BofA Securities 2020 Virtual Health Care Conference

LHC Group

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KEVIN: OK, I want to thank everyone, for joining us today. It's my pleasure to introduce LHC Group. LHC is one of the largest home care providers through its network of home health and hospice and personal care, as well as a long-term acute care hospital business. Presenting today, we have Keith Myers, who is the CEO of the company and Josh Proffitt, who is the CFO of the company. And with that, I'll just jump right into the questions here. Obviously the focus right now is on COVID. Everything seems to be focused on that. Tell a little bit about how it impacts your volumes so far and how you're seeing volume trends kind of return in May.

JOSH PROFFITT: Yeah, Kevin. This is Josh. And just let me start out by thanking you and the whole B of A team for putting together this virtual conference. We're all adjusting to whatever the new norm, at least the temporary new norm, looks like under COVID-19. And you all are doing a great job of putting this together, and we've had some good meetings. So thanks to Bank of America.

With regard to volumes, I guess I'll give you maybe even a little bit more current update from a census and an admissions standpoint. So last week when we released earnings in our supplemental deck, we put some pretty granular week over week information out there to show really what was going on. And I'll maybe stick to home health first on the average census by week, and then our weekly admissions.

So from an admissions standpoint, as the week ended May the 2nd, we were back up to, if you will, 6,700 admits from a low the week of April 18, of 6,167. I'm pleased to report, since we've got this call today, I've now got data through week ending May 9 that we didn't have in the deck last week that we had a 7,069 at midweek last week, which is up 14 and 1/2% over that April 8 week, and is the first week we've had north of 7,000 home health admissions since the week ending March 21.

So if you start to plot this out over a period of time, I think you're slowly starting to see those admissions volumes ramping up. From a census standpoint, we're now close to 76,800, so a little over 700 higher than we were when we reported last week for about a 2 and 1/2% increase over April 18. So that's kind of the granular data to give support to where we're seeing the volume bounce back. I would say it's a more macro level.

Not only are we seeing it in the trends and in the data, but you know, from 21 of our key states having reopened for elective procedures out of our 35 states, that represents 88% of our historical home health admissions volume. So we've got a pretty high degree of confidence that as we head throughout Q2 and into Q3, seeing an uptick in some of that pent-up demand from an elective procedure standpoint being admitted into the home.

KEVIN: So all in all, you know, we're not anywhere at pre-COVID levels, but we're definitely well beyond, we believe, the [INAUDIBLE] that occurred back in kind of the mid-April point, and starting to build back up.

And I guess, to that pent-up demand concept, how much of the volume that has been deferred so far do you think ultimately does come back? Obviously hard to predict, but when do you think things should get back to normal?

JOSH PROFFITT: Yeah, it's hard to predict the when. Embedded in your question was almost an if and a win. On the if side, I think we could all say that it's just a delay of elective procedures, not a canceling of them. So folks that were planning and scheduling procedures will still get rescheduled and replanned. So then you get to the when. And that, I would hate to even overly try to predict that for you, Kevin, other than to say all of our conversations we're having with our key JV partners is very positive. And now that these restrictions are being lifted-- and it's not just the medical restrictions on elective procedures, but most states are in various stages of phase one, phase two of reopening. And I think that's giving just their citizenry a newfound confidence to go out and have the procedures done.

So it's one thing to have the ability to do them. You still have to have folks that want to go into the facility and get out and do those sorts of things. So I still would say it'll be a slow ramp back up throughout Q2, and then hopefully by Q3, if there's no secondary spike in COVID activity or no new outbreak that would change this, that you would probably see it by then.

KEVIN: OK, great. The COVID dynamic has kind of skewed a lot of the conversations. Coming into this year, if you had asked me back in January what my first question to you would have been, it would have been about PDGM. So why don't we shift there, and say how has that gone so far? How is the rate impact on members' expectations, and the progress as shifting to the new stacking model?

KEITH MYERS: Hey, this is Keith. Josh, maybe we can split that up. Maybe you can take the rate part of this and feel free to chime in on the other as well. As it relates to PDGM, for us, PDGM is just another CNS rule change. And to us-- I mean, I'm just talking about LHC Group-- we operate a unique clinical delivery model that was developed in the 90s. It's patient-tailored, patient-specific, and it's based on industry outcomes and best practices, and updated annually. And we have a clinical team that does that every year. On years like this, where you have a significant change in the reimbursement model, then the workload is much greater. But the process is the same.

We've done this now-- I'd say this is the third time the clinical team has needed to go this deep into the model. So one-- the first time was in the originating model in the transition from cost reimbursement to prospective pay. And that was in 1998 to October of 2001 when we went live with prospective pay. Then again in 2008, we had a significant change in the model that caused them to do more work that year. I think the only thing that compares to the workload they had in 2019, preparing for 2020, goes all the way back to the work they did in '98 and '99.

But all of that work, which started in March of 2019 and went on for that whole year, is paying dividends now. So all that to say, PDGM is going very well for us. We're very conservative in our estimates or our expectations. So it's exceeding our expectations, but our expectations were conservative from a performance standpoint.

Josh, you want to speak to rate?

JOSH PROFFITT: Yeah. Thanks, Keith. Yeah, Kevin, if it wasn't for COVID, I think even our earnings call would have been really focused on PDGM. So I'm glad that you went there this early in this fireside chat. Because everything that Keith just described in the process that built up through us putting out guidance for this year, and having the confidence to speak to all of those metrics earlier in the year was because of all that hard work that the clinical team put in last year. And it got tested throughout all of our pilots.

As evidence buys to support what Keith just said, we were tracking ahead of schedule against all key metrics, not only revenue, but EBITDA, EPS. Across the board, our cost initiatives are going ahead of schedule that we were ramping throughout the year. Early on in January, February, we were accelerating those efforts, and even into the beginning of March.

COVID really hasn't impacted the underlying efforts and execution around PDGM. So we continue even now sitting here in the midst of COVID to execute upon those cost efforts. And then on the rate side, the behavioral adjustment was a little north of 4% in the final rule. We had said we expected in Q1 it could be 3% to 4%, and it came in at about a 3% headwind. We fully expect that to be behind us by the end of Q2, going into the back half of the year, and still have that expectation. So from all the key metrics that we monitor, from both the cost and the top line side, again, it's exceeding our expectations at the timing of when it's being executed.

The last piece, the PDGM that I would probably put out there is, we talked a lot heading into 2020 around the market share gain opportunity that PDGM would present, and the absorption of market share in the markets that we serve. And when we were coming out of the gate with an almost 12% organic growth rate for the month of January and February, it's hard to directly attribute how much of that was due to PDGM, but I've got to believe a portion of that was already attributable to PDGM.

So that's another really good positive early indicator of the execution of the new payment model.

KEVIN: Yeah. That's an interesting point. I think that coming in, investors look at PDGM as an opportunity for some of the larger players to take share. And part of the assumption was going to be that it was a difficult logistical issue to respond to from a coding perspective, from a staffing perspective, get the costs in line. But then part of it was going to be because RAPs was going to create disruption and pressure on these companies.

What do you think has been the biggest pressure on them so far? And is RAPs the headwinds you thought it would be because the CARES, because of the ability for companies to accelerate payments? Or is that still a kind of a tailwind to market share gains in the future?

KEITH MYERS: This is key. Josh, I know you're ready for the RAPs question. Let me just say this ahead of time. So I've spent a fair amount of time on [INAUDIBLE] and having conversations with different owners, and some of them I've known for a lot of years. One thing that, in addition to RAPs and all the other things they face, one thing I think that everyone realized is how fragile the business can be. And product of COVID-- the worst case scenario might have been cash flow. We've heard of pandemics are not disruptive as that could be to your business.

But in the home health industry, people were faced early on with the reality of patients in their homes not wanting the caregivers to come to their home out of fear they might catch something from them. Home health never experienced that before. Once we got the PPE and all that was geared up, then that got better. But I think a lot of, in addition to all the financial pressures, I think people are not taking their volume and their source of referrals for granted as much as they used to.

JOSH PROFFITT: Yeah, great point, Keith. So I'll start at the end of the question around RAPs and cash flow, and the accelerated payments, and some of the CARES Act items. But then I want to come back to something that Keith just said. So coming into this year, one of the largest primary disruptors from PDGM that folks were predicting to impact the smaller mom and pops and regional providers was the elimination of going from the RAP being at 50%, 60% down to 20% in this year, and then going away next.

As you duly noted, Kevin, with the accelerated payments program, that was fully intended to be a bridge for cash flow disruptions. Now it was intended to be a bridge for cash flow disruptions due to COVID, but it still serves a cash flow benefit for all providers. And then you've got the provided relief fund money as well.

So I think that all of that would indicate that the timing of some of the RAP-related disruption maybe pushed out a bit as they have some cash flow relief. But I think the more macro bigger point that we would not have seen coming, but for COVID, is what Keith was just alluding to. And how a lot of the referral sources, whether it's physicians offices, all the way up through large hospitals, and health systems, and our JV partners.

I would say they're all kind of leaning in right now toward the higher quality home health providers, that not only are high quality from the standpoint of patient outcomes, patient satisfaction, referral source satisfaction, all the key metrics that are always discussed around quality, but also those that have systems and infrastructure in place to be able to be a clinical partner to them in this type of a time of crisis and need.

And Keith alluded to PPE. The ability to obtain PPE and to be able to equip your workforce with appropriate clinical masks, and gloves, and other forms of PPE equipment was really a game changer for us very early on. And that not only gave the patient population the confidence Keith alluded to, but it gives the referral sources the confidence to work with you. So it's hard to unpack all the different layers between PDGM disruption and COVID disruption. But as evidenced by the pre-COVID ramp in admissions and now the post, current COVID uptick in admissions, we feel like we're very well positioned.

KEVIN: Yeah. So the question that I guess I'd ask then about that is when you think about these market share gains that you're targeting, how much of it is just going to be organic growth and kind of outcompeting the local competitors versus the desire or need to go in and spend capital to buy up some of these struggling providers?

KEITH MYERS: I think the way we look at it-- it's not an exact science. But generally speaking, if we're established in a market, then in most cases, we're going to first look to take share in that market where we're already established obviously. If we're looking at market where we aren't established yet, it's a great opportunity to plant a flag. And there are exceptions. There are some brands that are very strong and have been in the market a long time.

And they might be very sticky, and we might not be able to absorb that. So we'd certainly acquire and operate two brands in [INAUDIBLE] or something. We do that now. So we're not averse to that. It's not a bright line. Was it just about consolidation? What was the other part? Josh, you have anything you want to add to that?

JOSH PROFFITT: No, I think that's [INAUDIBLE].

KEITH MYERS: Yeah.

KEVIN: OK. All right. And then I guess we could talk a lot about some of the the organic opportunity. You guys did a pretty large deal buying AFAM. How has that gone? I guess there were some questions about what the growth in AFAM was initially during the integration. Can you provide any comments there?

JOSH PROFFITT: Yeah, Kevin, this is Josh. Across all key metrics and key measures of success for us, when we were exiting 2019, we really felt great about where we were with the AFAM integration. As we said all along, 2019 was really that final integration transition year where we converted all their legacy assets to our instance of home care base. In Q4, we then took it upon to convert all the home and community-based service locations from a legacy system that they had utilized to our third-party EMR for that service line. So all of the real heavy lift to the transition and integration is behind us.

But the real kind of tale of the tape of the success was going to really show itself in Q1. And again-- I hate to keep using pre-COVID and current period stats, but I guess that's the world we live in right now-- if you look at our total all-in organic growth as one of the key measures of success, we had constantly been talking about how 2020 was going to be the year that we reported the combined company and no longer broke out AFAM. We were tracking exiting February at a 12% organic growth all in.

And I know we mentioned this on our call last week as well, but Florida has gotten a lot of attention even pre-merger between LHC and Almost Family, Florida was always a topic of conversation for William and his team. And very pleased to report that in that same kind of two month period to start out this year, we were tracking just a little bit north of 15% organic growth in the state of Florida.

So I think from a growth perspective, we were hoping that 2020 would be a year that they would look just like a legacy LHC asset, and very pleased to report that they were starting that way. Also pleased to report that even in the face of the pandemic, thank goodness, we had fully converted them to all of our systems. Because there was really no difference between an LHC location and an Almost Family location from day one, helping to be a good health partner in all of markets we serve around COVID-19. So they have proven their ability to perform during this pandemic as the LHC assets have. So big kudos to all of their leaders, and the division presidents, and folks that are running those assets as well.

And the last piece I would say really on Almost Family, as it relates to transition and integration, is the only thing remaining is a little bit of incremental continued improvement in extender utilization. When we acquired AFAM, their LPN percentage was just a little shy of 30%. We've now gotten that up to 40% LPN versus RN. LHC runs somewhere between 50% and 55%. So we still got a 10% to 15% opportunity in our legacy AFAM locations for extender utilization. But otherwise, I would tell you that couldn't be more pleased with the team and couldn't be more pleased with where we're at with AFAM.

KEVIN: All right, great. And then, Keith, tell me a little bit about [INAUDIBLE] looking on the home health side. How do you see that as a growth area? And then how do you think about capital deployment there versus in the core home health business?

KEITH MYERS: This is Keith. So we're very bullish on hospice. I hope you heard us say that clearly. I think home health, we see a lot of opportunity for consolidation in markets where we already have a footprint. So we're still looking for opportunities in home health. But the majority of our corporate dev efforts-- I mean, let's call it two-third, one-third-- I think now are being spent on hospice and growing that service line. We've said that, but we've said that for a lot of years. But this has really created-- the conversion to PDGM and our need to focus operations on home health, and then the disruption slash opportunity resulting from COVID really causes us to focus more on growing home health organically, and perfecting the PDGM model. And for 2020 and probably early 2021, focus more intensely on hospice.

JOSH PROFFITT: Yeah, Keith, this is Josh. One thing I might add to maybe connect the dots that doesn't seem as clear to connect, but go back to the last question where we were just talking about our confidence in the integration of Almost Family, and then move that forward into a discussion around pipeline, and capital deployment, and acquisition appetite. You know, if pre-Almost Family, you know, LHC Group would primarily look to do $100 million or so a year in acquisitions, and most of those were in much smaller acquisitions and smaller hospital joint ventures, I think that the confidence that not only we have, and the team here at LHC has, but even in the board room, of our ability to evaluate, close upon, and effectively integrate larger acquisitions is probably at its all-time high for the company. Would you agree with that?

KEITH MYERS: Absolutely.

KEVIN: All right, great. And then maybe just then switching back to home health for a second. one of the big growth areas is Medicare Advantage. It seems like it's growing exponentially with the Medicare population, and you're growing that relatively well. How do you think about

growing that business? How can you grow it better? And how can you make progress on closing that gap in rate between fee for service and [INAUDIBLE]?

KEITH MYERS: Thanks for bringing that up, teeing up Bruce's job description for him.

[LAUGHTER]

No, I'm obviously going to flip it to you, Bruce, here. But I just want to say this question, we had this question on the earnings call Friday. And we believed, I believed for a long time that we had to work with managed care plan. Part of that, I'll admit, was forced upon us on pressure from our hospital joint venture partners to be able to take more payers from them. But also I'm a data guy. So I can see the math going in that direction. And you have to stay at the table to be able to work things out, and it takes a really long time.

Those are really long-term negotiations. I think our commitment has always been there. We weren't getting the response that we had hoped for 10 years ago. And I'm sorry for being the 10 year guy, but I've been doing this a long time. And I have to share this with you so maybe you'll give me a pass on this.

The 10 year language was told to me first by chairman Billy [INAUDIBLE] in the '90s, when I was much younger. Showed up in Washington DC, pounding the table, and wanted them to fix whatever our issue of the day was. And I really thought I'd make just a couple of trips up to Washington DC, they'd get it, and they'd quickly remedy whatever the problem was that was frustrating us.

And one day, Chairman [INAUDIBLE] sat me down and he said, you're going to have to calm down. He said, if you're going to be in this and make a life out of it, you have to learn to start measuring progress in decades. It let the air out of my balloon in a big way, and I'm sure all of you, many of you on the phone would agree.

So we still manage a business year to year, quarter to quarter, and all. But on some of these things, we really do have a long-range view. I'm not joking about that. And managed care is one of those things. So Bruce?

BRUCE GREENSTEIN: Well, I think I'll just go ahead and continue to pull that thread and think about some of the things that I'm going to talk about is going to be measured in a generation. Because it has to do with absolutely changing--

SPEAKER 1: Not your performance.

[LAUGHTER]

BRUCE GREENSTEIN: It's absolutely about changing the way that the American health care system views post-acute care, and that being from institutions into the home. So I'll just kind of park that, and we'll be able to talk about this as a group together over the next whatever 15, 20 years together. But really for managed care, there's three pieces that I want to go over briefly.

One is the core incremental rate increases for the business that we do today. The next is around better arrangements under value-based care. And the third is new products.

And so to start with-- I know Josh has spent much time talking about this phenomena for the two years that I've been here-- but we have a great team that addresses our managed care market, whether it's through because of an acquisition or where we have strengths and high quality in a market, we continue to make the case for better rates for the business that we have all day long. And we've seen-- I'll call it substantial-- because getting 1% increase is big, but now we're looking at 8% revenue growth based on-- think about it as same store sales-- for our services. So that rate increase is because of the great work that we do, and the way that we bring that data to payers and negotiate for better rates.

So that's one piece.

The next piece is around value-based arrangements. So we like, appreciate, and perform very well under the way Medicare pays us under an episode. And we continue to bring that thinking to our payers to take the chains of per visit and really telling us how to do our clinical work. We like to take those chains off and replace them with a give us the patient and let us do what we do well. And in ways that we've shaped up that argument to payers, we actually went back to look at the 180 day total cost of care for patients that we take care of. Now we use Medicare fee for service because we have complete data for that.

But what we found is across multiple diagnosis categories, from sepsis, COPD, CHF, and for diabetic patients, we had a range of between 7% and 11% total cost of care less than the rest of the Medicare market. And when we bring those data to payers and have them envision with us what it looks like to do bundles that have fewer re-certifications, fewer re-hospitalizations, fewer trips to the emergency depart, and better overall management of the patient's clinical conditions, we've been able to find ourselves in arrangements where we get paid our base rate and then have found ourselves in bonus arrangements that reward us for the fine clinical care and the management of the overall total cost of care for those payers. And we believe we'll see that moving forward.

In addition, we are coming up on some new arrangements that just changes the whole base and pays us more in a bundle or episodic rate, which we do best in.

Lastly, it's around new products. And let me tip my hat to the managed care plans that are thinking ahead, whether it's around COVID and wanting to prepare for the fall doing monitoring programs, ways to get their patients out of the hospital quickly when necessary, and I think more importantly, ways to substitute for an otherwise nursing home placement post-acute, and instead, substituting it with a robust, in-the-home SNF diversion visit or episode.

And that's what we've developed recently with a number of health systems, and we're doing it today. And our payer partners are very interested in ways of thinking about doing that for the foreseeable future. For the reasons of COVID, or the anxiety of patients and families, and then lastly, because it makes much better economic sense to bring a patient home for around, let's say,

$4,000, $5,000, than it does to do a SNF placement, which could be anywhere from $7,000 to $11,000.

So that's what we're doing there. It's been quite positive, and COVID has actually accelerated the positive progress we've been making.

KEVIN: That's really helpful. I guess maybe that [INAUDIBLE] my last question as we're getting near the end of time. You talked about new products and things like that. Is there anything that you guys would point to as things that you're doing as a company, the way you're doing your job, or maybe the way that people [INAUDIBLE] your health care system that you think are happening today because of COVID, but will actually persist over the long term?

BRUCE GREENSTEIN: We want to talk about SNF diversion as an example. At the request of a large health system partner, they're really getting backed up in their hospitals where SNFs wouldn't take patients discharging out of the hospital without two successive COVID-negative tests, or they just weren't accepting any patients period.

So we put together a program that we call the SNF diversion program, which is for patients that are still clinically appropriate for home health-- and I should just say that as a footnote, that most of our health system partners don't fully appreciate the degree to which we take complex acute patients. They just fall into the top 10% of home health patients. But we focus in that area.

And what this means is we have heavy interaction and collaboration with the discharge planners, and hospitalists, and patients' families to start with, usually in the middle of their hospital visit. And then we do a very speedy transition into the home, the robust assessment, and then we bring extra resources and materials to the patient when necessary. So it could be a full remote monitoring technology platform. It could be our intervention to smooth out the DME delivery to make it faster. And it may end up for us coordinating with home and community-based services to fulfill some of the social needs which could be around home sitting, meals, transportation, from outside of home health.

But that's an area that has shown the capabilities of home health to bring complex patients home. And we think that that's one of these findings that can never be unlearned, that there is always the opportunity to go home instead of an institution. And as we have been talking to our payer partners about what we're doing with these hospital partners, they're very interested in trying to put together some product that they can utilize with us for the foreseeable future. And like I said, I think that this is something that COVID has highlighted and really created a very urgent need.

But we want this to be a very durable for families, and health systems, and payers. We think home is the right place to go, the safe place to go. When it's clinically appropriate, it's the best place to go. And we think that that's going to be something that will have a cultural shift, again, I say, over a generation. It's being sped up through COVID, but I think it's something that will last for a really long time.

KEVIN: All right, that's perfect. I think that's all we have time for. Thank you very much for your time. Appreciate it.