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Encompass Health Corp. (EHC)

Q1 2022 Earnings Call

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MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone, and welcome to the Encompass Health's First Quarter 2022 Earnings Conference Call. At this time, I would like to inform all participants that their line will be in a listen-only mode. After the speakers' remarks, there will be a question-and-answer period. [Operator Instructions] Today's conference is being recorded. If you have any objections, you may disconnect at this time.

I would now turn the call over to Mark Miller, Encompass Health's Chief Investor Relations Officer.

Mark Miller

Chief Investor Relations Officer & Senior Vice President-Investor Relations and Strategic Planning, Encompass Health Corp.

Thank you, operator, and good morning, everyone. Thank you for joining Encompass Health's first quarter 2022 earnings call. With me on the call today are Mark Tarr, President and Chief Executive Officer; Doug Coltharp, Chief Financial Officer; Barb Jacobsmeyer, Chief Executive Officer-Home Health and Hospice; and Patrick Darby, General Counsel and Corporate Secretary.

Before we begin, if you do not already have a copy, the first quarter earnings release, supplemental information, and related form 8-K filed with the SEC are available on our website at encompasshealth.com.

On page 2 of the supplemental information, you will find the Safe Harbor statements, which are also set forth in greater detail on the last page of the earnings release. During the call, we will make forward-looking statements, which are subject to risks and uncertainties, many of which are beyond our control. Certain risks and uncertainties like those relating to our ongoing strategic review and its impact on our business and stockholder value as well as the magnitude and impact of COVID-19 that could cause actual results to differ materially from our projections, estimates and expectations, are discussed in the company's SEC filings, including the earnings release and related Form 8-K, the Form 10-K for year ended December 31, 2021, and the Form 10-Q for the quarter ended March 31, 2022 when filed. We encourage you to read them.

You are cautioned not to place undue reliance on the estimates, projections, guidance and other forward-looking information presented, which are based on current estimates of future events and speak only as of today. We do not undertake a duty to update these forward-looking statements.

Our supplemental information and discussion on this call will include certain non-GAAP financial measures. For such measures, reconciliation to the most directly comparable GAAP measure is available at the end of the supplemental information, at the end of the earnings release, and as part of the Form 8-K filed yesterday with the SEC, all of which are available on our website.

I would like to remind everyone that we will adhere to the one question and one follow-up question rule to allow everyone to submit a question. If you have additional questions, please feel free to put yourself back in the queue.

With that, I'll turn the call over to Mark Tarr. Mark?

Mark J. Tarr

President, Chief Executive Officer & Director, Encompass Health Corp.

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Thank you, and good morning, everyone. Our Q1 results provide further evidence of the growing demand for the services we provide as the inpatient rehabilitation discharges increased 7.6% and home health admissions grew 4.9%. Like all healthcare providers, we were impacted by the Omicron surge, particularly in the first half of the quarter, and by continued staffing challenges. The dedication of our team members allowed us to continue to make significant operational and strategic progress in spite of these challenges. We remain confident in the future prospects of our businesses and continue to enhance the positioning of each to capitalize on the growth opportunities ahead. On a consolidated basis for Q1, we generated 8.4% revenue growth. This revenue growth was offset by higher staffing costs in the quarter, resulting in a 2.3% decline in adjusted EBITDA.

In the IRF segment, the strong discharge growth combined with a 2.2% increase in revenue per discharge to drive 10.4% revenue growth. Average daily census increased to a new high of 7,330. These metrics and the balance between the same store and new store growth validate our de novo and bed addition strategies. The continued strong demand for our services in a tight labor market for skilled clinicians necessitated an increase in utilization of agency staffing and sign-on and shift bonuses, resulting in IRF segment adjusted EBITDA declining 3.7%.

We believe the utilization and rate of agency staffing has peaked, and we expect gradual improvement in the second quarter as net new hires replace agency FTEs and those staffing contracts that are renewed are at lower negotiated rates. We expect this improvement to accelerate in the second half of the year.

Our home health business generated solid admissions growth. Total admissions grew 4.9% in Q1, including 0.9% on a same-store basis. Same-store admissions grew 3.2% sequentially. As a point of comparison, total home health admissions in the quarter exceeded our prior historical high point achieved in Q1 of 2020. Hospice admissions declined in the quarter. The decline in hospice admissions was driven primarily by capacity constraints at some of our larger branches with historically high average daily census. High staffing costs led to a 1.4% decline in segment adjusted EBITDA.

On the Home Health and Hospice staffing front, hiring started slowly in the quarter due to the Omicron surge, but accelerated as the quarter progressed. We ended the quarter with a net increase of 30 full-time nurses. This is on top of the 133 net new FTEs in Q4 and 127 in Q3. We expect to see positive trends in nursing hires as a result of our recruiting strategies and the favorable impact on recruiting and retention, stemming from the changes we have implemented over the past year in our compensation structure, including salary market adjustments and updating our mileage reimbursement methodology.

Demand for home care remains strong. We will not accept a patient unless we are confident we can admit them timely and deliver the level of care they require. Based predominantly on required staff quarantines, we estimate that we lost 2,150 home health admissions in Q1 of 2022.

Given the strong demand for our services, we have continued our capacity addition strategy. We opened three de novo IRFs in the quarter and added 29 beds to existing hospitals. We anticipate opening an additional 6 de novo IRFs and adding an additional 89 beds to existing hospitals in 2022. We opened 4 Home Health and Hospice locations in the quarter, 2 of these via acquisition, and anticipate an additional 8 de novo openings in 2022.

CMS recently issued the 2023 proposed IRF rule and the 2023 proposed hospice rule. For IRFs, CMS proposed a net market basket update of 2.8%, which we estimate would result in a 2.9% increase for our IRF segment beginning October 1, 2022. As a reminder, this expected increase does not include the impact of sequestration. The IRF final rule is expected to be released in late July or early August. For hospice, the proposed net rate update is 2.7%. Again, this is prior to the impact of sequestration. The hospice final rule is also expected in late July or early August.

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While the rate updates in the IRF and hospice proposed rules are directionally positive, they do not adequately compensate for the elevated staffing costs. We are hopeful that the final rules will provide greater relief. We expect the Home Health 2023 proposed rule to be released in June or July.

Moving now to the spinoff of our Home Health and Hospice business into an independent, publicly traded company under the new brand name Enhabit Home Health & Hospice. We are targeting consummation of the spinoff on July 1, 2022, subject to the customary conditions, including receipt of a favorable ruling from the IRS and approval of the Form 10 by the SEC. The key assumptions related to the spinoff are included on page 5 of our supplemental slides and have not changed from our previous disclosures other than that rebranding expenses have been revised downward.

We believe the establishment of Enhabit Home Health & Hospice as an independent company will provide a number of significant benefits, including enhanced management focus, separate capital structures and allocation of financial resources, better alignment of management incentives, and the creation of independent equity currencies.

Moving now to guidance. Our guidance for 2022 consolidated revenue, adjusted EBITDA, and adjusted EPS has not changed. The key considerations underlying this guidance can be found on page 16 of the supplemental slides. As a reminder, this guidance assumes the current structure of the business continues throughout 2022. We anticipate providing 2022 guidance for Encompass Health and Enhabit on a separated basis during the first half of June.

With that, I'll turn it over to Doug.

Douglas E. Coltharp

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

Thank you, Mark, and good morning, everyone. Q1 was a very solid quarter for our company in spite of the persistent industry-wide challenges. We generated consolidated Q1 revenues of approximately $1.334 billion and adjusted EBITDA of $245 million. Our adjusted free cash flow was approximately $166 million, and Q1 was very strong.

The key trends that we experienced in the fourth quarter of 2021 continued in the first quarter of 2022. We saw good volume growth in both of our businesses. Inpatient rehabilitation discharges increased 7.6% with same-store growth of 3.8%. Home health admissions increased 4.9% with 0.9% same-store growth.

As was the case in Q4 2021, staffing challenges did not limit volume growth in our IRF business, but did lead to substantially higher costs. Also consistent with Q4 2021, staffing challenges impacted volume and led to higher costs for our Home Health and Hospice business.

In the IRF segment, revenue increased 10.4%, or approximately $100 million. But that $100 million was largely absorbed by an increase in labor costs, including agency staffing costs and sign-on and shift bonuses. First quarter 2022 agency staffing, sign-on and shift bonuses totaled $63 million compared to $21 million in Q1 2021 and $51 million in Q4 2021.

The $42 million year-over-year increase combined with annual wage increases for our existing internal clinical staff and the cost of staff hired at our new locations offset much of the incremental revenue in the quarter.

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Salaries and benefits as a percent of revenue in our IRF segment increased 320 basis points as compared to Q1 2021 from 52.3% to 55.5%.

As we indicated when we reported fourth quarter earnings, staffing constraints and elevated costs are expected to continue in 2022 with improvement skewed towards the back half of the year. We are seeing some early improvement in the reduction of agency FTEs our hospitals are using and in the ability to negotiate lower rates as agency contracts renew. The circumstances vary substantially by market.

Our first priority remains providing access to our services for patients in need of inpatient rehabilitation treatment and ensuring high-quality care once admitted. Although the timing and trajectory remain uncertain, we continue to believe the staffing challenges will begin to dissipate as a result of both our initiatives and general improvement in the demand/supply imbalance.

While our Home Health and Hospice segment does not utilize much agency staffing, it was also impacted by clinical staffing challenges. We estimate we lost 2,150 home health admissions in the first quarter of 2022 due to staffing constraints, and that translates to approximately $7 million in lost revenue. Higher staffing costs led to a 7.8% increase in home health cost per visit and a 6.4% increase in hospice cost per day.

As was the case for much of 2021, the home health admissions growth we generated in Q1 came predominantly under our Medicare Advantage and Managed Care contracts. A significant percentage of these contracts pay on a non-episodic basis and that a substantial discount to Medicare fee-for-service. Our cost per visit does not vary based on payment source. A central part of our mission is providing patients access to our high-quality care, regardless of the payer source. Many of these Medicare and Managed Care plans are not providing adequate compensation for the clinical services their members are receiving.

The continuation of this payment differential is difficult to understand in light of the rate increases Medicare Advantage plans have received from CMS, the relative cost effectiveness of quality in-home care, and increasing patient preference to receive care at home. We will be devoting substantial time and resources to further discussions with these plans, which we anticipate will lead to more value-based arrangements.

As Mark mentioned, we are reaffirming the 2022 net operating revenue, adjusted EBITDA, and adjusted EPS guidance. Given our year-to-date experience within our reaffirmed 2022 guidance, we have increased the range of expected staffing cost increases for the full year by 100 basis points for our IRF business. The 2022 guidance considerations can be found on page 16 of the slides accompanying our earnings release. I would also like to point out that we now expect 2022 adjusted free cash flow of $405 million to $555 million.

That's an increase of $40 million to $45 million from our prior guidance, and that is due primarily to the application of 2021 income tax overpayments to our 2022 income taxes.

And now, we'll open the line for questions.

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QUESTION AND ANSWER SECTION

Operator: Thank you. [Operator Instructions] Thank you. Our first question will come from Kevin Fischbeck with Bank of America.

Kevin Fischbeck
Analyst, BofA Securities, Inc.

Q

Thanks. Hello. I wanted to dig into labor a little bit. Helpful to get that hiring number in the [ph] quantities of 30 (18:46) in the quarter. I mean, but that's – can you put that into context? I mean, how many nurses do you need to hire each quarter in order for you to not be talking about staffing shortages, holding back volume growth in the business and to kind of get that temporary staffing back to where it has been historically?

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

A

Kevin, you're speaking specifically to the 30 on the Home Health and Hospice side?

Kevin Fischbeck
Analyst, BofA Securities, Inc.

Q

Yeah. I guess, yeah, that in particular. But then I guess, it's also kind of rounded out to the IRF side as well.

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

A

Okay. Well, Barb, why don't you start with Home Health and then I'll fill in the blanks on the IRF side.

Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.

A

Sure. So, for Home Health, I mean, quarter one was certainly a combination of the staffing constraints as it relates to open positions. But quarter one was also very much impacted by quarantines in the first half. At one point, we hit a peak of over 1,300 quarantine employees. That was the highest that we saw throughout the entire pandemic. So, the good news there is we are down to 20 as of this morning. So, much progress there.

On the hiring front, we do need to have some strong quarters like we had in third and fourth quarter with adding that 100-plus net new full time. Quarter one, we were at the 30 plus. The good news is, here in April, we're feeling confident we're going to end the month with higher net new hires than we had in the whole first quarter. So again, if we could repeat, quarter three and quarter four, as far as the number of net new hires, we'll be in a really good place.

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

A

But In terms of open nursing positions right now, it's...

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Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.

A

Yeah. Open nursing positions, we have 650 open nursing positions. That's only probably about 100 to 150 above where we kind of consistently run because we're always looking to staff up for even increased growth, even historically.

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

A

And then, Kevin, switching over to the IRF side, we hit a peak of 750 contract labor FTEs in the month of March. So, we expect that to decline on a monthly basis moving forward. It will not go to zero. In a more normalized year, looking back, say, to 2019, pre pandemic, we would expect at any given point in time to have about 200 to 250 contract labor FTEs. And the reason for that is you're always going to have some openings and there's some degree of efficiency in terms of filling fluctuations in volume with contract labor. So, with that, I'd say we've got about 500 FTEs that we need to cut into to get back to an ideal run rate.

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

A

So, Kevin, it's Mark. It's – I think it's worth noting we have added substantial resources to our talent acquisition teams, particularly here in Birmingham relative to the centralized recruitment functions where we now have over 60 FTEs. That's all they do, is recruiting. And they have shown themselves to be quite confident here in terms of applicant flow, as well as converting from an applicant to a hired staff in very quick form, as you may expect. First to market on these available nurses wins every time. So, we are doing everything we can from a resource standpoint to make sure that we are efficiently capturing opportunities and working and generating the applicants for nursing positions.

Kevin Fischbeck
Analyst, BofA Securities, Inc.

Q

All right. Great. And then maybe just second question, as you mentioned, you raised the outlook for wages on the IRF side, but it looks like you didn't raise it for the home health side or for the combined company overall. So, just wondering why it's showing up more on the IRF than it is elsewhere overall. Thanks.

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

A

It's really that increased use of contract labor. The rates for contract labor have remained elevated, north of $240,000 annualized per FTE versus an internal cost of $96,000. So, when we saw that higher level in the first quarter, it caused us to change that assumption.

Operator: Thank you. Our next question will come from A.J. Rice with Credit Suisse.

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

A

Good morning, A.J.

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

A

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Hey, A.J.

A.J. Rice
Analyst, Credit Suisse Securities (USA) LLC

Q

How are you?

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

A

Good.

A.J. Rice
Analyst, Credit Suisse Securities (USA) LLC

Q

Just first to pick up on your comments about the differential in payments between what Managed Care is paying you and what you get for Medicare fee-for-service in the home health arena. Can you – I know you said there's a substantial differential. Has that gap widened over recently or has it narrowed? And in an environment where you're having to turn away admissions because of labor constraints, Do you have – I mean, wouldn't that be something that naturally would put some – give you some leverage, vis-à-vis Managed Care to say, hey, we're going to take more of the fee-for-service patients? Or is that just not available to you to make that kind of pushback?

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

A

Yeah. So, A.J., I'll address the first part regarding the differential, and then Barb will hit the second part with regards to how we allocate our clinical resources. So, with regard to the discount, it's at about 40%, and it has been roughly stable for the last several quarters. It's impact on our P&L, though, has increased, and that is because we are seeing more growth in these non-episodic payments and a substantial portion of that is attributable to the United Health National Contract, the initiation of which we just anniversary at the end of February in 2022. Barb?

Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.

A

Yeah. So, I'm going to touch on first to give you a little bit of a backdrop when we look within the markets where we have our agencies, when we look at quarter four of 2019 to quarter two of 2021 based on market data, the Medicare fee-for-service enrollees in our markets decreased 6.4%, but the MA enrollees increased 19.1%. So, we know we need to have a focus on this. As you mentioned, though, one of the things that we do do though is look at in each individual location how are we handling our labor and how we assign that. Our conversion rates have remained at historical levels for episodic versus non-episodic. We're historically about a 73% to 75% conversion for episodic and about a 42% to 44% on non-episodic. That has remained stable, but we're just seeing those referrals increasing from the non-episodic.

So, what we've done recently is we've restructured certain aspects of our MA team to focus more on strategic relationship. And we have a proven leader that has spent a lot of her time with the DCEs, ACOs, really selling our value proposition. We have moved her over our entire team, and we're talking about payer innovation so that she can reengage with these MA providers to really sell on the value side of what we bring so that we can improve our rates with these plans.

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A.J. Rice
Analyst, Credit Suisse Securities (USA) LLC

Q

Okay. Maybe just my follow-up, you increased, as was mentioned before, your assumption about labor growth in the rehab hospital IRF business from 3% to 4%, to 4% to 5%. I'm assuming that doesn't reflect increased pressure in the therapist area, which is still, I think, a big component of your labor there. So, does that suggest that maybe the increase for the nurses is higher, or have you started to see some pressure in the therapist arena as well?

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

A

Yeah. A.J., it's Mark, I mean, we've – there's always consideration of this side, but the pressure has been much more significant on the nursing aspect than it has been on the therapists. I mean, we try to make sure that in all of our markets where you're paying competitive rates, there's competition for our therapists as well. But it's heavily skewed towards nursing right now.

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

A

It's nursing and it's nursing within contract labor.

Operator: Thank you. Our next question will come from Sarah James with Barclays.

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

A

Good morning, Sarah.

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

A

Good morning, Sarah.

Sarah E. James
Analyst, Barclays Capital, Inc.

Q

Good morning. It was really helpful you guys [ph] placed (27:26) out the different buckets of changes, and some of them sound like they could be more enduring in trends like the change to mileage reimbursement, maybe even gas prices and the hourly rates. Is there a way for you to break out those structural upticks in the 2022 guide, what you're assuming there versus 2021? Just so we can understand what is temporary versus what is more structural.

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

A

The mileage reimbursement is worth about $5 million to $6 million in EBITDA for 2022. And so, it wasn't so much attributable to higher gas prices, although that was the impetus for us initially looking at that. There are a lot of things that go into determining the mileage reimbursement. And actually, when you look at the composition, gas is in there, but it's not the most significant piece. It's things like vehicle depreciation and maintenance and so forth. When we look at our mileage reimbursement policy in the context of overall compensation structure in a tight labor market, we determined that it needed to be more competitive. And so, we made that adjustment.

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Sarah E. James
Analyst, Barclays Capital, Inc.

Q

And just to clarify on Kevin's question, you talked about needing about 500 FTEs to be fully staffed and adding 30 this quarter. So, how should we think about a reasonable timeframe in which you can bridge to that 500 if you are currently adding 30 a quarter?

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

A

And I would not use 30 a quarter as our run rate for two reasons. One is hiring was extremely difficult for everybody in the first quarter, largely due to the Omicron surge. There just – there was – there was no available supply and we're already seeing that improve. And if you put that together with the comments that Mark made about the substantially increased number of resources we have for recruitment and some of the things that we're doing to improve retention, we would expect the rate of new hires to accelerate. And so, we're hoping that by the time we exit this year, we're going to be down to somewhere in that kind of 250 contract labor FTE range.

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

A

It's not unusual for the first quarter to be the lowest quarter in terms of new applicants and new hiring. You're coming off the holiday period where people typically aren't looking for jobs. And so, that puts you into almost February before you start seeing a lot of activity. And we saw a lot of activity, but it just started later in the quarter. But that is typical of the seasonality of hiring.

Operator: Thank you. Our next question will come from Matt Larew with William Blair.

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

A

Hey. Good morning, Matt.

Matt Larew
Analyst, William Blair & Co. LLC

Q

Hey. Good morning, everyone. Thanks for taking the question. First is just a follow-up to A.J.'s on the MA versus fee-for-service as, obviously, that gap has persisted for a while. I know I thought of them that maybe moving to episodic would be a way to bridge that gap.

So, a couple of questions here. First, it sounds like, from a negotiating standpoint, you feel perhaps more confident because of the rates payers are getting. Do you feel like you have more leverage than in the past? I guess, what gives you confidence on negotiating , that'd be piece one?

And then, the second, you referenced perhaps a piece that's been taking some risks. So, how would you envision that being structured in terms of upside or upside/downside?

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

A

Yeah. So, I'll take the first part, and then I'm going to pass it over to Barb. We definitely feel like we have increased leverage and that is because clinical labor is in short supply, and we have it. And it's also been proven that home health care is extremely cost efficient. So, if these plans are predominantly driven on trying to get

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members and keep their medical loss ratios as low as is possible, they're going to have to compete in a tight market for limited resources. And, again, we have those resources, and the quality of care that we're consistently producing for those patients is high.

Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.
A

Yeah. So, to add to that, obviously our focus is we would like more contracts that are on at the episodic payment, but if not, then certainly we'd want those value-based components. We had industry-leading low rehospitalization rates. That's critical to these MA plans. And as I mentioned, we moved our leader into the payer innovation because she has historically done a good job selling that as it relates to ACO, where we have received those value-based components, as well as DCEs. And so we're going to use that same information to go to the MA players. And so, I think, you know, she's going to have a really important role with that going forward. But as Doug mentioned, you know, the other talking point we have is, you know, we don't want to deprioritized their members, but they're going to force us to if we're not being paid the fair rates that we need to turn around and pay to our clinicians.

Matt Larew
Analyst, William Blair & Co. LLC
Q

Okay. It makes a lot of sense. And then just, obviously, you've spoken a lot about recruiting today. And obviously, the other piece of this is retention. And I know you gave increases. Doug, you just alluded to some of the increased reimbursement around mileage. Just curious what else you're doing to improve retention. And then I guess more broadly, is workforce turnover and workforce stability something that is today involved in executive compensation, or might it be something given the strategic nature of it that becomes a bigger piece of that in the future?

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

Matt, are you talking specific about the Home Health segment at this point or...

Matt Larew
Analyst, William Blair & Co. LLC
Q

Well, no, just sort of both segments thinking more about nursing more broadly.

Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.
A

Yeah. So, on the nursing side for home health, I will say that we certainly made some good progress as it relates to the retention of our home health nurses. A lot of that has been around the market adjustment that we did, as well as this mileage piece. But, in addition, we're adding things like leadership development. We see individuals coming in, wanting to know what opportunities they have for growth and so focusing a lot on leadership development as it relates to our nurses and our therapists. And we think that's going to have a big piece as it relates to the retention.

We've not seen that same progress on retention on the hospice side. We are piloting some new staffing models in a few of our markets, and our early signs are these are going to be received well. And if so, we'll look to make some changes in how we model our staffing as it relates to hospice that, I think, will drive improved retention.

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

Yeah. Many of the same strategies work in the hospitals are nurses. Of course, they want to be paid a marketable rate, and we want to make sure that we compensate accordingly. But they're also very focused on additional clinical education. They're interested in the ability to get certifications such as the CRRN for our nurses. They want to learn about additional programmings where they can get more specific knowledge into whether it's a neuro patient or stroke patient or orthopedics.

So, clinical education means a lot for these clinicians. And so, we make sure that we have a robust agenda and opportunities for them to gain that education. So, certainly, compensation is a big part of it, but there are the other non-compensation categories that play a big role in retention.

Operator: Thank you. Our next question will come from Andrew Mok with UBS.

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

Good morning, Andrew.

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

Good morning, Andrew.

Andrew Mok
Analyst, UBS Securities LLC
Q

Hi. Good morning. Just wanted to follow-up on that 100 basis point increase in costs per IRF FTE assumption in the guide. That seems like a pretty big assumption to change and hold guidance. So, can you take us through the impact of that increase and any offsetting assumptions to consider here? Thanks.

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

Yeah. So, first of all, you may recall, at the outset of the year we issued guidance with wider ranges than we historically have. And that was somewhat a function of the fact that our company has been growing larger. But it was also because – and we cited this in our Q4 call – there was a greater uncertainty regarding some of the assumptions. And the primary assumption was around the increase in labor costs. So, there was some capacity built into that guidance forward.

It's also – as you know, there are tradeoffs up the P&L from that predominantly around volume and price increases. And we clearly saw favorable results there in Q1. So, you put all of that into the mix and we were comfortable reaffirming the guidance ranges that we have out there. And those do accommodate this change in the assumption regarding IRF labor cost increases.

Andrew Mok
Analyst, UBS Securities LLC
Q

Got it. That's helpful. And then, just a follow-up on the discussion around home health and mix. If we try to isolate the impact of United converting its national contract to per visit reimbursement, is there a number that you can

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share that helps us understand how the core fee-per-service episodic admissions growth has been trending over the past year or so? And what percentage of your MA revenue is now episodic versus per visit? Thanks.

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

So, I'll answer the second one first because I've got it at my disposal. I'll have to think about the first one. The percentage of our MA and Managed Care business that is episodic is 30%, and that does come at a much more narrow discount than those of the non-episodic. The episodic non-Medicare fee-for-service business is at about an 8% discount to the non-episodic. In terms of the trends on the episodic, what I can tell you is that we saw sequential growth in our episodic admissions growth from Q4 to Q1. So, the trend line there is positive.

Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.
A

And in March, we actually had our strongest episodic admission month since March of 2021. When you do look at that move, that contract, which is anniversarying now this first quarter, in quarter one, 500 of what historically would have been episodic admissions under the UHC converted to non-episodic this quarter.

Operator: Thank you. Our next question will come from Brian Tanquilut with Jefferies.

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

Hello, Brian.

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

Good morning, Brian.

Jack Slevin
Analyst, Jefferies LLC
Q

Hey. Good morning, everyone. It's Jack Slevin on for Brian. Apologies for the – to disappoint.

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

No, it's an upgrade.

Jack Slevin
Analyst, Jefferies LLC
Q

No – thank you. So, I wanted to touch a little more on the volume side, a lot of conversation around labor. I mean – and I don't want to belabor the point. I think you gave us great data points. So, when we look at the IRF business specifically, can you give us a sense of what mix is looking like right now? And specifically, I'm thinking about, as elective procedures get on, we look at maybe orthopedics. I know that mix had gone down a little bit in 2020 for you all. How should we be reading mix and how that trends to sort of same-store discharges in the IRF business for the rest of the year?

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

A

I think the best way to think about it, if you recall, we placed a big emphasis on our stroke program, and we saw that come back nicely. The first quarter, we had 18.8% of our discharges were stroke. The – we had over 22% were neuro. Relative to elective procedures, we did start to see a few more orthopedic patients, and there recall that it's still a fairly small part of our overall mix. But we did start to see some joint placements come back in, particularly those that have a high degree of comorbidities that go with it.

So, we are pleased across the board in terms of the ongoing demand. We saw clearly some of the acute care hospital systems start to run into a more normalized pattern as the number of COVID cases dropped and they resumed a normal course of both planned surgeries, as well as what we saw on the higher acuity patients.

And so, our overall acuity was relatively constant in Q1 in terms of what we ran for most of 2021, which is a positive thing. And, again, it was that strong growth in stroke and neuro that Mark mentioned. From a payer mix perspective we saw really nice growth in the quarter in our fee-for-service book of business. That was up 9.5% on a year-over-year basis. Medicare Advantage actually declined in the quarter by 3.7%. But, remember, that's up against a 34% increase that occurred in Q1 of last year.

I actually think what this is evidence of is that we had suggested previously that there would be a stickiness to the accelerated MA volume that we had recognized from 2020 through 2021, and we're seeing that. So, we're seeing a more normalization in the payer mix, but with an elevated level of Medicare Advantage. And the success that we've had demonstrating our value proposition to the MA plans on the IRF side has led to a continued narrowing of the payment differential there. More than 80% of our Medicare Advantage revenues on the IRF side are paid on an episodic basis, and the discount is right at 5%.

Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.

A

And then, as far as for home health, our admission, the patients that underwent elective procedures have actually recovered from the pandemic and actually are now above our 2019 level. We saw a 20% increase quarter-over-quarter, quarter one of last year to quarter one of this year, in the electives.

But while they have recovered [audio gap] (41:59), there's been a shift on those referral sources of those electives. You probably remember us talking about spending more time in ambulatory surgery centers as we saw electives moving to those centers. So, what we've seen is, because of that shift in where those referrals are coming from, it's good to see electives coming back. But the electives that have come are coming at a 50-50 mix of MA versus Medicare. And a lot of that, we feel, is because of the referral sources.

As far as our ALS and ILS patients, back in 2019, 22% of our Medicare patients resided in these facilities. That percentage has declined to 13% in quarter one of this year. Access is back to pretty normal at these facilities and their [ph] census (42:44) are beginning to increase. So, we're back piloting the community care program that was so strong for us prior to the pandemic and seeing some initial positive trends in those pilot markets. So, we'll be expanding that further into – in each of these subsequent quarters.

Jack Slevin
Analyst, Jefferies LLC

Q

Okay. Got it. Really helpful color. And then, for my follow-up, it's for Barb. Two quick metrics I wanted to touch on in the Enhabit business. One, visits per episode continues to track above peers. Should we be thinking about that

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as an opportunity going forward given the challenging labor environments and things like sequestration rolling off throughout this year [indiscernible] (43:26) forgiveness? And then the second one being length of stay in the hospice business, how did that track towards the end of the quarter? And how is it looking early in Q2? Thanks.

Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.
A

Sure. So on visits per episode, it's an area that we continually put focus on particularly with our use of Medalogix. What I will say is when you look at the patients that come to us from our IRF facilities, they're very therapy and nursing focused. And so any time you have a strong combination of that therapy need and nursing need, you're going to have more visits per episode. As we've seen our electives grow, that also increases a little bit on that visits per episode because it tends to be, again, that combo of nursing and therapy intensity. So we continue to focus with using Medalogix. And what we've seen is that we continue to manage well, and we're managing below what the Medalogix recommendation is. But a lot of it does have to do with the mix of the patients.

And then your second question, I'm sorry...

Jack Slevin
Analyst, Jefferies LLC
Q

Hospice length...

Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.
A

Hospice length of stay, that's been pretty consistent for us. What I would say is it's an area that when you compare quarter four, our length of stay was 106; quarter one, it was 108. We continue to look to diversify our referral sources. We've historically received a lot of referrals from the ILS/ALS, SNFs and from home health. We're spending more time in the acute care hospitals. That's where you tend to get some of the patients that have more of that shorter length of stay. And so we are continuing to focus on diversifying that referral source.

Operator: Thank you. Our next question comes from John Ransom with Raymond James.

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

Hello, John.

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

Good morning, John.

John W. Ransom
Analyst, Raymond James & Associates, Inc.
Q

Hey. Good morning. I guess this one is for Barb. A while ago, there was a big public fight with April, and she was poaching some of your people. If you were to look at, say, your top maybe six or seven key executives in the home health, how many of those have you had to replace and has the rate of poaching settled down since you filed the lawsuit?

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Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.
A

Well, at the executive level, I've not had to replace any of the key executives. We added a chief human resource officer, but my key executives over sales and operations are folks that have been there for a long time. So, they are well committed and doing a great job. We also were able to get commitment for the next level of senior executives that manage ops and sales in the field. So, I think we're in a good place both as it relates to senior level and executive management.

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

And, Barb, you have been adding to your team in anticipation of the spin-off. So, for instance, recently hiring a chief information officer.

Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.
A

Correct.

John W. Ransom
Analyst, Raymond James & Associates, Inc.
Q

Great. And my follow-up is when we think about these deals with managed care and home health and two-way deals, I know re-hospitalization is obviously a big one. But, let's say, it's a fee-for-visit with a kicker. What are some of the other things that you would get rewarded for? And are these kind of upside/downside deals or are these kind of fee-for-service with outside kickers if you can jump over a couple of hurdles?

Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.
A

Yeah, it would be both. I mean, obviously, we're looking always for any sort of value-based positive impact. I would say in addition to hospitalization rates – so, you have hospitalization rates that is for patients that came to us from a physician. So, they've never even been in the hospital. So, you're looking at ER visits, hospitalization rates, readmission rates, timely initiation of care because we know that's really connected to the overall patient satisfaction as well as quality outcomes. So, those are the main ones that we would focus on.

John W. Ransom
Analyst, Raymond James & Associates, Inc.
Q

Okay. And Medalogix is having a tool and the tool coming out that's kind of in episode – the ability to make in episode adjustments. Do you think that could be meaningful as that gets rolled out or is this kind of a nice-to-have feature?

Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.
A

No. I think it will be meaningful. In fact, we are piloting that new tool called Medalogix Pulse. It is very similar to Muse, and that has been well accepted by our hospice clinicians because of that. It looks at the current status of the patient and any changes in their status versus just a snapshot. So, we think that this will be even more well received by our clinicians. And it also does help us because some patients progress quicker than others. Some decline. And I think this will be helpful for us to know where and when do we need to apply those visits and make

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it appropriate to the current status of the patient versus that initial snapshot at the start of care. So, we're excited early into the pilot, but excited about where it's moving.

Operator: Thank you. Our next question will come from Matthew Borsch with BMO Capital Markets.

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

Hey. Good morning, Matt.

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

Hi, Matt.

Matt Borsch
Analyst, BMO Capital Markets Corp.
Q

Hi. My first question was, you talked about the amount of unmet demand that you had to turn away in home health. Can you talk to where that – you think that went?

Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.
A

It's kind of hard to say where it went. I think when you look at – a lot of folks in the market have been dealing with some of the same challenges from a staffing perspective. And so, we have seen, though, that there's some of our competitors in the local markets that will accept the referrals, but potentially not be able to provide that timely initiation of care.

It's something we have consistently said to our team that the reason we have great quality metrics, particularly as it relates to that hospitalization, readmission rate is because we provide the timely initiation of care. So, we won't accept a referral unless we can do that.

I will also mention that certainly we have used some agency dollars to help with that. We [ph] tend though (49:22) because agency cost us about $107 more per visit than our own staff. We will only use agency where it is that short-term solution, so either we have somebody out for a period of time or [ph] we hire, and run (49:38) orientation so that we can keep those referrals coming. But if we're in a market where we don't see that light quickly at the end of the tunnel, we just can't afford to use those resources even though they're available.

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

And, Matt, historically, about somewhere between 20% and 25% of patients who are referred to home health agency wide actually wind up not receiving that care for various reasons, including just a lack of certain companies to whom they are referred to initiate staffing. My guess is that in recent periods that number has been elevated. And where you're seeing it show up is increased length of stay in in-patient settings, and that is substantially more costly. And so I think that's all going to contribute to some of these discussions that we'll be having with MA and managed care plans.

Matt Borsch
Analyst, BMO Capital Markets Corp.
Q

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Well, picking – just my follow-up, picking right up on that, you touched on the possibility of maybe needing to turn away some of the MA volume selectively if you can't make headway on the reimbursement front. I guess I'm just curious why you're not doing that already given the amount of demand that you're facing and the reimbursement differentials.

Barbara A. Jacobsmeyer
Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.
A

Yeah. So we mentioned the consistent conversion rate. So that's something we watch. What I will say it is market-by-market because the markets where we have full staff in place, we're accepting those referrals both from – we wouldn't be turning away any episodic first. We would certainly be accepting all the episodic initially.

The other thing that we're watching is to make sure that the referral sources that are sending us, that non-episodic business are doing it with episodic is what we've heard from our sales team is there are truly referral sources that actually kind of close their door over the years to us because they said I can't just give you one type of patient.

So, we were happy to see that when we looked last year at the full year of 2021, those referral sources that sent us that non-episodic sent us an additional 4,500 Medicare admissions. We looked at that again here in quarter one. Those referral sources that are sending us non-episodic sent us an additional 1,400 Medicare. So, we're following that very closely.

Operator: Thank you. Our next question will come from Scott Fidel with Stephens.

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

Morning, Scott.

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

Morning, Scott.

Scott J. Fidel
Analyst, Stephens, Inc.
Q

Hi. Good morning. Thanks. First question, just wanted to go back to the proposed IRF rates that you had talked about, and you had mentioned the ESG-specific estimate of 2.9%. I know that in the proposed rule, CMS had predicted a 2.8% for the industry, and then that partially offset by an 80-basis-point reduction in the outlier thresholds. Just interested whether – do you have any similar impact from the reduction in the outlier thresholds or is that 2.9% estimate net of that proposal?

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

So, we have such little exposure in the high-cost outlier that it rarely is impactful, and that was the same way it was on this particular proposed rule. So, that affects other providers to a much greater extent than it does us, just simply because we have such a low percentage.

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

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Yeah, that 2.9% is all inclusive, and it's because of the phenomenon that Mark just mentioned. We have less than one-half of 1% in the way of outlier payments.

Scott J. Fidel

Analyst, Stephens, Inc.

Q

Got it. And then, just as my follow-up, and I guess I'll return to the ongoing discussion around the MA discounts versus fee-for-service. And maybe, if we just try to use 2023 a bit as an exercise on this since the MA plans, just in the rate book alone, are going to be getting around a 5.25% rate bump. That's even before some more benefits they'll get from normalization of risk adjustment. And if we look at the IRF and hospice proposals and assume HA is relatively similar, we're sort of in that high to 2s to 3%. So, I guess, my question is, would you be assuming that for your two segments, that your MA sort of business rate updates would be more in line with the 2.5% to 3%? Or do you really see any more opportunity to close the gap with that much healthier rate increase that the MA plans themselves will be getting?

Mark J. Tarr

President, Chief Executive Officer & Director, Encompass Health Corp.

A

It's the latter.

Operator: Thank you. We – I am showing no further questions at this time. I would now like to turn the program back over to our presenters for any additional or closing remarks.

Mark Miller

Chief Investor Relations Officer & Senior Vice President-Investor Relations and Strategic Planning, Encompass Health Corp.

If anyone has any additional questions, please call me at 205-970-5860. Thank you again for joining today's call.

Operator: Thank you. Ladies and gentlemen, this concludes today's event. You may now disconnect.

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