PARTICIPANTS

Corporate Participants

Crissy Buchanan Carlisle – Chief Investor Relations Officer, Encompass Health Corp.
Mark J. Tarr – President, Chief Executive Officer & Director, Encompass Health Corp.
Douglas E. Coltharp – Executive Vice President & Chief Financial Officer, Encompass Health Corp.
Barbara A. Jacobsmeyer – Executive Vice President & President-Inpatient Hospitals, Encompass Health Corp.
April K. Anthony – Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.

Other Participants

Matt Larew – Analyst, William Blair & Co. LLC
Bradley Bowers – Analyst, BofA Securities, Inc.
Matthew Dale Gillmor – Analyst, Robert W. Baird & Co., Inc.
Whit Mayo – Analyst, UBS Securities LLC
Brian Gil Tanquilut – Analyst, Jefferies LLC
A.J. Rice – Analyst, Credit Suisse Securities (USA) LLC
Pito Chickering – Analyst, Deutsche Bank Securities, Inc.
Sarah E. James – Analyst, Piper Sandler & Co.

MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone, and welcome to Encompass Health's First Quarter 2020 Earnings Conference Call. At this time, I would like to inform all participants that their lines will be in a listen-only mode. After the speakers' remarks, there will be a question-and-answer period. [Operator Instructions] Today's conference call is being recorded. If you have any objections, you may disconnect at this time.

I will now turn the call over to Crissy Carlisle, Encompass Health's Chief Investor Relations Officer. Please go ahead.

Crissy Buchanan Carlisle, Chief Investor Relations Officer, Encompass Health Corp.

Thank you, operator, and good morning, everyone. Thank you for joining Encompass Health's first quarter 2020 earnings call. With me on the call today are Mark Tarr, President and Chief Executive Officer; Doug Coltharp, Chief Financial Officer; Barb Jacobsmeyer, President, Inpatient and Rehabilitation Hospitals; Patrick Darby, General Counsel and Corporate Secretary; and, April Anthony, Chief Executive Officer of Encompass Home Health and Hospice.

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 risk and uncertainties, many of which are beyond our control. Certain risk and uncertainties, like the magnitude and impact of the COVID-19 pandemic, 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 the year ended December 31, 2019, and the Form 10-Q for the quarter ended March 31, 2020 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, reconciliations 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.

Before I turn it over to Mark, 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.

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

Thank you, Crissy, and good morning, everyone. I hope that you and your family are at home, safe and healthy. We had a lot of momentum heading into 2020, and January and February were a strong start to the year. In mid-March, we began experiencing a significant impact from the COVID-19 pandemic. While we will touch on our results for the quarter, I will focus my comments on our response to the pandemic and the current operating environment. Specifically, I'll address patient and employee safety, supply chain management, current observations in both of our business segments, and legislative and regulatory relief efforts by the federal government. Doug will address steps we have taken to enhance our liquidity and ensure availability under our credit agreement.

Our healthcare workers are a critical part of the national infrastructure in this battle against COVID-19, and our employees are exhibiting heroic actions during this unprecedented period. I cannot emphasize enough how much we value and appreciate the efforts of our frontline teams in providing excellent care to our patients and contributing to our nation's well-being.

In recognition of their inspiring efforts, we invested approximately $50 million to support our frontline workers in both of our segments through an award of additional paid time off. To our teams in the field, I thank you for your commitment to your profession and for contributing to our country's safety and future.

The safety of our patients and employees is of paramount importance to us at Encompass Health. We have taken numerous steps to ensure their well-being, including the creation of COVID-19 task forces for each segment comprised of company leadership with a variety backgrounds, both clinical and non-clinical. These task forces are working daily to stay up to speed on the latest information from state and federal resources, constantly evaluating and updating the measures in place to help our patients and employees stay safe.

A primary focus of the task forces is supply chain management and, in particular, the availability of personal protective equipment for our patients and employees. The increased utilization of PPE resulting from COVID-19 pandemic has created supply chain challenges for all healthcare providers, and we have not been immune to the challenges. We have experienced reduced allocations of PPE from primary suppliers and have had to find alternative suppliers, paying premium prices that are as much as 15 times our normal pricing, and managing through limited visibility into production schedules and shipment status. We believe production capacity, both

domestically and internationally, is increasing, but we expect these supply challenges, including elevated cost, to persist for at least the next several weeks.

I need to pause here and thank the members of our supply chain teams who are working around the clock to secure PPE and other medical supplies for us. They have demonstrated resiliency and resourcefulness. Thank you for your commitment to keeping our patients and employees safe.

In addition to our persistent efforts to secure PPE, other steps we have taken include limiting patient visitors in our hospitals to primary caregivers while required training in order to safely discharge a patient home. We implemented screening procedures for anyone entering our hospitals, including employees, physicians and vendors. We also are following the CDC social distancing recommendations in our therapy gyms and performing therapy in patient rooms as needed.

For home-based care, we implemented self-screening protocols for all employees and are performing pre-visit telephones calls to access risk factors within the home, including the current health status of our patient and anyone else who is frequently in the home, prior to sending our clinical staff into the home for their visit. In addition, most home office and non-essential field personnel are working at home, and we have halted non-essential travel.

Now, let's shift the discussion to current operating trends and actions we have taken in response to them. Prior to the explosive growth of COVID-19 cases in United States, all of our business lines were experiencing strong volume growth. However, beginning in mid-March, we began experiencing decreased volumes in both segments, and the lower volume trends we saw in March have continued in April.

In our inpatient rehabilitation segment, we believe volumes are slowly beginning to recover, although remaining at lower than planned pre-pandemic levels. We entered March with an average daily census of approximately 6,800. We exited March with an ADC of approximately 5,300. The ADC hit a low point Easter weekend of approximately 5,150. Since that time, it has slowly and steadily recovered to its current level of 5,930.

In home health, our starts of episodes, which includes starts of care and recertifications, dropped 5% in March compared to the January and February average of approximately 28,000, and they're expected to decline by an additional 18% in April. Recent weeks' trends suggest a leveling off of decline. In hospice, ADC has remained relatively stable, going from an average of 3,677 in January and February to an estimated 3,633 in April.

We believe a number of factors related to the COVID-19 pandemic have contributed to the decrease in our volumes in both segments. The deferral of elective surgeries has served to lower census levels at acute care hospitals. While this is not a large percentage of our overall inpatient rehabilitation volume, we do take care of patients with multiple comorbidities that have elective surgeries and who need our level of post-acute care for the medical management and therapy interventions. Those patient volumes are significantly down in our hospitals in April. The deferral of elective surgeries has impacted our home health business as these patients have historically represented approximately 15% of our admissions.

Shelter-in-place orders have reduced emergency department traffic and, in turn, lowered census levels at acute care hospitals. Restricted visitation policies in place at acute care hospitals have severely limited access to patients and caregivers by our clinical rehabilitation liaisons and care transition coordinators. Assisted Living Facilities have also been on lockdown, which has resulted in a decline in home health admissions and our ability to provide in-person care to existing home health patients.

In addition, the heightened anxiety among patients and their family members regarding the risk of exposure to COVID-19 during acute care and post-acute care treatment has meaningfully impacted our ability to admit new patients and continue to care for existing patients. The message from the government and health officials has been consistent and clear to the public at large: stay home. We believe it has been so clear and consistent that some individuals having strokes, heart attacks, and other life-threatening medical emergencies have chosen, and continue to choose, not to call 911 or go to an acute care hospital for treatment due to fear of contracting the virus. This has served to further lower census at acute care hospitals and, in turn, has resulted in a decrease in our volumes.

While we cannot address a patient's fear of contracting the virus while receiving care at an acute care hospital, we've taken steps to address these fears for patients in our care. For example, in our inpatient rehabilitation segment, we are conducting more therapy individually in patient rooms when possible and appropriate. For home-based services, we are conducting pre-visit phone calls with patients and supporting our in-person care with telephonic visits when possible. We are in constant communication with our referral sources to ensure they know we are ready and willing to provide the care needed by patients.

During this time, we are conducting bed side assessments virtually and using phone conversations to educate patients and their families on the risk associated with avoiding post-acute care. In addition to limiting overall volumes in our segments, the fear of exposure resulted in a decrease in the length of stay in our inpatient rehabilitation segment and a decrease in visits per episode in home health, which has resulted in an elevated proportion of LUPA period.

To summarize, the COVID-19 pandemic is creating near-term pressures on our operations. It's impacting volumes, revenue per patient and expenses. At a minimum, we expect this choppiness to continue in the second quarter. But at this time, we cannot reasonably predict when it may end. As I mentioned earlier, although still well below our run rate for the first two months of 2020, we are beginning to see gradual increase in referrals and admissions in both segments.

For or our inpatient rehabilitation hospitals, we believe some of this may be resulting from improvements in the turnaround of COVID-19 testing results. We follow the CDC's guidelines for admitting patients in our markets. The CDC strongly encourages two negative COVID-19 tests before accepting a patient that was exposed or positive for the virus.

As COVID-19 spread across the United States, the results of tests were taking seven to 10 days to obtain. In early April, the timing of testing results began improving. In most markets, we can obtain results in three to five days, and in some markets, we are receiving results within 24 hours. Thus, we are now able to take patients more quickly from acute care hospitals.

We also believe our clinical liaisons and care transition coordinators have now adapted to working remotely. Normally, our liaisons are in the hospitals communicating directly with referral sources, patients and families. They had to learn to work remotely and find ways to improve their communication and processes to stay in contact with acute care case managers and obtain patient information in order to complete prescreen procedures. Finally, we are starting to hear that acute care hospitals in some of our markets are resuming elective surgeries, and we believe this trend will continue to expand over the next several weeks.

These are unprecedented times for our country and our Encompass Health family. We must be good stewards of our resources in order to ensure we are here for the long-term to care for the patients in our communities. After lengthy consideration to align staffing with current patient demand, we have developed plans to manage labor costs in response to lower volumes in both operating segments. In our inpatient rehabilitation segment, we have implemented market specific furloughs. In home health, we are considering changes to our compensation structure to create a greater level of variability in our cost structure to respond to significant declines in visit volume.

As described in the Form 8-K we filed on April 16, another important part of our company's and our nation's ability to combat COVID-19 pandemic is legislative and regulatory relief from the federal government. We are appreciative of the decisive actions that have been taken by the White House, Congress, HHS and CMS. The scale of this relief is unprecedented. The CARES Act, along with a series of waivers and guidance issued by CMS, includes efforts to help healthcare providers ensure patients continue to have adequate access to care throughout the pandemic.

Specifically, the CARES Act temporarily suspends the automatic 2% reduction of Medicare program payments, known as sequestration, for the period from May 1 through December 31, 2020. CARES Act also authorized the distribution of Relief Fund grants from the Department of Health and Human Services to healthcare providers to support healthcare-related expenses or lost revenue attributable to COVID-19. We began receiving payments on April 10 and, to-date, we have received approximately $237 million. As we previously noted, these funds are subject to terms and conditions, including restrictions on permitted use.

At this time, and without further clarification from HHS, we cannot reasonably estimate what portion, if any, of these funds we will be able to keep and use. We are holding these funds itemized in special accounts and are not spending or dispersing these funds while we assess the terms, conditions and permitted use associated with them.

For our inpatient rehabilitation segment, other regulatory relief efforts include temporary suspension of the 60% rule and the requirement that patients must be able to tolerate a minimum of three hours of therapy per day for five days per week. For home health, the relief includes revisions to the definition of homebound status during the period of the public health emergency, the allowance of nurse practitioners and physician assistants practicing in accordance with state laws to certify patient eligibility and provide orders for home health care services, and the ability to accept telehealth visits for purposes of the required face-to-face physician encounter. These regulatory actions have given our hospitals and agencies the types of enhanced flexibility they need to care for our patients and assist acute care hospitals in maintaining hospital capacity in the current environment.

We've also seen a constructive response from managed care organizations, which is particularly relevant for our Medicare Advantage business. Many managed care organizations have waived pre-authorization requirements for post-acute care, and a few are permitting and paying for home health televisits.

Lastly, in regards to regulatory updates, on April 16, CMS released its notice of proposed rulemaking for inpatient rehabilitation facilities for fiscal 2021. The proposed rule includes a net market basket update of 2.5% comprised of a market basket update of 2.9% offset by a productivity adjustment of 40 basis points. As expected, the proposal focused on routine updates and minor technical changes. It does not include any new quality measures or amendments to existing quality measures. Using our patients from October 1, 2019, through March 31, 2020, we currently believe the fiscal year 2021 proposed rule would result in an estimate of 2.4% increase in our Medicare reimbursement rates within our inpatient rehabilitation segment, effective October 1, 2020.

As I bring my prepared remarks to a close, I want to emphasize that our operating environment continues to change rapidly along with the COVID-19 pandemic and each market's response to it. As noted in our 8-K filing on April 16, with so much uncertainty, we withdrew our 2020 guidance. In addition, because 2020 served as a base year for our five-year growth targets, we withdrew those targets as well.

Throughout all of this, one thing has not changed. We remain confident in the prospects of both of our business segments based on the increasing demands for the services we provide to an aging population. This confidence is further supported by our strong financial foundation and the substantial investments we've made in our businesses. We have a proven track record of working

through difficult situations, and I believe in our ability to overcome current and future challenges. Encompass Health is a resilient organization whose foundation is its people. Whether you are a frontline clinician providing patient care or someone who serves in a support function currently working from home, I want to thank all of our employees for what they are doing in this time of altered routines and the countless changes in their daily lives. As noted in our core values, we are stronger together.

With that, I'll turn it over to Doug for more details on our financial results.

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

Thanks, Mark, and good morning, everyone. I'll start with some observations on Q1, and then I'll discuss liquidity and cash flow.

It bears repeating, prior to the onset of the COVID-19 pandemic, we were off to a really strong start this year. As previously disclosed, over the first two months of the year, IRF discharge growth was 7.7%, including 5.4% in same-store. Home health admissions were up 18.5%, including 5.8% in same-store, and hospice admissions increased 31.5%. This momentum had continued into the first part of March. These trends serve as further validation of our strategy and business model.

For the IRF segment, Q1 revenue per discharge was in line with our expectations, including our estimate of the impact of Section GG, which is increasingly difficult to isolate. Expenses were negatively impacted by the sudden slowdown in volume in March and the increased demands for PPE and cleaning supplies.

The volume decline we experienced in the IRF segment in the back end of March and extending into April cut across virtually all patient conditions, and we believe it resulted from a number of factors. For conditions like stroke and neurological that are appropriately viewed as nondiscretionary in nature, we believe there may have been a modest impact from patients choosing not to seek care; but, the larger impact appears to stem from these patients remaining in the acute care setting. This was due both to the excess capacity created in many of the acute care hospitals in our markets as they ceased performing elective surgeries, but did not experience a surge of COVID-19 patients, and patients choosing to forego post-acute inpatient care due to fear of COVID-19 exposure. Other patient conditions viewed as nondiscretionary and resulting from major trauma appear to have declined as a result of a reduction in accidents, as much of the country sheltered in place.

Finally, patient conditions such as lower extremity joint replacement are highly co-related to elective surgery procedures. We can see no reason why demand for these services will not return to pre-COVID-19 levels as the environment normalizes, and the volume trends we have experienced in April support this thesis.

We continued to see strong trends in Medicare Advantage. Our Q1 Medicare Advantage discharges increased 21.3%, including 19% in same-store growth. This portion of our business has proven to be relatively more inelastic than Medicare fee-for-service, likely owing to the higher concentration of stroke patients. For Q1, 36% of our Medicare Advantage discharges were stroke patients.

Our IRF de novo pipeline remains robust, including the significant opportunities within the state of Florida, as we discussed at our Investor Day in early March. I'm pleased to say that our business development team has continued to make progress on many projects, even in the midst of the current environment.

In the home health and hospice segment, we continue to be very pleased with the integration of Alacare, which was primarily responsible for the Q1 revenue growth. We also made significant progress on the continued deployment of the Medalogix Care module, although the COVID-19 pandemic has caused us to pause the rollout of this initiative.

As Mark stated, the effects of PDGM have been greatly exacerbated by the COVID-19 pandemic. Our Q1 revenue per episode, excluding the positive effect of the ZPIC reversal, was minus 5.9%. The largest impact within PDGM has been a substantial increase in LUPA episodes. For Q1, our visits per episode declined to 16.3 versus 17.7 in the prior year period. This decline was largely due to the heightened anxiety regarding COVID-19 exposure of patients and their families, resulting in declined visits. Although, we were able to substitute telehealth visits to support the needs of our patients for a portion of the declined in-home visits, Medicare does not reimburse us for telehealth visits and these visits do not count in the LUPA determination.

Additionally, as acute care hospitals' censuses have declined and visitation restrictions have been implemented, our referral source mix has shifted away from institutional into community, which under PDGM carries a lower reimbursement. Finally, as admissions have declined and recertifications have stabilized, an increased percentage of our 30-day payment periods are classified as late versus early; again, resulting in a lower reimbursement under PDGM.

Our home health volumes have been negatively impacted by the cessation of elective surgeries by the acute care hospitals, evidenced by a significant decline in the musculoskeletal rehab category of our patient mix. We believe this trend will improve with the resumption of elective surgeries in an increasing number of our markets, but it's going to take time for this pipeline to rebuild.

For Q1, the clinical collaboration rate was 35.9%, essentially flat with Q1 2019. However, as we've discussed on prior calls, the accelerating growth in our IRF Medicare Advantage business weighs down the all payor collaboration rate. As can be seen on page 19 of the supplemental slides, in order to illuminate this effect, we have provided the collaboration rates for both Medicare fee-for-service and Medicare Advantage, and each demonstrates continued progress. For Q1, the Medicare fee-for-service clinical collaboration rate increased to 43.8% from 43.4% in Q1 2019, and Medicare Advantage increased to 16.3% from 13.5% in the prior year period.

I'll turn, now, to liquidity and cash flow. Dealing with a global pandemic certainly was not a consideration when we engaged in proactive financings during the fall of 2019, but the actions we took have provided substantial flexibility to deal with this unprecedented set of circumstances. You may recall that, last fall, we issued two tranches of senior unsecured notes totaling $1 billion split evenly between 2028 and 2030 maturities. We utilized those proceeds to replenish capacity under our revolving credit facility and to retire a portion of our 2024 notes. We also amended our senior credit facility, increasing the revolver commitment to $1 billion and extending the maturity date to 2024. During Q1, we funded the final tranche of the Home Health equity puts and the exercise of the SARs, a total of approximately $263 million.

We ended the quarter with approximately $105 million of unrestricted cash and cash equivalents on hand, $613 million available under the revolver and with our leverage at 3.5 times. We have completed an amendment to our senior credit facility providing for substantially increased financial covenant flexibility through 2021. We believe the amendment helps to ensure access to the full amount of our revolving credit facility even if the effects of the pandemic persist throughout the year.

I should note that this time our plans do not contemplate any utilization of the CARE Act (sic) [CARES Act] (32:25) relief funds we have received or might receive in the future. We continue to evaluate the terms and conditions governing the utilization of these funds.

Turning to cash flow, there are a number of factors that will serve to at least partially mitigate the negative impact of lower revenues and higher expenses: the Medicare sequestration holiday covering the period of May 1 through December 31; the deferral in payroll taxes; a reduction of $100 million to $150 million in 2020 planned capital expenditures, largely based on project pacing; and, the suspension of activity under our share repurchase program.

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

QUESTION AND ANSWER SECTION

Operator: Thank you. [Operator Instructions] Our first question comes from the line of Matt Larew of William Blair.

<A – Mark Tarr – Encompass Health Corp.>: Good morning, Matt.

<Q – Matt Larew – William Blair & Co. LLC>: Hi. Good morning. Thanks for taking my question. Doug, I wanted to follow up on some of your comments about sort of patient stratification in terms of volume levels. Just wondering if you could maybe help quantify a little bit what the patient categories looked like in the back half of March, again focusing on things like stroke down to LEJR, and what things have trended like in April. And then, how you factored into your outlook sort of that return to procedures starting, potentially, on May 1 in some of your markets and what you're hearing from your referral partners on prioritization of procedures?

<A – Doug Coltharp – Encompass Health Corp.>: Well, Matt, there's a lot there. Let me try to start with the first part of that question. So I think very much like March, what we're seeing transpire in April is a tale of two different periods. So for March, obviously, the volumes changed very dramatically from the first half to the second half, and in April we're seeing kind of a reversal of that in the second half of April from a continuation of those trends into March.

For the first part of March, we were seeing trends such as neurological conditions down in excess of 35%, stroke down more than 20%, lower replacement joint down in excess of 40%, and the declines were really across all patient categories. The rebound that we've seen in volumes, as Mark discussed in his comments, since really the Easter weekend in April have been predominantly in the non-discretionary categories, but we are seeing a lift across all of those categories.

In terms of the resumption of elective procedures, it's really a market-by-market thing, and we haven't had enough time to really see how the prioritization is taking place and how that book of business is building.

<A – Mark Tarr – Encompass Health Corp.>: Matt, I'll just add on. This is Mark. Having the elective procedures start back up at the acute care hospitals will clearly help to impact home health as they benefit a lot more from the elective procedures. But I think, even though a lot of our patients in our rehab hospitals aren't from elective procedures, just having the activity back in the acute care hospitals where you have the discharge planners and social workers and potential referral sources for us to, once again, have one-on-one clinical conversations and have the ability to evaluate patients first-hand versus having to do all that work over the phone with our clinical liaisons and care transition coordinators will have a positive impact in our regaining our volumes that we lost during this period.

<A – Doug Coltharp – Encompass Health Corp.>: And, Matt, I think it's worth underscoring – again, I know we threw a lot at you during the prepared comments, but the ADC comments and the trends that Mark referenced in his portion of the script. So to reiterate those, we came into March running an ADC in our inpatient rehabilitation segment of 6,800. We hit a low point on Easter weekend at 5,150, and today we sit with an ADC of 5,930. With the low point, we were off from that trend at the beginning of March almost exactly 25%, and we have now regained half of that back, as we sit today, with an up-sloping curve.

<Q – Matt Larew – William Blair & Co. LLC>: Got it. Thanks. That's helpful. And then, just as a follow up, Mark, you alluded to sort of a number of the legislative changes. I just wondered if maybe Barb and April would be able to chime in on whether those have actually impacted your ability to or whether you have actually taken additional patients as a result of those rule changes. And then, of those rule changes, what you think might be most impactful or have the most staying power, thinking about sort of post COVID-19.

<A – Mark Tarr – Encompass Health Corp.>: Matt, we'll start first with Barb, and then I'll ask April to comment

<A – Barb Jacobsmeyer – Encompass Health Corp.>: Hi, Matt. Some impact may be coming from the waivers of the – particularly, the 60% rule and the 3-hour rule. It's a little early to tell exactly what's coming from that. We focused a lot on the communication of these waivers to the referral sources, but with so many folks working remote, both on our side and the acute care side, this communication and understanding of the waivers takes a little bit more time than usual. But I will say the one that probably has the greatest benefit is that 3-hour rule waiver, because there are patients historically that may have been able to come to IRFs, that had the medical necessity, needed a medical oversight, but maybe could not tolerate three hours of therapy. And today, we'll be able to admit those patients. And I think that's going to be a big support to the acute care hospitals.

<A – April Anthony – Encompass Health Corp.>: On the home health side, Matt, I would say the biggest kind of long-term value for us is the ability for NPs and PAs to be able to sign orders prospectively. I think that's going to give us a much easier flow of communication when we have larger practices where they have NPs and PAs. And in our rural markets where many of the patients are being served primarily by those NPs and PAs, it's going to open up a whole new avenue of referral source for us. I would say to-date, that that's had a relatively minimal impact, but I think there is – over time as that new provision stabilizes and is long term, that's going to create opportunity for us in the future.

I think in the near term, probably the biggest value we've seen is the ability to virtually have a presumptive homebound status. Obviously, in this environment, our high-risk seniors are advised to stay home. So the ability to document that homebound status and rely on the physician's recommendation for them to be homebound has been helpful, probably again, more administratively than anything, but it's certainly a help during the course of this PHE.

<Q – Matt Larew – William Blair & Co. LLC>: Great, thank you.

Operator: Our next question comes from the line of Kevin Fischbeck of Bank of America.

<A – Mark Tarr – Encompass Health Corp.>: Hello, Kevin.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, Kevin.

<Q – Brad Bowers – BofA Securities, Inc.>: Hi. You actually have Brad Bowers on for Kevin today. Thanks for taking the question. So on the home health side of the business, episodes were down more than admission. Is that the normal fluctuation or is that a result of COVID-19, or is that because you're not counting some of the telehealth business that you might not have been getting reimbursed for?

<A – April Anthony – Encompass Health Corp.>: Well, not sure I'm completely following your question, but certainly as we see admissions decline, that has a pull-through impact on episodes. But because episodes are still 60 days in nature, even though broken down into two 30-day payment periods, we're not really seeing – the slowdown in admissions that happened in the second half of March will really start to have an impact on ended episodes more as we move into the late May and June timeframe as those episodes start kind of fading out. I don't think that we've necessarily seen anything specifically indicative in our ending episode PDGM. It's just the nature of the waterfall. So I don't still think there's anything there.

<Q – Brad Bowers – BofA Securities, Inc.>: Okay. That's helpful. And then, just as a quick follow up to that, is there any way that you could quantify the impact from the LUPA, or is that the majority of the decline in the pricing?

<A – April Anthony – Encompass Health Corp.>: So we still count those patients as episodes even when they are receiving a low utilization payment. So I would say the impact of the LUPAs is more reflected in the revenue per episode than it is in the decline in episodes, because they are still considered an episode even if they're a LUPA. And we're looking at the decline in revenue per episode related to LUPAs in the back half of March that were accelerated because of COVID-19 being about 0.7% on the rate.

<Q – Brad Bowers – BofA Securities, Inc.>: Okay. Got it. That's very helpful. Thank you.

Operator: Our next question comes from the line of Matthew Gillmor of Baird.

<A – Mark Tarr – Encompass Health Corp.>: Good morning, Matt. Hello, Matt?

<A – Doug Coltharp – Encompass Health Corp.>: Matt?

<A – Crissy Carlisle – Encompass Health Corp.>: Matt, we can't hear you.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Hey, I'm sorry. Good morning. I had muted myself. Sorry about that.

<A – Mark Tarr – Encompass Health Corp.>: That's all right. [indiscernible] (42:16)

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: I was hoping you could talk about the CARES grant just a little bit. I know you're seeking clarity on some terms. Can you talk about sort of the clarity you're looking for, and then just where do you stand in the process? Are you still waiting for HHS to come back to you?

<A – Mark Tarr – Encompass Health Corp.>: Well, this is Mark, and I'll ask Doug to weigh in, too. I think that, as we said, we've parked them in specific accounts of which we have no anticipation of using those funds or moving them out until we get additional clarification. And there's a lot of language around the terms and conditions that we'd like to get additional clarification on. If you think back about other similar types of government funding that's been done in the past, there's not a lot of information relative to the definition of lost revenues or language around appropriate ways to use this for expenses. So we would just – we're taking a very cautious stance on it. We know it's not free money and we're being very diligent in our review of the circumstances and language around these funds.

<A – Doug Coltharp – Encompass Health Corp.>: Yeah. Matt, let me try to give you just a couple examples of why we've at least got a sense of caution as we approach this. First, the current form of the attestation is open ended, and it seems clear that additional terms and conditions can and will be added after the fact; and, we don't know what those might be or how onerous those might be.

A second example is the funds will require extensive reporting and auditing, and those requirements are likely to increase with time. Those requirements could also prove to be somewhat onerous and, as an example, we received funds at 209 separate legal entities and it remains unclear at this point as to whether or not we'll be able to aggregate those funds for utilization or reporting purposes.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Got it. Fair enough. That's really helpful. And then, as a follow up on some of the labor cost initiatives, that seemed a little bit new with this press

release. Is there a way to quantify sort of what you've already implemented versus what you're thinking going forward? And then, on the home health side, it sounded like there is a plan to move to a per visit comp model. Can you give us a sense for kind of how you're approaching that on home health?

<A – Mark Tarr – Encompass Health Corp.>: Yeah, Matt. Hey, this is Mark. I'll say a few points, then ask Barb and April to weigh in. Just a reminder, as we went into this COVID-19 period, we are very much working with our primary referring acute care hospitals, which were all gearing up using various models to anticipate a surge in these patients coming through the acute care side. So we wanted to make sure that we're there to service our acute care partners. And so, we were very careful not to eliminate a lot of staff that would have been needed to help manage that surge in patient flow through the acute cares and to post-acute.

Now, in most of our markets that never came to be. I think through social distancing and other measures taken, luckily, we saw a flattening of the curve, so to speak, and did not see that big surge of patients coming through. But if you would have looked at how we've managed our labor outside the pandemic setting, we would have taken quicker action to it, but we wanted to make sure that we were being responsible in our marketplaces to be part of the answer for the acute care and this anticipated surge.

So I'll ask Barb to talk about the furloughs first, and then go on to April relative to the compensation change.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: So first, before we started evaluating for the furloughs, we were flexing staff. And I think it's important to note that as we flexed staff, it was not to what you would consider our prior labor metrics, and that is mainly because of the decrease in productivity that has been occurring during the COVID-19 times. That includes things like the bedside therapies, the time that it takes to don and doff the personal protective equipment. So we've had to look really hospital by hospital as we've looked to manage other labor metrics.

When it came time to really make the decisions on the furloughs, the furloughs are affecting about half of our hospital markets. It's approximately 1,000 FTEs. It is difficult to associate a dollar savings at this time as there are folks that will be using their paid time off, initially, and then, also, as Mark alluded to in his opening comments, the volume is starting to recover. And in some markets, we may be pulling staff back from furloughs earlier than anticipated, but obviously that would be good news.

<A – April Anthony – Encompass Health Corp.>: In the home health market, we have, as you know from our prior discussions, a pretty high percentage of our visits, historically right around 80%, has been performed by our full time salaried and full-time hourly staff. And so, when you see a rapid decline like we did beginning in mid-March continuing through into April, it's hard to make that quick of a course correction. And as Mark said, we wanted to be very cautious, both to ensure that we had the staff available to support the surge if it were to come, but also to take care of our valued staff members along the way. And so, we have been taking our time in making that decision, trying to make good decisions and good use of our sources. We actually see that the percentage of our visits that are being completed by those full-time staff since the middle of March have continued to increase week-over-week as we offload per visit staff and begin to align more of the visits with our full-time staff members.

That being said, as we move into the eighth week of this pandemic, I think we definitely recognize that we're going to have to make some alterations. Don't think we're going to go all the way to what you suggested, which is to move our staff fully to a per visit model. We think we've had a lot of benefit, over the years, from having a dedicated full-time staff that focuses on the quality of care, that supports the mission of our organization, that makes sure that our patients are getting the very best outcome and that our culture is supported. And so, we think that we can find a way to do both,

to retain our full-time status of those employees and, yet, create a little bit more variability in the cost structure. So we hope to be announcing some adjustments that will create some of that flexibility and, yet, still honor our full-time staff members.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Great. Thanks for the detail.

Operator: Our next question comes from the line of Whit Mayo of UBS.

<A – Mark Tarr – Encompass Health Corp.>: Hello, Whit.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, Whit.

<Q – Whit Mayo – UBS Securities LLC>: Hey. Thanks. I was hoping you could just elaborate a little bit more on the reprioritization of capital spend, what you're deferring, what you're just canceling outright. And Doug, I know it's super early, but how do you think about your 2021 plan at this point? It might just be helpful to hear how you're thinking about the puts and takes that might go into your three-year plan at this point.

<A – Doug Coltharp – Encompass Health Corp.>: So with regard to the capital spending, again, we believe that we'll be taking $100 million to $150 million out of our original planned CapEx; and, the bulk of that is project pacing related to both de novo activity, and then also, to a lesser extent, to some of the major remodels we have. And some of that, frankly, is not driven by choice. It happens to be a favorable consequence, but just given the overall environment, work has slowed on any number of projects because of things like the availability of licensing and permitting personnel and even zoning variance requirements, and so forth, where you can't get administrative personnel at the state and local level because they're on work at home status or they're not working at all.

It's not going to materially change what the pipeline looks like in terms of 2021 and beyond; although, and you see this indicated in the supplemental slides, there is the possibility that some projects could shift from one year to another. But overall, that's where the bulk of it is. We also have that $50 million to $100 million allocated for home health and hospice spend. We do think that there are going to be additional consolidation opportunities that emerge out of this environment, but that has not manifested itself so far, and we're getting further along into the year.

In terms of 2021, there's a reason that we pulled our guidance for this year and it's because we're dealing with an unprecedented set of circumstances. We don't know how prolonged or severe the impact of COVID-19 is going to be. Now, again we are very optimistic by the trends that we've seen in both business segments, but particularly on the IRF side in the back end of April. And if that trend continues, it may put us in a position where we could be looking at a 2021 that is not materially different from the expectations that we had coming into the beginning of this year.

If there is a resurgence of COVID-19, which many in the medical community anticipate to some extent in the fall or winter of next year, that's obviously going to have an impact on our business; although, we think we'll be going into that better prepared to deal with the response. And I believe that will be the case for the entire medical community.

<A – Mark Tarr – Encompass Health Corp.>: Whit, we remain very committed to our long-term growth prospects, as Doug mentioned, starting in 2021. We're very pleased to be bringing on four hospitals this year. We already opened up our Murrieta, California hospital in February. We have two coming on in June, and then we'll have Toledo coming on towards the end of the year. And then, we've acquired one new home health agency in Fredericksburg, Virginia. So we're very excited – actually, Lynchburg, Virginia, but we're very excited about our growth prospects for the long term.

<A – Doug Coltharp – Encompass Health Corp.>: And Whit, as I mentioned in my comments, one of the things that I'm very pleased about is our business development team has continued to make progress on adding projects to the pipeline even as most individuals in business development, both in our organization and on the acute care hospital side, have moved to work at home status.

<Q – Whit Mayo – UBS Securities LLC>: Okay. No, that's super helpful. Thanks guys. Crissy, I'm good. Thanks.

Operator: Our next question comes from the line of Brian Tanquilut of Jefferies.

<A – Mark Tarr – Encompass Health Corp.>: Hey, Brian.

<A – Doug Coltharp – Encompass Health Corp.>: Hey, Brian.

<Q – Brian Tanquilut – Jefferies LLC>: Hey, good morning, guys. Good morning. Hope you guys are all doing well and safe. I guess my first question is, as we look past COVID-19, assuming we normalize, we're facing the possibility of a recession and high unemployment. I think, Mark, in your prepared remarks you talked about the resiliency of your business and how you've done well – or you've done okay in the past in tough environments. So would you mind just walking us through how you're thinking about that and the track record that you guys have in recessionary environments, especially given the kinds of services that you provide?

<A – Mark Tarr – Encompass Health Corp.>: Yeah. So Brian, given the nature of our patients and the fact it's a senior population, we've just not seen any impact, historically, from recessions. If anything, it's been recession proof. It doesn't impact our business a great deal. So as I said, we see, clearly, a near term impact from this pandemic. We'll get through this and there will be some sense of normalcy. We continue to believe that the demand for our services will grow. As I said earlier, we're committed to the long-term growth prospects in both of our segments. We believe that there will be significant opportunities on the home health front, once things settle down with the pandemic. We have outlined a number of the attractive markets that we believe that we'll have growth opportunities on the IRF side of our business. So we're very confident in the underlying drivers of the continued need for our services and our opportunity to grow.

<Q – Brian Tanquilut – Jefferies LLC>: No, I appreciate that. And then, I guess my second question is for Barb. Medicare Advantage has been growing quite well for you guys. Is there anything that we should be thinking about in terms of like rate differentials or any thoughts on what's driving MA growing faster than the rest of the books.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: I think it's helped things on the growth side. It's really been about them understanding the value proposition. I mean, we don't have their data, but we have Medicare claims data. So when we can bring that information to show how we compare, particularly to the skilled nursing facilities in our market in a much less readmission rate, that obviously becomes a cost to the MA provider. So when we can really have them understand the value proposition, I think that's been the piece that's been – what's helped us convert so many of the certifications to being allowing the admission, particularly on the stroke sides, to our hospitals. And over the years, as Doug has talked about in the past, we've really moved away from those per diems on the MA side to really a CMG level, like we are with Medicare. So we've made great progress there.

<A – Doug Coltharp – Encompass Health Corp.>: Yeah. Our payment differential between Medicare fee-for-service and Medicare Advantage for the first quarter was down 6% and, as Barb suggested, that relates in large part to the fact that we've moved an increasing percentage of our Medicare Advantage book of business to a case rate but it also has to do with the patient mix. As I

mentioned for the first quarter, 36% of our patient mix in Medicare Advantage was in stroke and that carries a higher revenue per discharge.

Operator: Our next question comes from the line of A.J. Rice of Credit Suisse.

<A – Mark Tarr – Encompass Health Corp.>: Hello, A.J.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, A.J.

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Hey, everybody. I guess when you guys talked about the different volumes you're seeing in home health, it sounded like you may have had three main drivers behind that: the lack of post-acute referrals coming out of the acute care setting; the lockdowns in the assisted living area; and then, I think there was also the mention of people just worried about the risk of taking on the – taking on home health visits in their home when they're on lockdown. Anyway, because obviously, we can track each one of those separately, I think, or get a sense of how they're evolving. Can you say how much, roughly, each of those is driving the softness versus one of the others?

<A – April Anthony – Encompass Health Corp.>: It's a little bit difficult to pin them down totally, but we think the elective surgery component, that has historically made up a mid-teens to high teens level of our total referrals. So we've seen those virtually dry up, all the orthopedic procedures for hips and joints and shoulders. Those components have been pretty significant. They're not zero, because some of those are still happening if it's the result of a break or a fracture, but seeing a significant decline in those components.

When we look at the risk of patients kind of rejecting care, we've seen a little less – haven't seen as much of a decline in our conversion from referral to admission. That's dropped by about 3 basis points, but we mostly are seeing that patients are sort of accepting the initial admission, but then they're weaning down the visits to a point that we're seeing our LUPA rates have jumped from sort of the 8% level pre-COVID-19 up to about a 14% level at this current time. So that one is really a little bit less than the conversion to admission, more so that once they get here they want a fairly slim number of interactions and we're doing a lot of the support of those patients with slim visits via telephonic interventions, which as Mark mentioned, are not yet billable in the homecare space. We certainly hope Medicare will revisit that at some point. But at this stage, we can support patients that way, but we can't count it as a visit.

The AL/IL component, I would say as well, is a little bit less substantive as it relates to the admissions and more impactful as it relates to the LUPA rates, because we do see that the patients we're serving in those communities were having less access, and they might let our nurses in, but not our therapists. And so, we're just seeing more LUPAs being created in that market as well as opposed to pure volume. So I would say most of our volume declines have been as a result of low hospital census and elective procedures not occurring at the moment.

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Okay. And then, maybe just a follow-up on PDGM. Obviously, we were watching how that played out. There's clearly a lot of noise, now, given everything else that's going on, but have you been able to offer assessment of how – is that tracking as you thought it would, better, worse? And I guess, this was about the time you guys said that you thought PDGM would drive some inquiries from some of the smaller home health agencies. I know it's hard to complete a deal when you can't be with people face to face, but are you seeing that or is the crisis sort of mitigating the need somehow for people to go given that they maybe are more willing to take the federal money that's available or something?

<A – April Anthony – Encompass Health Corp.>: Yeah. So let me first sort of address your question about PDGM. I think going into kind of the mid-March timeframe, we were actually feeling like PDGM was coming out slightly better than we had hoped that it would from a rate per episode

basis. That took a pretty hard turn in the back half of March as LUPAs expanded. We found the transition to be a little bit more costly moving from the PPS wind-down and PDGM. But as far as a recurring basis, I think we were feeling pretty good about the effectiveness with which we were managing through the PDGM process and that the rate impact was definitely within the realm of our expectation that we painted in the fourth quarter.

What we think we're seeing on the acquisition side is, obviously, folks are not having necessarily time to enter into proactive discussions about acquisitions, and the combinations of the advanced payments by Medicare, the PPP loans to small providers, and then the pro-rata share of these CARES Act dollars, all of those have created a bridge for those small agencies who are struggling from a PDGM perspective to kind of live through it. And so, we haven't seen a wide scale interest level in talking about transactions right now, but we think those three federal support programs is the reason that things have sort of slowed down on that front.

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Okay. Thanks.

Operator: Our next question comes from the line of Pito Chickering of Deutsche Bank.

<A – Mark Tarr – Encompass Health Corp.>: Good morning, Pito.

<Q – Pito Chickering – Deutsche Bank Securities, Inc.>: Hey. Good morning, guys. Thanks for taking my questions. Going back to the IRFs for a second, looking at the stroke and the neuro patients, I understand from the script that some patients are not seeking care, but I believe you said that the larger impact was in patients staying in the hospital. Are those patients staying in an IRF setting in the hospital or just longer length of stays within the hospital, and then being discharged directly into the home? I just want to make sure I know where these patients are going.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: Yeah. I think it's actually both. You do have hospitals that have their distinct part units, and in those situations, because they don't have the elective surgeries and those other things, those are the patients that they are keeping. So we're not seeing that overflow come. But I also – we did feel the impact in those hospitals that do not have the distinct part units from the standpoint that it was – those patients were staying a lot longer initially, particularly in March and early April. It was taking so long to get the COVID-19 test back that – our length of stay is 13 days and there were times those patients were 10 days waiting for results of those tests. The results are coming back much quicker now, and so we're able to move those patients out of the acute care hospitals into our IRFs much quicker, now, as we get to the back half of April.

<A – Mark Tarr – Encompass Health Corp.>: I think it's important to point it out. When the acute care hospitals started really winding down and making sure they had open capacity for these COVID-19 patients, they also sent all their discharge planners and case managers, or a lot of them, to work from home and on the phone, and that gave us – that took away all of our visibility in a lot of these acute care hospitals relative to what types of patients they had or what types of patients would be suitable for our care. I think it also was very distracting relative to just the overall flow of patients through the continuum from acute to post-acute. So like I said, I think it's very important to note that with the increase in elective procedures there will be a more normal pattern with onsite discharge planners that we'll have the ability to have access to. We'll know a lot more about what's going on in acute care hospitals.

<A – Doug Coltharp – Encompass Health Corp.>: The last thing on that, Pito, is it took more time than I think most folks would have anticipated for the regulatory relief that Barb described in one of her earlier responses, and April alluded to as well – we're speaking, now, to the IRF side and for the benefits of the elimination of the pre-authorization within the Medicare Advantage plans and within the MCOs, in general, it took a longer period of time for those to make their way down to the market by market level

<Q – Pito Chickering – Deutsche Bank Securities, Inc.>: Okay. Thanks.

<A – Doug Coltharp – Encompass Health Corp.>: Those required clarification of specific guidelines that had to be disseminated all the way down before they could become actionable and have any impact on volume. We believe we're just now starting to see the benefit of those items on our volumes.

<Q – Pito Chickering – Deutsche Bank Securities, Inc.>: Okay. That makes a ton of sense. And then, for April on the televisits via telemedicine, I understand the lack of reimbursement and the margin pressures coming from that, but can I ask how effective you've seen televisits at this point? And if Medicare starts to reimburse it, could this be a margin game-changer for home health if it becomes permanent?

<A – April Anthony – Encompass Health Corp.>: I think we have certainly seen that, if done well and thoroughly, that a televisit can be a valuable interaction. There is no replacement for the nurse putting her eyes on the patient, taking their vital signs, communicating directly, observing their health status. And so, we don't think it's an equivalent trade. We do think that it could be supportive to hands-on care, but we would never see it as something that we think would be a significant replacement of hands-on interaction, but perhaps just an addition and a potential small volume substitution for live visits.

<Q – Pito Chickering – Deutsche Bank Securities, Inc.>: Great. Thanks so much, guys.

Operator: And ladies and gentlemen, we have time for one more question. Our final question will come from the line of Sarah James of Piper Sandler.

<A – Mark Tarr – Encompass Health Corp.>: Good morning, Sarah.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, Sarah.

<Q – Sarah James – Piper Sandler & Co.>: Hi. Good morning. Thanks for squeezing me in. I wanted to follow back on the comments you made earlier about consumers choosing to sort of wean their home health visits. I'm wondering, within April, if you saw a difference from the beginning of the month to the end of the month on that as consumers sort of get used to the new normal that they might be living with this contagion out there through 2021 or until a vaccine is created? Are they opening up towards the end of April any different than you saw in the beginning of the month of wanting to have home health visits?

<A – April Anthony – Encompass Health Corp.>: We are actually seeing a return to that, and I think it's multi-fold. I think, particularly, we're seeing some of the ALF/ILF communities realize that if you – we're, again, into that kind of the eighth week of this pandemic, that these folks can't go without care for that extended of period of time. And so, as proper PPE became more readily available, as we could come in fully donned in PPE, the risk for both our caregiver and for the patient in the community went down dramatically. So we've seen some of those facilities open back up to us under those guidelines of full PPE.

We've also seen that, with patients in their individual home, kind of the same reality, not only of just the duration of this, but you may be able to go a week or two without your therapy and not notice it, but you get three weeks and four weeks into it and it starts to really affect your quality of life, your risk of falling, a combination of factors. And so, I think as patients have come to the realization that this is really not an elective choice, I really need this, I might be able to postpone it short-term, but long-term it's going to have a negative health impact. We've been able to have conversations with patients and bring that back, and so we have seen a slight recovery. We certainly hope that our

LUPA rate that I mentioned sort of hit a high point at about 14% begins to come down, now, as we move into the May timeframe, and we're seeing little bit of hopeful signs in that direction.

<Q – Sarah James – Piper Sandler & Co.>: Great. And last question is, earlier in the call you guys mentioned a mix shift to community referrals away from institutional and that the community referrals pay less. Can you help us understand the difference in the payments of community versus institutional referrals, and then are you starting to see, in April, any reversal of that trend?

<A – April Anthony – Encompass Health Corp.>: Yeah. In the last two weeks of April, we've seen a little bit of progress in our overall referral trend and it is being driven by institutional referrals, we believe. And so, that's an encouraging sign; and hope that as elective procedures begin to come back online in a number of states that we'll slowly see the trickle increase to a steady flow of opportunity. The reimbursement differential – I don't have that statistic right in front of me, but there is, in fact, a reimbursement differential between episodes that are early institutional versus early community. And so, we could pull that data and Crissy could provide that to you more specifically after the call, but there is definitely a – just a structural difference in that reimbursement within the PDGM system.

<Q – Sarah James – Piper Sandler & Co.>: Okay. Thank you.

Operator: Ladies and gentlemen, that was our final question. I'd now like to turn the floor back over to Crissy Carlisle for any additional or closing remarks.

Crissy Buchanan Carlisle, Chief Investor Relations Officer, Encompass Health Corp.

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

Operator: Thank you, ladies and gentlemen. This does conclude today's Encompass Health's first quarter 2020 earnings conference call. You may now disconnect, and have a wonderful day.