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PRESENTATION

Operator

Good morning, and welcome to the LHC Group Third Quarter 2020 Earnings Conference Call. (Operator Instructions) Please note, this event is being recorded.

I would now like to turn the conference over to Eric Elliott, Senior Vice President of Finance. Please go ahead.

Eric C. Elliott - *LHC Group, Inc. - SVP of Finance*

Thank you, Danielle, and good morning, everyone. I'd like to welcome you to LHC Group's earnings conference call for the third quarter ended September 30, 2020. Hopefully, everyone received a copy of our earnings release last night. I would also like to highlight that we have posted some supplemental information on the quarter and the impact of COVID-19 on the Quarterly Results section of our Investor Relations page. The supplemental deck as well as a copy of the earnings release, the 10-Q, and ultimately, a transcript of this call, when available, can be found on this page. Our supplemental deck includes all of our reconciliations and breakdown of adjustments. We will refer to these non-GAAP measures during our call today.

In a moment, we'll have some prepared comments from Keith Myers, Chairman and Chief Executive Officer; and Josh Proffitt, President. We are also joined by Dale Mackel, our recently announced Chief Financial Officer; Dr. Ben Doga, our Chief Medical Officer; and Bruce Greenstein, our Chief Strategy and Innovation Officer, who will all be available, along with Keith and Josh during Q&A.

Before we start, I would like to remind everyone that statements included in this conference call, in our press release and our supplemental financial information may constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act. These statements include, but are not limited to, comments regarding our financial results for 2020 and beyond. Actual results could differ materially from these

projected in forward-looking statements because of a number of risk factors and uncertainties. Certain risk factors and uncertainties, such as the magnitude of the impact of COVID-19 pandemic that could cause our actual results to differ materially from our projections and estimates, are more fully set forth and described in our annual and quarterly SEC filings included in our earnings release and related Form 8-K, our Form 10-K and our Form 10-Q when filed. LHC Group shall have no obligation to update the information provided on this call to reflect subsequent events.

Now I'm pleased to introduce the Chairman and CEO of LHC Group, Keith Myers.

Keith G. Myers - *LHC Group, Inc. - Co-Founder, CEO & Chairman*

Thank you, Eric. And thank you, everyone. Thank you for dialing in and participating in this morning's call.

Before we begin, I want to thank all of our LHC Group family members for the amazing work that they do every day. Thank you. You, our people, are our greatest differentiator and our most valuable asset. Because of your unwavering dedication and commitment to serving others and to excellence in all that you do, our LHC Group family of health care professionals continues to benefit from opportunities to grow our founding mission of service that began nearly 3 decades ago. It is truly a privilege to work with all of you. Again, thank you.

This morning, I'd like to lead with what we do best, which is providing high-quality, cost-effective health care services to people throughout our country in the safety and comfort of their homes. Everything we do starts there, and it's encouraging to see how our singular focus on caring for people in the setting of their choosing is lining up with the increased demand for quality health care services delivered in the home. This demand is broad-based across all payers, referral sources and joint venture partners, resulting in strong organic growth. We are also seeing an increasingly more favorable regulatory environment that is fully recognizing the crucial need that in-home health care fulfills.

Over the past decade, we focused intensively on becoming an industry leader in quality of care and patient outcomes. Our success in these efforts continues to pay dividends in many ways, including consistent industry-leading year-over-year organic growth.

As we described in August, we continue to see a new normal in referral patterns, one where patients, families, physicians, discharge planners and other referral sources are increasingly choosing the safety, effectiveness and efficiency of in-home health care services over more costly and potentially higher-risk congruent inpatient care settings.

At the height of the pandemic, we saw primary care physicians referring higher-acuity patients to home health. We also saw medical directors and SNFs reassessing patient population and writing discharge orders to home health. These trends were reflected in the number of new physician referral sources that in April were above our pre-COVID pace and then hit double-digit year-over-year growth in the second and third quarters.

Some of these gains in new physician referral sources were related (technical difficulty)

Operator

One moment while we connect the speaker line. Your line is back into the -- your line is open in the call. You may proceed.

Keith G. Myers - *LHC Group, Inc. - Co-Founder, CEO & Chairman*

Okay. Thank you. After returning quickly to positive organic growth throughout July, we experienced a 4.7% year-over-year increase in home health admissions for the third quarter, an 11.6% sequential growth for the second quarter of 2020.

With hospice, we saw an even greater improvement with a 12.8% increase in organic growth for the quarter and 4.3% sequential growth over the second quarter of 2020. These positive organic growth trends continued throughout October.

Throughout the pandemic, we've experienced unique opportunities to demonstrate our range of capabilities and potential, but we don't feel that we have been pushed to our limit of patient acuity. It's clear that the number of referrals to SNFs from institutions is down, and referrals from institution directly to home health is up.

SNF diversion, which was an increasing trend, has become a best practice. We believe that, at a minimum, the lower-acuity 1/3 of patients referred to SNFs are clinically appropriate to be cared for in the home, achieving equal to or more favorable outcomes and patient satisfaction, and of course, at a lower cost. This is backed up by our experience in our growing ACO population. We are also seeing more physicians referring directly to home health from their offices or virtual visits. We believe these institutional and community trends that are being put in place are durable and contribute to a significant organic growth tailwind for us going forward.

We have also seen our M&A activity materially increase in recent months. After completing the joint venture with Orlando Health on August 1, we finalized the joint venture with the University Health Care System for home health and hospice in Georgia and South Carolina, a joint venture with Northeast Georgia Health System for home health in Georgia and expanded an existing joint venture with CHRISTUS Health to add a hospice location in Texas.

We also completed the acquisition of a hospice provider in Aurora, Colorado that will operate in conjunction with our existing home health location in that market. We believe that this recent activity will continue to gain momentum with increased M&A and continued strong organic growth trends in Q4 and 2021 as we anticipate an historic consolidation opportunity in home health and seeing an increasing number of hospice opportunities in our pipeline.

In summary, we believe we are well-positioned for a strong finish in 2020 and a strong start in 2021.

Turning to the regulatory environment. The CARES Act and the policies that were put in place to free up nurse practitioners and physician assistants to take on a greater role were a good start earlier this year and so were the final rule that CMS released for hospice and home health for 2021. More consequential legislation is in play through the Home Health Emergency Access to Telehealth legislation, or HEAT Act. This bipartisan legislation that was introduced late last month in both the House and the Senate. The HEAT Act legislation has strong sponsorship and directly addresses a hole in CMS's approach to the pandemic. While they have allowed the use of telehealth to facilitate visits, it has been without any reimbursement to this point. We will continue funding it internally to deliver the care that is required for our patients. But if this becomes law, it will allow home health agencies to be reimbursed for the duration of this public emergency.

In conjunction with industry colleagues through the Partnership of Quality Home Health, the National Association for Home Care and state associations throughout the country, we are working closely with members in both the House and Senate to build consensus on this important piece of legislation.

Late last week, CMS posted their home health final rule for 2021. Overall, there weren't any surprises in the rule. And more importantly, there are no additional cuts this year and no recalibration of case weights. The final rule resulted in a net positive 1.9% for home health reimbursement and loop of payments. There was no modification of the 4.36% behavior adjustment under PDGM.

CMS had originally proposed a 2.6% increase, but more data for both inflation outlook and productivity reduced the amounts. CMS refused to reduce or eliminate the 4.36% behavior adjustment because they feel it is premature to do so, and they are required to go through notice and comment rule-making for any changes to the national standardized 30-day period payment rates to account for differences and assumed versus actual behavior change. There were no other major policy changes, but I do want to note that they made the changes from the March 30 interim final rule permanent regarding flexibility in the use of telecommunications equipment in the home. They will also let home health agencies claim administrative costs on the cost report for telecommunications technology, which will help with rate setting in the long-term.

I want to close my prepared comments by once again acknowledging and thanking the special people who make all of the above happen, our growing family of 32,000-plus employees. We strongly believe that we have the best team in the industry, and we will continue to make investments to ensure that they are safe, protected and have access to the best resources and support available. It's important to us that they have as much peace of mind and quality of life as they provide to patients and families throughout our country each day.

Before I turn it over to Josh, I want to introduce Dale Mackel, our new CFO. Dale joined us earlier this week. He comes to us most recently from Blue Cross Blue Shield of Nebraska, where he was Executive Vice President and CFO with a broad portfolio of direct responsibilities across that organization. His experience with the Blues and Aetna, in addition to other roles he has had throughout his career, will prove beneficial as we accelerate our ongoing work with payers and partners. Dale?

Dale Gerard Mackel - *LHC Group, Inc. - Executive VP, CFO & Treasurer*

Thank you, Keith. It's a pleasure to be here this morning and to be a part of this team. Having watched firsthand what LHC Group has accomplished in the industry from my time on the other side of the table, this is a great opportunity to join a leader at the forefront of value-based care. I look forward to bringing my experience to bear as we work with payer and joint venture partners.

As I did my detailed due diligence on the company and met more members of the leadership team, I quickly realized just how strong and deep of a finance and accounting team we have here at LHC Group. I expect to complement this team, and I'm looking forward to supporting them in every way possible as we collectively continue to support the growth and performance of the company.

Since I transitioned into health care at the start of 2008 on the payer side, and as my wife as a registered nurse, I have often thought about and considered when might be a good time to move over to the provider side. With the health care landscape evolving so much and given LHC Group's history of and commitment to the highest standards of clinical quality, compassionate care and unwavering commitment to compliance and integrity, this was the natural choice for me at this time in my career.

Now I'll turn to Josh to provide some additional color on our financial and operational results as well as our updated outlook.

Joshua L. Proffitt - *LHC Group, Inc. - President*

Thank you, Dale, and good morning, everyone. Thank you all for joining our call. I'll begin my prepared remarks by saying how much I appreciate all of our clinical professionals and support personnel across the country and what they do each and every day. It is a true privilege to serve you as you give so much of yourself serving others.

From the transition to PDGM to historic pandemic to several severe weather and wildfire natural disasters that have affected some of our providers within our national footprint, 2020 has been a challenge to say the least. However, it is a challenge that has highlighted our resolve and strengthened us in ways that we could have not foreseen as we entered this year. I could not be more proud of our entire LHC Group family and truly humble to be in a position to represent you all on this call and to support and advocate for you each and every day.

I would also like to take this time to welcome Dale to the team. We conducted a very thorough national search over the past few months and placed a particular emphasis on experienced, financial and accounting professionals who came from the managed care world. Dale is extremely qualified to lead our finance team and brings a skill set that will help us accelerate the work we're doing in payment innovation and care models. I have been getting to know Dale over the past couple of months, and I'm excited about how well he fits the LHC culture and how well he will complement our strong and deep team of financial professionals. He's already hit the ground running.

Our supplemental financial information is posted on our website with detail on the breakdown among sector performance as well as a significant amount of detail on the monthly trends. I encourage you all to review the supplemental financial deck as it provides additional details to my comments this morning.

The third quarter was once again impacted by expenses associated with COVID-19 for purchases of PPE, additional supplies and employee-related costs and expenses, including employee bonuses, increased wages and wage supplements for frontline caregivers and other categories of costs and expenses incurred in response to the pandemic. The $10.5 million in pretax or $0.24 per diluted share was nearly half of what we experienced in COVID-19 costs in the second quarter. We expect that these COVID-related costs and expenses will continue in the near term, but we anticipate they will continue to decline sequentially.

Another major change in our results is worth highlighting as well. As most are aware, the government continues to adjust the eligibility requirements and the related calculations associated with the Provider Relief Fund. However, based on the continued strength in our results and the favorable outlook for our business, we have decided to return the entire $93.3 million in funds we received from the Provider Relief Fund. We remain extremely thankful for the government stepping in during an unpredictable and unprecedented crisis for our country. We appreciate the support of the policymakers who advocated for and provided relief on behalf of health care providers across the continuum to pass the CARE Act (sic) [CARES Act] and the benefits afforded by the CARE Act (sic) CARES Act during the early months of the pandemic when our business was impacted and the recovery was yet unknown.

We believe returning these taxpayer dollars is the right thing for us to do and that these funds can best be used elsewhere in assisting with the ongoing response to the pandemic. As a result, for the third quarter, we reversed $44.4 million or $0.87 per diluted share, net of NCI and tax and government stimulus income that we had recognized in the second quarter. The reversal had no impact on our adjusted EPS as we had previously excluded the impact. The full amount we received was recorded as a short-term liability and government stimulus advance in our consolidated balance sheet.

I will also note that there was a change by CMS in the repayment schedule for the $317.9 million in accelerated Medicare payments we received in April. Recruitment will now be in the stages that begin 12 months from our receipt of these advanced payments by CMS withholding 25% of future Medicare fee-for-service payments for claims for 11 months and then withholding 50% of future payments for an additional 6 months. An interest rate of 4% will be assessed on any outstanding balances 29 months from the date of the initial advance, but we fully intend to repay the full amount before any interest will accrue.

The reversal of the government stimulus and the impact from the higher COVID-related expenses have once again created a bit of noise in our reported results, but what is abundantly clear is how remarkable the pace of weekly and monthly improvement has been across all our segments. If we go back to our COVID-induced low, we are up approximately 12.4% in home health centers, and we are up 7.1% from where we were prior to the pandemic.

In home health admissions, we are close to where we were pre-COVID. And in hospice, we are in line with pre-COVID levels already. As Keith highlighted earlier, sequentially, we are up 13.1% in home health same-store admissions in Q3 from Q2. And in hospice, we're up 8.3%. We have a little more work to do on the institutional versus community mix returning back to normal, but we are close, and that metric is definitely moving in the right direction. That's a tribute to the commitment of our clinicians and the investments that Keith mentioned earlier as well as the many months of preparations pre-COVID we had putting in place our PDGM care model and operational strategies.

Similar to last quarter, I'd like to break down these comments on the monthly improvement with each of the key drivers. First, home health average daily census went from a low point of 74,817 for the month of April to a high of 84,091 for the month of October, which represents a 12.4% increase in home health ADC since April. This monthly improvement has come, even though there are a number of states that were slow to lift the ban on elective procedures and reinstated them in some cases. And my last data point on home health ADC is that, as of this morning, we are sitting at 85,259 patients on census.

Home health admissions were at our lowest point in April with 27,948. As our supplemental information shows, the third quarter monthly average was 24.4%, above that COVID low, with between 34,400 and 35,200 admissions per month. That improvement led to posting a 4.7% positive increase in organic home health admissions compared with a 4.7% decline in the second quarter. For October, we have reached 36,786 admissions.

I would also note that our non-Medicare episodic same-store admissions have grown 34% year-over-year from 7,778 in Q3 of last year to 10,422 this quarter. The majority of this growth is from episodic contracts that pay at Medicare equivalency.

For our missed visits due to COVID-19, we saw a similar trajectory. Our highest point was the month of April with 22,913 missed visits. You can see in our supplemental deck that we have experienced a steady decline each month since October and had 722 missed visits due to COVID-19 that month.

Our expected LUPA rate is between 8% and 9% of total home health episodes, and that's what we saw pre-COVID. We hit a high point in April of 11.4% and have now been within our targeted range of 8% to 9% each month since. We were at 7.9% in October.

The number of patients declining admission due to COVID-19 has also been trending down by month ever since the high in April. As of last month, we were down to only 103 refusals.

Our LTACs maintained their strong pace with average daily census climbing to 264 patients from 257 in the second quarter and 206 a year ago. We received full LTAC reimbursement for every patient admission for the entire quarter, which brought our revenue per patient day to $1,346. This public health emergency-related relief is currently scheduled to be in effect through mid-January of next year.

Our new referral sources, which, again, are a key driver of our organic growth, showed monthly improvement. For the first quarter, we had 3,915 new sources of home health referrals. That improved to 3,996 in the second quarter and was up again to 4,582 in the third quarter. That's an increase of almost 42% over the third quarter of last year. Within the third quarter alone, we saw increases of 40.3% in July, 35% in August and 51% in September. These new referral sources are early indicators and read-throughs to market share gains and organic growth.

Another strong indicator has been the number of confirmed COVID-19 and suspected patients we have treated since the pandemic began. Through the end of the quarter, we have provided care for 11,567 patients who were either COVID-confirmed or suspected, of which 94% were cared for in our home health segment and 6% in hospice.

As Keith mentioned earlier, all of these measures help connect the dots on how much in demand our industry-leading quality is among our referral sources and partners as well as how confident patients and families are in receiving the best care in the comfort and safety of their home or place of residence. Our partners have experienced firsthand throughout the pandemic just how well we have been able to deliver for them through close integration and collaboration with the highest level of quality in the most cost-effective setting. That's having a positive impact, not only on our organic growth, but also on our M&A pipeline as we are extending current joint ventures and reviewing an increasing number of inbound requests for new partnerships to fulfill similar needs.

The sheer number and quality of our partnerships was represented in the new joint ventures with Orlando Health in August, University Health System and Northeast Georgia in October and CHRISTUS in November. We expect we'll have a few more transactions to announce by the end of the year as well. All told, we've completed joint ventures representing approximately $14 million in annualized revenue since early August. And with our value proposition on display, our pipeline is as active as ever.

Let me now turn to our segment performance. Recall that we are still benefiting from the CARES Act's temporary suspension of Medicare sequestration through December 31 of this year. We saw a full-quarter benefit from the approximate 2% increase in fee-for-service Medicare payments, resulting in $6.5 million in additional revenue in the third quarter due to the suspension of sequestration. We still expect this to be a positive impact to revenue for us in 2020 of approximately $15 million to $20 million.

This sequestration effect and PDGM are meaningful enough to impact our revenue per episode, so let me drill down into these factors. Our revenue per episode was down approximately 1.4% in the third quarter from prior year, which is an improvement from the 2.5% decline we experienced last quarter. From a sequential standpoint, our revenue per episode is up 1.9% from $2,771 in the second quarter to $2,824 in the third. While we still remain ahead of our original expectation on the revenue and cost initiatives associated with PDGM, we continue to see the impact from COVID-19, offset by the suspension of sequestration.

COVID-19 caused increases in our community admissions as a percent of overall admissions as well as the shift of our patient mix from early payment periods to late payment periods. These were partially offset by the $5.1 million of additional revenue in the third quarter from sequestration. As a result of our focus on operationalizing PDGM, we continue to see rate improvements on episodes in progress, which gives us confidence in our ability to mitigate the remaining portion of the impact of PDGM that's previously planned once the impact from COVID stabilizes. The lower revenue per episode was offset by cost savings associated with greater efficiencies.

Our hospice and LTAC segments continued to perform well with volumes improving year-over-year and sequentially. The revenue impact from sequestration in these segments were $1.2 million and $204,000, respectively. The LTACs also received an additional $6.4 million in revenue from the change to full LTAC payment on site-neutral patients as required by the CARES Act during the PHE. We did see an increase in contract labor in the LTAC division and higher labor and wage costs in the third quarter due to COVID and expect those to normalize as we head into next year.

Our home and community-based services segment reported a 130 basis point sequential improvement in EBITDA for the third quarter as compared to the second quarter. During the quarter, we also experienced an impact related to COVID-19 with billable hours declining 14% as compared to last year, but that is up 1.1% compared to last quarter. We have been anticipating sequential improvement in our billable hours, and we continue to see this number improve to where we need to be entering next year.

I would also like to highlight the strong performance in our Healthcare Innovation segment. The primary driver was the outperformance of our ACO management company subsidiary, which yielded a $9.6 million Medicare-shared savings payment. This was well above the $5 million we had budgeted for the quarter and more than triple the $2.9 million we received in Q3 last year.

As we illustrated in Slide 17 of the supplemental deck, even if you normalize our Q3 results with only the $5 million we expected from the MSSP payment, our underlying performance across all other segments were still ahead of expectations. That said, we could not be more pleased with the results of our ACO management company and how our ACO model has demonstrated that independent physician ACOs and health system ACOs can achieve success in value-based health care.

We are extremely proud of our provider partners and look forward to sharing with them the financial rewards they have earned by delivering more primary and preventative care and referring to the highest-performing post-acute providers in order to keep Medicare patients healthy and avoid unnecessary costs. This strong performance by our ACO management company subsidiary is also very encouraging as a predictor of and to provide data and further learning that will benefit us in our home health service line as we move to more value-based and shared savings models with our managed care payer partners.

Based on these results, we've increased the guidance we reinstated only last quarter. We are now expecting net service revenue to be in the range of $2.06 billion to $2.07 billion, adjusted EPS to be in the range of $4.90 to $5; and adjusted EBITDA less NCI to be in the range of $232 million to $237 million. These new ranges compare to previous midpoints of $2.025 billion in revenue, $4.70 in adjusted EPS and $225 million in adjusted EBITDA.

With the strong sequential results we posted this quarter and the implied improvement for the fourth quarter, we are where we originally intended to be for finishing out 2020 with our new PDGM care model and operational strategies in place and entering 2021 with great velocity.

Turning to Page 27 of the supplemental deck, we have updated all of our debt and liquidity metrics for the quarter end. We have approximately $500 million of liquidity with cash availability on our credit facility and an accordion feature for up to $200 million of additional capacity, net of Medicare-accelerated payments and provider relief funds.

Adjusted free cash flow was $46.3 million for the 3 months ended September 30. Recall that the CARES Act permits employers to defer and deposit the payment of the employer's portion of social security taxes that otherwise would be due to -- would be due between March 27 and December 31 with half deposited by the end of next year and the other half by the end of 2022. As of September 30, we have deferred $33.6 million, which keeps us on track for a cash benefit of approximately $50 million to $55 million in 2020.

I'm pleased to report that DSOs continue to improve down to 54 days in the third quarter compared to 61 days in the second quarter. We expect mid-50s to be the normal range moving forward.

Stepping back and looking at how far we've come through the pandemic to get where we needed to be with our care model in place and being ahead of schedule with our cost structure for PDGM, combined with what we have learned through COVID and we have gained with new physician referral sources and partners that has accelerated our improvement, we are very bullish on our growth going forward. There could still be challenges ahead to overcome with COVID, but all the pieces are in place.

Our organic growth is accelerating from our COVID-induced lows with all key drivers moving in the right direction. Our inorganic growth has only scratched the surface with a number of joint venture opportunities adding to our M&A pipeline, and our potential acquisitions are currently comprised of nearly 2/3 hospice locations. This historic consolidation opportunity we have been anticipating in home health is materializing now that the government stimulus is wearing off for some smaller agencies, and that should begin to add to our pipeline as well. With the substantial liquidity we maintain on our balance sheet and the continued ability to execute on our co-location strategy through de novo's, we have a number of very compelling ways to accelerate our growth in 2021 and beyond. We look forward to sharing more of these details in the coming months.

That concludes my prepared remarks. Operator, we are ready to open the floor for questions. Thank you.

QUESTIONS AND ANSWERS

Operator

We will now begin the question-and-answer session. (Operator Instructions) The first question comes from Brian Tanquilut from Jefferies.

Brian Gil Tanquilut - *Jefferies LLC, Research Division - Senior Equity/Stock Analyst*

Congrats on the quarter. I guess my first question, Josh, as I think about guidance, from the guidance that you gave for the year, it's implied that it will be down sequentially from Q3 to Q4. I know you've got some moving parts in the Q3 number with MSSP, but just want to hear how you're thinking about that internally, just the progression of earnings.

And then, I guess, while we're in the topic of MSSP, how sustainable do you think that level of earnings would be as we look at next year?

Joshua L. Proffitt - *LHC Group, Inc. - President*

Yes. Thanks, Brian. I guess as it relates to guide, we tried to illustrate on -- I believe it was Slide 17 in the supplemental deck, but let me take just a moment to break it into its parts to illustrate that we actually do continue to expect sequential quarter-over-quarter improvement from 3 to 4 in the core base business, setting us up nicely for the glide path that we've been talking about for next year. So if you look at the midpoint of our reinstated guide from August, and I ran through those numbers in my prepared remarks, so I won't kind of re-go through the exact numbers now. And then the midpoint of our raised guide that we just put out, the differences are an increase of $40 million at the midpoint in revenue, almost $10 million in EBITDA and $0.25 of EPS.

So if you think about where we had originally guided with the MSSP expectation at $5 million, then the incremental upside created by the MSSP was approximately $4.6 million of revenue, which is all -- falls down to EBITDA, as well as $0.11 of EPS. So the implied guide increase from our core business, if you take the $40 million at the midpoint, back out the $4.6 million that is just inherently from the betterment of MSSP, that's almost $35.5 million of an implied guide raise on revenue and about a $0.14 implied guide raise on EPS with about $5 million of guide raise attributable to core business EBITDA being better than we expected when we put it out in August.

And then when you overlay that to kind of the midpoint to the upper end of our guidance range for the year and what it implies for Q3, we're actually implying almost about a $10 million to $15 million increase in revenue quarter-over-quarter with some potential for EBITDA growth and EPS growth as well from Q3. Does that help, Brian?

Brian Gil Tanquilut - *Jefferies LLC, Research Division - Senior Equity/Stock Analyst*

Yes, that helps. Yes. And then just the MSSP component, Josh.

Joshua L. Proffitt - *LHC Group, Inc. - President*

Yes. So I could not be more proud of and excited about our entire team and how they executed on the MSSP program. If you think about it, this relates to last year's performance, which is really the first full year that we at LHC Group had the accountable care management company subsidiary within our family. As most of the folks on the call might recall, this was part of the Almost Family segment and/or HCI when we merged with them in 2018.

So from 2 years ago, having performance at about $3 million of shared savings to being able to triple that year-over-year is really a testament to not only the leadership at the ACO management company that is all part of our team now. But really, I'm sitting here looking across the table adding, it's a testament to what a lot of the things that Bruce and his team have brought to bear as well as just the analytics that we have improved over the year in targeting those ACO patients and working with those payers, and specifically, the providers in the market on identifying areas to do preventative care and to really lower their cost of care.

So Brian, I'm going to ask Bruce to fill in some more details because I'm sure he's got a lot to add here. But for me, I don't know that I would replicate almost $10 million next year. If you're thinking about rolling into your next year numbers, you might pull that down a little bit because it does have a lot of play in it. Not really even sure how COVID is going to impact those numbers because, again, the numbers we just reported were pre-COVID. So there's going to be some COVID impact to the MSSP, which could go either direction.

But at a high level, I would like to highlight what we're learning from the ACO management company is directly translatable into all of the contracts that we have been entering into throughout the course of the year with a value-based component. And Bruce and his team are taking those learnings, getting with Dr. Doga and working with our operators to implement improvements operationally that will really be driving performance over the next few years, not just in the ACO. Bruce?

Bruce D. Greenstein - *LHC Group, Inc. - Executive VP and Chief Strategy & Innovation Officer*

Yes. Thanks, Josh. That was very well said. It's been one of our sort of secret incubation centers within LHC Group because we have harvested so many learnings from it with full Medicare fee-for-service data to prove out what these tests are.

But Brian, let me go back to answering your question. Yes, we do believe that we can carry on this performance forward. It really gets down to 3 areas within the subsidiary. We, one, have now our data analytics system fully ironed out. We onboarded it last year. Now we're running 100%, and we think that we're making further innovations on top of the analytics that we're able to run there to know how to target different physician practices and patients to get greater savings.

Number two, it's the programs that have been set up and now are running at full force. They are yielding significant savings, and we think there are still a lot of savings to harvest through those programs. In addition to that, we continue to build new programs to target patients and new locations. Lastly, it's the high level of cooperation with the physicians with whom we work.

So it's one thing to say that our MSSP payment was very high, which it was, but the other is the percentage of the ACOs that we work with that all triggered the MSSP payment to start with. You have to get over 5% of savings to trigger that. There's something about the feeling that a physician practice gets when they recognize all the work that they've put into it over the previous year now is continuing to show how it pays off by creating better savings and more efficiencies within their practices.

So those 3 areas, I think, put a lot of wind in the sails in our ACO program moving forward. And then sort of the positive wake that, that boat creates are the learnings that we then bring into the LHC family, home health, particularly, as we put those parts into our value-based arrangements and our performance in the field.

Brian Gil Tanquilut - *Jefferies LLC, Research Division - Senior Equity/Stock Analyst*

Got you. And then I guess my second question, Josh, as I look at hospice, revenue down sequentially. And then if I look at your supplement, right, admissions are up every month, census started trickling down and then billable hours down from, say, June and July. Just if you don't mind walking us through the dynamics there. Like what are the moving parts in your hospice business? And with admissions going up, does that mean that we should expect an uptick in census and billable hours as we get into Q4?

Joshua L. Proffitt - *LHC Group, Inc. - President*

Yes. Great observations, Brian. And yes, there's a little bit of, I hate to call it noise but, moving parts in the hospice numbers this quarter. Really pleased with, as you just noted, the admissions trajectory. There was a little bit lower average length of stay throughout the quarter. Some of that is attributable to COVID patients, which inherently have a lower length of stay. But as we expect the length of stay to kind of get back to a normal level, those admissions will then translate into census growth that we normally experience in hospice.

And then on the revenue side, as we pointed out in our supplemental deck, I believe it was -- I think that segment is on Page 22. We had a little over $2 million of some write-offs from some older periods in the hospice segment that is directly related and brought down the revenue. So if you add that back, your revenue is not only up a little bit, but your EBITDA margin normalized for the quarter is still in that 14% range.

And I would tell you, Brian, from the hospice segment standpoint, not only do we have good growth momentum, but we've been eyeing that 14% to 16% EBITDA margin for a while, and we've been talking to that -- about that with you all for a while. And sitting here, having some real good visibility into October and how we're projecting for the rest of the year, I mean, I think that 14% to 16% EBITDA margin for hospice is where we'll be in Q4.

Operator

Your next question comes from Andrew Mok of Barclays.

Andrew Mok - *Barclays Bank PLC, Research Division - Analyst*

Wanted to follow up on the strong gross margin performance in the quarter on the home health side. How did that perform relative to your internal expectations? Can you help us break down how much of the improvement was related to PDGM initiatives versus COVID? And relatedly, how should we think about the sustainability of that margin performance heading into 2021?

Joshua L. Proffitt - *LHC Group, Inc. - President*

Yes. Thanks, Andrew. I would say the lion's share, the -- almost all of the margin improvement was just from core fundamental operations, which inherently relates to the PDGM model. I wouldn't say there's any of that, that is COVID-induced or COVID-benefited with one caveat being, our visits per episode -- our in-person visits per episode are around 13 right now. And we could see that possibly tick back up a little bit to maybe the 14-or-so range, maybe throughout the rest of this year, maybe into next year. So incrementally, that little bit may be COVID-related. It's really hard to kind of break that apart, but I feel really good about where we are. We were a little ahead of our internal expectations on home health, which helped lead to the outperformance and the guide raise, but I believe that our internal modeling has that continuing through the fourth quarter with a lot of confidence going into next year, but this is now a new kind of run rate for us.

Andrew Mok - *Barclays Bank PLC, Research Division - Analyst*

Great. And then maybe a question for Dale. I know you're still settling into the new role but would love to hear some of your initial impressions on the balance sheet, including where you're inclined to deploy capital over the next 12 to 18 months.

Dale Gerard Mackel - *LHC Group, Inc. - Executive VP, CFO & Treasurer*

Yes. No, I mean, obviously, very strong balance sheet. And just -- first of all, I'd like to say and reiterate what a privilege it is to be with this great company and team. But LHC has a very impressive, strong balance sheet. And I think as you heard from both Keith and Josh in the prepared comments, the pipeline for M&A, joint ventures is very robust. And so I think we'll continue to be very disciplined in our approach of deploying capital to where we see the best opportunities for that.

Operator

Your next question comes from Scott Fidel of Stephens.

Scott J. Fidel - *Stephens Inc., Research Division - MD & Analyst*

Great. First question, just interested in your thoughts on the legislation that's been introduced to reimburse home health agencies for telehealth that's been introduced in both the House and the Senate. And how meaningful do you think that could be if it is approved?

And then potential legislative vehicles that you're tracking that you think that could be added to, for example, maybe the next stimulus package.

Joshua L. Proffitt - *LHC Group, Inc. - President*

Yes. Bruce, do you want to add something?

Bruce D. Greenstein - *LHC Group, Inc. - Executive VP and Chief Strategy & Innovation Officer*

Well, yes. I mean, it's -- we've been in a position in contrast to other providers with regard to telehealth reimbursement where other telehealth or other providers have been getting direct reimbursement, being able to drop CPT codes. And on the home health side, we did receive flexibility in mid-March to be able to count our -- to be able to exchange our visits but not count them towards LUPAs or required visits. And this would allow us to move forward in that area. So we find this very positive and also would sort of calibrate home health along with other providers, so we think it's a very judicious approach to move forward.

Now when it comes down to vehicles, probably a stimulus bill would be the most elegant and straightforward way to do that, but it certainly is possible that it stands on its own or picks up another bill that is health care related that it can be attached to.

Obviously, at this point, we have a clearer picture on what the leadership looks like in the House and the Senate. So despite a lot of uncertainties, in general, with the election. But this looks like it's got a strong base of support from the provider community, all the large advocacy groups, and we're having very favorable discussions with the leadership in the House and Senate that have been long supporters of the home health world.

Scott J. Fidel - *Stephens Inc., Research Division - MD & Analyst*

Okay, great. And then just had a follow-up question just on the institutional mix picking up again in October in home health, looks like that was up a little bit north of 200 basis points. First, just interested in terms of observations around geographies in terms of whether you saw that being pretty broad-based. And then also thoughts on sustainability of that. Just given the COVID surges across the country, whether you're still seeing that institutional mix hold steady or even improving? Or if you think that could be volatile just around the COVID trends?

Joshua L. Proffitt - *LHC Group, Inc. - President*

Yes, Scott. This is Josh. I think it's pretty steady. Now I would always say 1 month doesn't make a trend, but we're back up to 63% in October. Here, the early -- we track this daily, as you might imagine, so it's holding through the early days of November. And really, that breakthrough has been fairly broad-based. There are still some markets where the shutdowns in the elective procedures are not quite where they have been. But I would tell you, it's not only broad-based geographically, it's getting more and more broad-based among who the referral sources are as well. So our JV partners, as you might imagine, we continue to see that improvement and getting back to, what I would say, pre-pandemic levels of the mix we receive. And then other hospitals and institutional referral sources in the marketplace.

So if we can -- we're at 63% now. We were around 67% pre-pandemic. If we could get into that 65% to 70% range, which is where we had modeled earlier in the year prior to the pandemic even being a thing and when we were thinking of our PDGM. So we still got a little bit of improvement to go, but I feel good about all the market indicators we're seeing across our footprint.

Bruce D. Greenstein - *LHC Group, Inc. - Executive VP and Chief Strategy & Innovation Officer*

If I could just add one piece, Josh. When we look at this number, we tend to look at the percentage of. And so I'd like to consider what we are comparing the institutional admissions to, which is our community-based admissions. So 2 things. One is we've been tracking elective procedures as the sort of measure of hospitals bouncing back. But at the same time, that elective procedures have been down since March and even February.

Emergency department visits have been down quite dramatically as well. So while emergency department visits have come back, they're still not at pre-Covid levels, and there is a maldistribution in the ages. So those that are over 65 have come back at a lower level to the emergency room. And the emergency room admissions then many times get converted into an inpatient admission, and many of those patients end up being discharged to home health. So you can still see that there's going to be a lag of admissions to home health that will come out of the hospital sector. So we're watching this very closely as we move along.

At the same time, when we compare it to community-based admissions, we should not shy away from being proud of increasing the admissions from the community. We are picking up new admission sources. Our clinicians around each of our markets are explaining the way home health can be used as a pre-acute visit to home health, and in many cases, alleviates the need from going to the hospital at all. So we're using them, especially in the public health emergency, to help Medicare enrollees avoid going to the hospital altogether. It's a better deal for the Medicare Trust Fund, and it's keeping patients even safer in their home and anxiety lower. So that's something that we don't want to reverse or erase. We just want to see even higher volume coming from the hospitals, particularly when both elected and emergency department numbers move back to pre-COVID levels.

Joshua L. Proffitt - *LHC Group, Inc. - President*

Great point, Bruce.

Scott J. Fidel - *Stephens Inc., Research Division - MD & Analyst*

Got it. And when we think about what's sort of built into the implied 4Q revenue guide, is that 63% a pretty good baseline to think about? Or do you have that still -- are you building in the assumption that, that continues to improve over the rest of the quarter?

The 63% is pretty much what we've built in. So if there is improvement there, you could have a little bit of upside to that number.

Operator

Your next question comes from Justin Bowers of Deutsche Bank.

Justin D. Bowers - *Deutsche Bank AG, Research Division - Research Associate*

In the context of 5 or 6 hurricanes you guys dealt with this quarter, it was a great performance. Just kind of continuing on the last question, is there a way to think about what kind of the opportunity set is like from a pre-COVID perspective? So an example would be we -- typically, we generate 10% of our admissions from electives. We've only recaptured 5% of that. And so that -- and I'll stop there for the first.

Joshua L. Proffitt - *LHC Group, Inc. - President*

Oh, go ahead. Go ahead.

Bruce D. Greenstein - *LHC Group, Inc. - Executive VP and Chief Strategy & Innovation Officer*

So we do know. We've been tracking it all along. We're generally 7%, 8% of our admissions coming from elective procedures of the hospital. We're not quite back there yet. So we are seeing certainly higher rates since March, April, but we're not quite back to that full amount yet.

Again, at the same time, when we think about overall institutional, you think about, well, what makes up the rest? And again, many of those referrals that haven't gotten back to pre-COVID levels are patients that end up in the hospital through the emergency room, not through the front door. So we're really tracking on both sides.

At the same time, we're getting a greater share of hospital discharges relative to SNFs. And I know we've been fielding a lot of questions from the investor community over the last 6 months, and we're tracking these data very closely. So that's an area where despite lower discharges from the hospital in an absolute number, we're picking up a higher percentage of those that are coming out for any kind of post-acute care as we continue to take market share from patients that otherwise would have ended up in the SNF.

Joshua L. Proffitt - *LHC Group, Inc. - President*

Yes. And Bruce, this is Josh. I would add as well, when you take our answer from the last question and the extra color Bruce just gave here, that also -- it not only has an implication to the institutional percentage, it implies a betterment in case-mix as well because you've got a higher-acuity patient population that you're caring for, and you can see that in our numbers.

On Slide 21, we've got several different component parts that build the revenue in the PDGM world. So our case-mix, we also expect to continue to climb, and we see good progression there.

And then I would point you to the percentage of P1s versus P2s. And now that we have such strong and steady admissions growth on the home health side, that will continue to trend nicely for our percentage of P1s that also get a higher reimbursement in PDGM. So if you take all of those parts together, Justin, it's the institutional piece. It's the higher case-mix that's attributable to the institutional patient referral and then the P1 percentage.

Justin D. Bowers - *Deutsche Bank AG, Research Division - Research Associate*

Got it. And then for my follow-up, I just wanted to go back to the commentary that what you guys are learning from the ACOs is directly translatable to the home health business. And then in the slide deck, I think you said that your non-fee-for-service episodic visits were up kind of like an astounding 34% year-over-year. And then if I look at your -- the rates across that book, the non-fee-for-service, too, it looks like it's up a good like 8% year-over-year. So it looks like you guys are kind of going after that business with some targeted programs. And I just wanted to leave the floor open to kind of talk about some of the skunkworks initiatives you have going on there.

Joshua L. Proffitt - *LHC Group, Inc. - President*

Yes. Justin, it's Josh. Thanks for the question. So there's a lot to unpack there. I want to start off, and then I want to ask each of Bruce and Dr. Doga to jump in as well to really put some meat on the bone about what we're doing clinically and innovatively to make this happen. But I want to just highlight the numbers again. We've gone from just under 7,800 non-Medicare episodic admissions Q3 last year to almost 10,500. There's that 34% growth factor that you referenced. Those have also translated into -- at the start of the year, on January 1 of this year, we had around -- just under 8% of our home health census was non-Medicare episodic.

As we sit here today, we've been bouncing between 11% and 12% of our home health census over the quarter is non-Medicare episodic. And really, kudos to our managed care team. We've got a great leader that has been driving this, and we've been talking about it for several quarters on how this is a journey. And you have small wins and then you have incremental better wins. But we have been negotiating and getting much stronger contracts over the past 2 years that has turned into this explosion in episodic growth. Our top 3 contracts, which I won't say what they are, have each more than doubled over the course of this year in our volume. So yes, we definitely have targeted approaches that we are putting forth.

The other thing that I would highlight and then ask others to jump in here because this is really an exciting strategic part of where we're going is we're not moving away from Medicare. It's kind of like what Bruce was just saying about institutional versus community. We want the community to keep going up, but we want the institutional to keep going up with it. We're aggressively going after some of this good managed care and episodic and value-based contracts, but we definitely want to keep going aggressively after Medicare.

And in this last quarter alone, we've entered into a few new contracts with what's referred to as a DCE, or a direct contracting entity, which is, for a lack of a better way of saying, kind of a new age ACO vehicle where it's Medicare populations that are under the contract. They are narrowing and tightening those networks with high-quality providers, and you have the ability through performance to earn above Medicare equivalent rates.

So there's a lot of different areas that we are actively pursuing right now that has us extremely excited. So...

Keith G. Myers - *LHC Group, Inc. - Co-Founder, CEO & Chairman*

Yes. Let me just add, I want -- Bruce, I want you to chime in. You mentioned that -- but our references in the past to remaining engaged with managed care partners, it's been quite a long journey. I mean, 10 years or more since we've all had this discussion, and it wasn't always so pleasant. I'd like to be able to say that we alone would have stayed in it this long. But really, I have to give credit to our hospital joint venture partners for doing that because of our partnership with them and their need for us to accept those patients in care form. It kept us at the table with managed care payers and having to learn the things that were important with them and how we could do business with them. So I just -- it is a great place. We've also added some different perspectives to the team, Bruce and Dale, perfect timing for you to show up. 10 years ago, probably would -- we probably weren't ready for you. Glad you are now, Dale -- Bruce?

Bruce D. Greenstein - *LHC Group, Inc. - Executive VP and Chief Strategy & Innovation Officer*

Yes, thanks. You're definitely detecting a lot of restraint in how we're talking about our enthusiasm for this. We're clearly not ready to claim victory in the value-based world. It is not over. And Keith, from my perspective, we've been pursuing value over volume from the government side for well over 15 years, and we probably have another 10, 15, maybe 20 years to go until that journey is completed. But it's really important for the reasons that I think that we have made so much progress really is two-sided.

One, we are absolutely proving value through our clinical excellence to the payers, period. That is so important to note. The second is, as Josh had mentioned, the woman that heads our managed care team is absolutely tenacious. And so she has just negotiated, negotiated, showed value, used data as a way to negotiate contracts that really reflect the value that we convey to the patient and the health plan. And that's going to be the strategy that we continue to use moving forward. It's really, really important.

You also asked about the ACO learnings. And what's quite interesting is the world of the ACO-changing behavior is moving more slowly even than in the health plan world in many spaces. But during COVID, especially, maybe 1 year or so before that, the downward substitutability has been one of the major takeaways. And so that could mean doing procedures in one location compared to another.

Clearly, for post-acute care, it means using home health rather than SNF for patients that are clinically appropriate. You saw over the last 2 or 3 years, significant savings results coming out of BPCI bundle programs, primarily from shifting patients from SNF to home health. And now we're starting to see a more orchestrated or choreographed way of thinking about home health rather than SNF in a way to provide an equally important clinical experience, but also saving significant amount of funds.

All of this, when we think about COVID has not been a game-changer in so much as it's been an accelerator of what we were already seeing in the value world. Clearly, in the shift from SNFs to home health, it's been absolutely highlighted by the imperative of safety, for patient safety, and we're watching continually what's happening within congregate living facilities and SNFs. We're also helping patients and their families reduce the anxiety of being in an area that they're not comfortable with.

Now lastly, I want to talk about an example. It goes back to the data that Josh shared in terms of higher-acuity patients that have a higher rate under PDGM, and it also triggers more P1s as they come in. And I'm going to hand it over to Dr. Doga in a second because early in our COVID experience, with both JV partner health systems as well as those with whom we don't have a JV but work very collaboratively with. They asked for help. They asked for help moving their patients out of the hospital where they couldn't admit to a SNF or patients were refusing to go to a SNF.

They wanted a clinical program, a highly disciplined, deliberate program from home health where they can transfer patients that were at high acuity from their hospital to the home. They needed to free up hospital beds for new COVID patients, which we're starting to see the tightness in markets around the country right now, looking a lot like it was in March. And they also needed to throughput patients that were either COVID-positive or PUI patients, patients under investigation or suspected. And they turned to us to deliver these programs.

And so Dr. Doga, can you talk briefly about the protocols that we developed and what we were already capable of doing and talk to discharge planners, what they could rely on us for?

Benjamin N. Doga *- LHC Group, Inc. - Chief Medical Officer*

Yes. Thank you, Bruce. So big picture, ongoing, we've been working with our joint venture partners as well as our referral sources to deliver efficient care in the home at a very high quality. Bruce mentioned the fact that not just associated with COVID, but even before, our focus was on high-acuity patients and how to capture those patients that can return to home rather than go into a congregate living facility or institution.

So I'll take you back briefly and then walk you through to answer the question. At the end of 2019, we reevaluated our major diagnostic category pathways and treatment programs, which included an in-depth educational piece for all of our 20,000 clinicians that included a focus on in-depth physical examination and risk stratification of our patients. Based on that, we developed the latest use of technology as well as protocols for pathways and treatment plans to be accessible to those clinicians.

The key component here is that those pathways and treatment plans using best practices are now part of our electronic health record. So it is embedded in there for availability of our clinicians at the click of a button. And then based on the risk stratifications or the needs of the patient, getting back to our ACO learnings from our high-cost, high emergency department utilization patients, there can be some customization component and laid out there that they can choose, and it makes it more efficient through that process.

So that plan was developed in late '19, early '20, and the rollout of the pilot was scheduled to happen mid-summer of this year. Now with COVID-19, we still felt that it was of utmost importance to roll this out despite the COVID situation because we thought it could be also helping the efficiency of care of those patients, which we did on a small scale and then began to expand.

As early as last week, we met with the clinical team, and we reviewed the findings of this study of our pilot program, and it was evident that the satisfaction of both our patients, patient families, joint venture partners and our referral sources, we're very pleased with the outcomes. We were

able to care for, as Bruce mentioned, some of those 15% higher-acuity patients that are a huge part of a SNF diversion program in getting patients out of those congregate living facilities.

So the initial plan was to expand the pilot in early 2021, specifically January 1. As we reviewed the findings and the data analysis, it became clear that we can't wait, and we are planning to roll out and expand that pilot program before the end of this month here in November and then with the hopes of going company-wide in 2021.

So that's bridged the gap between lessons learned for those high-cost patients, keeping them out of the emergency departments and hospitals. Learned through our ACO in collaboration with that physician group as a trusted partner, moving to our joint venture partners and getting those lessons learned and bringing those hospitalists as well as their engaged physicians onboard. And then rolling it out across the board to our many referral sources that we see today, as illustrated by the numbers that Josh presented earlier.

Operator

Your next question comes from Joanna Gajuk of Bank of America.

Joanna Sylvia Gajuk - *BofA Merrill Lynch, Research Division - VP*

I guess we're running all the time. So just 2 quick follow-ups. So the commentary on home health, I guess it was focused on gross margin, but obviously the EBITDA margin was very impressive, 15%, and that includes $4 million of these higher IT costs. So can you first talk about sustainability of the EBITDA margin and also of the cost? Should we expect this cost to continue?

Joshua L. Proffitt - *LHC Group, Inc. - President*

Yes. Joanna, this is Josh. As I was responding to one of the questions earlier, I have a high degree of confidence in the sustainability of the EBITDA margins that we are now generating. This is -- at the level we were modeling -- a little bit above the level we were modeling at the start of the year for where we'd be at the end of the year. But I would say there's a couple of puts and takes in there.

In this particular quarter, we have the higher IT cost that we noted on our supplemental deck. Those overlapping costs with some of the initiatives we've deployed will continue into the fourth quarter, but there will be a tail where that runs off because there truly is some overlap duplication of costs. However, when that rolls off, if our VPE, visits per episode, were to tick up a little bit from that 13%, up a little higher, it could offset some of that.

So I think all in all, I would continue to run with EBITDA margin percentages that we're hitting with maybe a little bit more upside to that as we enter next year with some more growth.

Joanna Sylvia Gajuk - *BofA Merrill Lynch, Research Division - VP*

Okay. That's great. And then a second follow-up was on the very good discussion on the contracting with the MA plans. And I appreciate the numbers in terms of the growth in this business. But is there a way to quantify how far you moved in closing the gap, on average, in these rates? I mean, clearly, the 8% that was quoted in terms of the average revenue for that book of business growth per visit. But when you kind of compare MA to fee-for-service, where are you now versus, let's say, a couple of years ago? And what are you -- are you expecting this gap to actually eventually close?

Joshua L. Proffitt - *LHC Group, Inc. - President*

Yes. Joanna, we continue to see that gap narrowing. And whether that gap fully closes on the base rate, kind of hard to maybe go that far and predict that. But I think there is a pathway where it can not only be completely narrowed, but you have some upside in some of the value-based arrangements that we're entering into.

When you look at all of the non-Medicare book of business, the fact that the episodic has been the -- one of the big growth engines gives you that blended rate improvement. But I do want to acknowledge the improvements we've made over the past few years, just in the hand-to-hand combat negotiations of per-visit contracts as well. And those continue to climb, and we see betterment in those rates also.

So when you take all that into account, Joanna, and then I know we haven't given a whole lot of stats on this, but the percentage and number of contracts that have a value-based performance component to them. And that is both in the area of the per-visit models as well as the episodic models with some shared savings generation and upside to the base rate continues to grow every quarter. We're entering into new arrangements and having a broader group of our home health locations under those models. So I would tell you, continue to watch that gap come down and shrink over time.

Operator

Your next question comes from Matt Larew with William Blair.

Matthew Richard Larew - *William Blair & Company L.L.C., Research Division - Analyst*

So Josh, when I kind of look at the sequential build throughout 2020, Q2 down about 6%, ex-MSSP, maybe down 1% in 3Q, and then 4Q up slightly in terms of revenue. I know you've talked about kind of this long-term acceleration to maybe high single-digit plus home health same-store admits 5% to 10% plus same-store hospice admix. Could you just maybe help us bridge how you're thinking about 2021 at a high level? I understand it's not guidance, but kind of bridging what we've seen in terms of sequential build throughout this year into 2021?

Joshua L. Proffitt - *LHC Group, Inc. - President*

Yes, Matt. So I would -- maybe I'll take it both from a growth perspective and from an earnings perspective. So there's going to be some noise in the growth numbers next year, just because the comps are going to be a little bit off with what has happened this year. So one thing that we tried to illustrate on in our supplemental deck on Slide 7, which is a sequential look as well because that not only illustrates the pace of recovery but where we're headed because, with all the COVID numbers, it's making some of the organic comps be a little bit off.

Next year, you'll have a little bit of that same phenomenon in the second quarter. So to say we expect x percent of organic growth, you got to factor in the comparable year. But what I would tell you is now that we're back up to that 8,300 to 8,500 admits per month run rate that was kind of getting back to where the pre-COVID level is. Now that we have all these new referral sources that we have engaged with through the pandemic, once we get some of those other referral sources, getting back to the levels that they were referring at, whether it's elective procedure-related or otherwise.

If we get that run rate more close to 8,500 to 9,000, then you're going to have even more aggressive growth than we had pre-pandemic. And we were at double-digit growth in home health, as you might recall. With the entire company, AFAM, included, we were running 12%, 13% organic growth before the pandemic hit. So take out the organic comp nuance, and I would just tell you, we would expect an even higher pace of what would have been organic growth into next year with the run rate that we're experiencing and the momentum we've got on the referral side.

On the -- and then I would also hate to keep highlighting it, but our organic growth itself being positive 4.7% for this quarter, embedded within that, we've talked a lot about the non-Medicare episodic. There's some highlight looking at, well, what was the Medicare only. If you add the Medicare and the non-Medicare episodic together, we had positive growth organically in the third quarter in that area as well when you combine all episodic with Medicare and non-Medicare. So that's another real healthy indicator, Matt.

And then on the earnings side, when you unpack what I said earlier about our implied guide for Q4, Eric and I were saying even at the start of this year, if we could exit 2020 -- this was all pre-pandemic. If we could exit 2020 with a $65-or-greater million EBITDA run rate as we enter 2021, then you throw on top of that the growth that we just discussed and that we feel so bullish about. Then our 2021 right now is going to be better than we had originally expected our 2021 to be when we started this year. Because we're right at that $65 million to $70 million EBITDA range quarterly as we sit here today going into next year. So I feel really good about it.

Matthew Richard Larew - *William Blair & Company L.L.C., Research Division - Analyst*

Okay. That's helpful. And then, Bruce, obviously, you all talked about SNF diversion but just wanted to maybe get an update on sort of the SNF at home and Choose Home platform you've talked about. I know that's something you've been kind of building internally and maybe looking to pilot out with some payers and then, I guess, in theory take the CMS at some point. So any comments there would be interested.

Bruce D. Greenstein - *LHC Group, Inc. - Executive VP and Chief Strategy & Innovation Officer*

Yes, certainly. So we have had really quite positive experience with the SNF diversion program, so much so that we have sort of genericized it to make it a program for simply high-acuity patients. So as to not dissuade discharge planners from being very, very selective on who they choose. So 2 things. One is, despite having overall higher acuity, we have lower readmissions this year compared to last year.

From a PDGM perspective, in other words, how does the economics work around the highest acuity patients? Well, I like to say this every once in a while that we think the government got it right when it comes down to the PDGM case-mix and paying appropriately for more complex patients where our op margins are about the same for these high-acuity patients as they are for patients around the 50th percentile. So it's not dissuaded any of us from taking the high-acuity patients. They actually work well in the system.

Lastly, on this topic, though, when we thought about SNF diversion patients, and we worked with our clinical teams led by Dr. Doga along the way and we prepared these robust protocols, we found that the patients in SNF diversion programs looked very much like other patients that we have always been taking. They represented the top 10%, 15%. So our clinical teams in the field were pretty well prepared to take these high-acuity patients.

So that set of programs and protocols have been propagating across the company -- across different geographic regions, and we'll continue to do that. And we will not stop doing that after COVID because it makes sense from a value perspective as well.

On the Choose Home or the new set of, say, legislative activity going on in Washington, D.C., we're seeing a lot of very positive movement. We're seeing high levels of interest on both chambers, both sides of the aisle. We think that this definitely has legs moving forward. We think that this would be a very positive addition and expansion to the Title XVIII, the Medicare program itself, and would allow a very high percentage of patients that otherwise go to the SNF to be able to come home. As Keith had mentioned, our data shows somewhere between 1/4 and 1/3 of those that go to SNF can be clinically appropriately taken care of at home.

Operator

Your next question comes from Whit Mayo of UBS.

Benjamin Whitman Mayo - *UBS Investment Bank, Research Division - MD of Equity Research and Equity Research Analyst of Healthcare Facilities & Managed Care*

I've got just one quick one. I'm just still confused on the revenue per episode. In the third quarter of last year, you reported $30.70, which implies that it would be down 8%, but the disclosure this year now recast the prior year to $28.63. So what's the difference between the 2? None of the other metrics changed.

Joshua L. Proffitt - *LHC Group, Inc. - President*

Yes. Whit, can you restate the question? You were coming in a little low?

Benjamin Whitman Mayo - *UBS Investment Bank, Research Division - MD of Equity Research and Equity Research Analyst of Healthcare Facilities & Managed Care*

Yes. On revenue per episode, last year, you reported $30.70. And this year, you're reporting that the prior year was $28.63. So I'm just having a hard time reconciling that large of a change. Like what's the difference? None of the other metrics in the organic or the disclosures changed.

Eric C. Elliott - *LHC Group, Inc. - SVP of Finance*

Whit, this is Eric. I can get with you off-line and kind of walk you through it. Basically, it's looking back at last year and trying to recalibrate where the Medicare revenue per episode was with adjustments, without adjustments and trying to get it in line with where it kind of is this year as opposed to kind of reclassifying kind of some of those issues. But I'll get with you off-line and kind of walk you through it.

Benjamin Whitman Mayo - *UBS Investment Bank, Research Division - MD of Equity Research and Equity Research Analyst of Healthcare Facilities & Managed Care*

Well, let me ask it a different way. So if your organic admissions are up 4.7% and your organic revenue was down 4.1%. How do you reconcile the difference? It seems like that would imply an 8% decline on your revenue per episode on a like-for-like basis.

Eric C. Elliott - *LHC Group, Inc. - SVP of Finance*

It's really if you look at where the admissions are and where the episodes are and then you roll in that -- we're down the 1.4% year-over-year but is being offset a little bit by sequestration. So that's kind of how that plays in.

Operator

The next question comes from Frank Morgan of RBC Capital.

Frank George Morgan - *RBC Capital Markets, Research Division - MD of Healthcare Services Equity Research & Analyst*

I wanted to go back to M&A that you talked about earlier. I'm just curious when you characterize that, do you see most of that coming through PDGM-related opportunities finally coming to fruition? Would it be a result of JVs? And then what's sort of the mix that you would expect to see between, say, hospice and home health care?

Keith G. Myers - *LHC Group, Inc. - Co-Founder, CEO & Chairman*

Yes. Frank, this is Keith. So I think it's -- let's start with the joint venture pipeline. When -- throughout the COVID pandemic, really, I guess, starting in April, conversations that we had in the pipeline got put on hold as we worked through COVID. So we thought those would come back. And then we continue to talk to more potential candidates about something in the future. But that pipeline kind of stalled, and that picked back up.

Continuing with home health on the consolidation of freestanding home health agencies and hospital agencies, the -- I think, the stimulus money when that began to flow. Also caused people to -- let's not say, put on pause, but it certainly decreased the sense of urgency to do something with that home health agencies.

And then as the clarifications began to come out, and there's more restrictions than first thought on the stimulus money, then we saw that begin to pick up. Now I see the consolidation that we thought that was going to happen as a relative PDGM pre-COVID is now picking up. And I think that's what's driving the -- what's going to drive the consolidation in home health.

And then related to your hospice question, unrelated to COVID, we're just very focused on office. I know we've said that we want to grow that platform more aggressively and have it be more equal to our home health platform, but I just -- right now, we have more resources that we're deploying around that strategy. And I think that we're going to see a significant acceleration in that. So that's what I mean when I talk about the M&A activity.

Operator

This concludes the question-and-answer session. I would like to turn the conference back to Keith Myers for closing remarks.

Keith G. Myers - *LHC Group, Inc. - Co-Founder, CEO & Chairman*

Okay. Thank you, everyone, for dialing in today. And as always, the team is here to respond to you if you have any questions at all. So thanks for joining in, and we'll talk to you next quarter. Thank you.

Bruce D. Greenstein - *LHC Group, Inc. - Executive VP and Chief Strategy & Innovation Officer*

Thanks.

Joshua L. Proffitt - *LHC Group, Inc. - President*

Thank you.

Eric C. Elliott - *LHC Group, Inc. - SVP of Finance*

Thank you.

Operator

The conference has now concluded. Thank you for attending today's presentation. You may now disconnect.
