time to roll out anything of any significance relative to regulatory changes or rate impacts. I think we would expect something similar on the home health front in terms of the fact that marketplace has been significantly disrupted and PDGM came out this year, and we're still digesting that. And that it would just not be appropriate time for major shifts from a pricing or a regulatory standpoint.

<<Douglas E. Coltharp, Executive Vice President & Chief Financial Officer>>

And then Matt, from a PDGM perspective, we would characterize it as really rough start and is all of the challenges that we had identified on the front end with regard to the implementation of PDGM were exacerbated by the COVID-19 pandemic and the trend line has improved steadily as the business has recovered.

<<Matthew Larew, Analyst, William Blair & Company LLC>>

Okay, very good. Well, that concludes our 30 minutes. Mark, Doug and Crissy, thank you for spending time with us, being here with us with the conference, and hope to see you next year in person, hopefully back in Chicago. So, thank you.

<<Mark J. Tarr, President & Chief Executive Officer>>

Appreciate the opportunity. Thank you.

<<Douglas E. Coltharp, Executive Vice President & Chief Financial Officer>>

Thank you.