LHC Group, Inc.
First Quarter 2021 Earnings Conference Call
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Company Participants:
Eric Elliott, Senior Vice President of Finance
Keith Myers, Chairman and Chief Executive Officer
Joshua Proffitt, President
Dale Mackel, Chief Financial Officer

Analysts:
A.J. Rice, Credit Suisse
Scott Fidel, Stephens Inc.
Justin Bowers, Deutsche Bank
Brian Tanquilut, Jefferies
Matt LaRue, William Blair
Frank Morgan, RBC Capital Markets
Joanna Gajuk, Bank of America

Presentation:

Operator: Good morning, and welcome to the LHC Group First Quarter 2021 Earnings Conference Call. (Operator Instructions). After today's presentation, there will be an opportunity to ask questions. (Operator Instructions). And 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 Elliott: Thank you, Robert, and good morning, everyone. I'd like to welcome you to LHC Group's earnings conference call for the first quarter ended March 31, 2021. We issued our earnings release last night and I would also like to highlight that we have posted some supplemental information on the quarter on the quarterly results section of our Investor Relations page. This 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 as well.

Our supplemental deck includes our full year 2021 guidance assumptions, the impact of COVID-19, detail on the breakdown among sector performance and a significant amount of detail on the monthly trends. All of our non-GAAP reconciliations and breakdown of adjustments are included as well. We will reference this information in our remarks today.

We expect today's prepared comments from Keith Myers, Chairman and Chief Executive Officer; Josh Proffitt, President; and Dale Mackel, Chief Financial Officer to run for approximately 20 minutes to allow time for Q&A.

Before we start, I would like to point everyone to our forward-looking statements on Page 2 of our Supplemental Presentation and encourage you to read them carefully. They apply to statements made in this in this call, in our press release and our supplemental financial information.

Now I'll turn the call over to Keith.

Keith Myers: Thank you, Eric, and thank you, everyone. As always, I want to begin by thanking our more than 30,000 LHC Group colleagues who daily live out our mission and vision of caring for people in need in communities we are privileged to serve throughout our country.

I also want to acknowledge our recently-published environmental, social and governance report that is available on our website. Since our founding nearly 3 decades ago, our goal has always been to be an invaluable asset and a responsible, contributing citizen of each community we are privileged to be part of and serve, well beyond being a valued community healthcare provider. This new ESG report brings to light the many activities and actions our team members throughout the country have undertaken to provide an even broader positive impact in thousands of communities we are privileged to serve throughout our country today.

Now, I'd like to begin by providing some perspective on how our policy efforts and current legislative and regulatory activities are providing tailwinds, or shaping our business and that of the broader in-home healthcare services industry in a very positive way.

We view 2021 as the beginning of a new extended period of perhaps unprecedented opportunity for LHC Group, in part, due to the heightened awareness in the wake of COVID of our full range of capabilities as a high-performing in-home healthcare services provider organization with a national footprint and legislative and regulatory tailwinds, including innovative waivers from CMS, flexibilities for remote certification of homecare, telehealth, continued legislative relief from the 2% sequestration cut throughout the remainder of 2021, and broadly supported policies that (inaudible) significantly increase access to in-home healthcare services.

As I mentioned on our last earnings call, we are encouraged by the current administration's plans to increase funding by up to $400 billion over the next 10 years to expand healthcare services delivered in the home. In addition, at least one legislative draft circulating on the Hill by Senator Casey, Chair of the Aging Committee, and Senator Hassan and others, exceeds this goal by creating a new entitlement under the Social Security Act for home and community-based services. Among other things, this proposal increases the Federal Medicaid Assistance Program, or FMAP funding, to 100% for home and community-based services; and for the first time, proposes to nationalize a presumption for in-home healthcare services. We are particularly encouraged by the administration, the Senate and the House's focus on ways to improve coordination of the traditional Medicare Home Health benefit with Medicaid in-home services.

For decades now, proven and time-tested innovative state Medicaid programs, such as the Passport Program in Ohio that you've heard me mention before, and the Oregon Health Plan, have given seniors the choice to age in place by being cared for in the comfort and privacy of their own home as an alternative to more costly long-term institutional care. Our Choose Home legislation builds on these successful state programs, which deem seniors eligible for in-home

healthcare services as a first option, blending the traditional home health Medicare benefit with Medicaid non-skilled services.

We continue to build congressional support for this legislation, and expect it to be introduced later this year. I would also point out that the proposed rules of fiscal 2022 related to hospice and [LPAS] are also very positive for us, and will provide additional momentum later this year and in 2022. For more details on our policy efforts and policy-related focus areas, I would point you to the Policy Tailwind summaries we have provided on Pages 7 and 8 of our supplemental deck.

On January 8, 2021, CMS formally recommended expansion of the home value-based purchasing demonstration from its current 9-state to a nationwide program. We strongly believe that given our proven capabilities as a national in-home healthcare services provider, consistently delivering higher-quality outcomes and patient satisfaction at materially lower costs, resulting in consistent incremental earned performance-based incentives, expansion of home health value-based purchasing would provide additional opportunities to us to leverage our proven efficient and effective in-home healthcare services delivery model to drive organic growth.

To shed additional light on the significance of this opportunity, there were over 9 million attributed ACO lives in markets LHC served through our current footprint of home health providers in 2020. Of these 9 million ACO-attributed lives, roughly 925,000, approximately 10.3%, received home health services in 2020. We, LHC Group, provided home health services to only 9% of those individuals that received home health.

From a provider performance perspective, however, LHC was the top performer, with an average home health spend per patient in excess of 18% below the average home health spend per patient, and for all providers, 1.4% below the average total cost of care for the entire 925,000 patients that received home health. All that to say our proven ability to consistently deliver high-quality outcomes and higher patient satisfaction at consistently lower costs across our footprint have currently served over 60% of the population in our country.

We have good reason to be confident in our ability to significantly grow our market share, as performance-based payment models become more popular, and traditional fee-for-service models transition to models that place a greater emphasis on objective measures of effectiveness, outcomes, quality and patient satisfaction, and away from reimbursement models based solely on the volume of provider activity.

Turning to M&A, our active pipeline of acquisitions and hospital joint venture opportunities we are pursuing at this time, totaled slightly over $500 million trailing 12-month revenue, with over $300 million or 60% of that amount being opportunities where we are currently in exclusive discussions with sellers. Up to $500 million in trailing 12-month revenue, 71% is hospice, 28% is home health and the remaining roughly 1% is home and community-based services on personal care.

With the amount of high-quality and high-probability M&A opportunities in our pipeline today, and the overall M&A momentum we see at this point in early May, we are confident that we will surpass our budgeted target range of $150 million to $200 million of acquired revenue in 2021.

We also expect 2021 to be a record year for our hospice segment as a result of the increased acquisition volume, of course, but also due to additional investments we've made over the past year in our hospice segment. Our commitment to hospice services, as part of our continuum of care, is nothing new. (Inaudible) and our founding Clinical Leadership Team opened our first hospice location in 1998, which was co-located in the same market as our first home health agency that opened just 4 years earlier in 1994.

The vision of our Clinical Leadership Team from day one has always been to provide hospice services in each community we serve, as a part of our continuum of care with home health. With a higher volume than anticipated M&A growth in 2021 and beyond, we look forward to making meaningful strides toward fulfilling our founding vision of providing home health and hospice as a coordinated continuum of care in each community we serve.

In summary, the significant advances we see on the legislative and regulatory front, combined with our continued organic growth, significant expansion and M&A activity, and a 9.1% year-over-year increase in admissions from our growing national network of physician referral sources and hospital JV partners, in addition to ACOs and payers, other payers, demonstrate that we have managed through the COVID pandemic with a level of professionalism and dependability that has resulted in an even higher level of trust, respect and loyalty among the many patients, family members, physicians, discharge planners, hospital partners, community referral sources and payers who collectively make up our customer base.

Without question, today we are better, stronger, more agile and more responsive organization than we were at the beginning of 2020. Our experiences, lessons learned and improvements implemented over the past 5 quarters have created a new normal in our day-to-day operations throughout our organization, that will continue to benefit our organization, and more importantly, the patients, families and communities we serve in the future.

We will never rest on our laurels, never take success for granted. We are a continuous learning organization committed to continuous improvement and a relentless pursuit of excellence in all that we do at every level of this organization every day.

And now I'll turn it over to Josh to provide more color on the growth and operations. And Dale will provide more details related to financial results and guidance before we begin Q&A. Josh?

Joshua Proffitt: Thank you, Keith, and good morning, everyone. Thank you for your time this morning. I'm very excited to provide more details on our strong start to the year, and why we are so bullish on our current operational and growth trajectories. Following up on Keith's comments, continued inorganic and organic growth, as well as increasing tailwinds from a legislative and regulatory perspective, are perfect starting points from our prepared comments today.

Last quarter, we set the table for the strategies we have created to deliver differentiated growth in 2021, and framed up our near and long-term growth potential. Today I want to focus on how well we are executing on this growth potential, our confidence in the trajectory over the next several quarters, and the strength of the sequential improvement.

Ensuring we generate quality growth has been a top priority, and as you'll see on Slide 10 of our supplemental deck, we are delivering with joint ventures, continued and sequential growth in

episodic admissions, continued momentum with bringing on new referral sources, and the continued buildout of our co-location strategies.

As highlighted on Slides 11 and 12, we're pulling multiple organic and inorganic growth levers to hit our objectives, in particular, the levers on earnings share from competition, executing on the co-locations, driving margin growth from JVs and recent acquisitions and capitalizing on the upside opportunities afforded in connecting with the movement to more value-based reimbursement models, which I will touch on more in a few moments.

We received positive feedback since last quarter on the data we provided on these slides to help model out the growth opportunities this year and going forward. With the exception of the M&A pipeline increasing 20% from the fourth quarter, those assumptions remain unchanged from Q4.

To put this quarter and the next several in the proper context, it's important to note that we are now past the 1-year anniversary of operating under PDGM, and a year of living and operating within the coronavirus pandemic. While those are two distinct events that permanently altered our industry, we have used each as an opportunity to tap into our LHC Group DNA to always learn from change and improve upon our clinical and operating models in ways that will always prioritize patient outcomes and satisfaction and prove sustainable and valuable for years to come.

Thank you so much to our frontline workers and all of our quality, operations and growth leaders and support team members all across the country for such stellar execution in the face of such historic change. We are better today because of you.

Let's shift gears now to some of our key metrics. The year-over-year comparisons are still a little muddied, while the sequential comparisons, despite 3 successive waves of COVID-19, including the most recent post-holiday season surge, are positive and more indicative of our underlying growth. This will likely be the last quarter where we break out the PDGM-specific metrics, as they have remained within a tight range of expectation the last several quarters.

Given how meaningful they are to our expectation for the year, I now want to spend a moment on our sequential trends. Slides 14 and 15 show the progression over the last 5 quarters, as well as March and April. We wanted to break down the last 2 months in particular because we overcame the post-holiday COVID surge in December and January, the number of clinicians on quarantine during the first quarter and the ice and snowstorms that occurred during the quarter.

Dale will share more details on these trends on our key metrics in a moment, but I want to highlight in particular the fact that despite all the headwinds, our home health admissions for the first quarter were essentially flat with our Q1 2020 admissions, at that point, an all-time high in LHC's history. And when you peel back the data a little further, you see a couple even more impressive indicators to our home health growth, one being that our admissions per day in Q1 this year were higher than they were in Q1 last year; and two, that our total home health admissions in Q1 2020 was 12.4% higher than in Q1 of 2019. So to be back on that pace after having that hurdle rate for this quarter, with all the headwinds, is a true testament to the growth momentum we currently have in our home health segment. We are also pleased with the fact that our hospice admissions are tracking above pre-pandemic levels as well.

I would now like to share one additional observation that not only further speaks to our sequential momentum, but also provides additional evidence to the environmental momentum that is leading to more care shifting to the home. Although during the early months of the calendar year, home health census has historically performed well and experienced growth, you'd typically see us starting to flatten out and then have a modest seasonal decline.

For example, in the non-COVID year of 2019, for the 60-day period from the start of March to the beginning of May, our home health census declined from 78,320 to 77,107, for a 1.5% decline. However, this year over that same 60-day period, we've actually grown home health census from 85,994 at the start of March to 87,696 at the start of May, which is a 2% increase.

Our full year guidance is based on achieving home health and hospice organic admissions growth of 8% to 10% each. We've outlined in the quarterly breakdown of organic growth across the 2 segments on Slide 15, and we are on track to achieve these targets. The Q1 admissions per day trend, particularly in March, after getting past all the headwinds and again, in April, give us the strong confidence to be very bullish on our second quarter trajectory, and thus, the momentum we expect for the remainder of the year.

One point I will make here is that hospice, we have seen similar trends as others in the sector with average length of stay impacted during the quarter by the same headwinds, and the fact that patients are being discharged later from institutional settings and our percentage of referrals from ALS, ILS and SNFs are 200 to 300 basis points below pre-pandemic levels. Since exiting the quarter, we have seen hospice length of stay begin to stabilize. In addition to the PHE and Medicare sequestration extension that we'll discuss, all these trends in home health and hospice give us confidence to raise our full year guidance. Our confidence is also based on how well we are performing in other areas too.

In addition to the leading quality scores and increased amount of unique physician referrals, including nearly 5,200 new physician referrals in Q1 that we have highlighted in recent quarters, I want to call out on Slide 13 what our recruiting and hiring trends have been across our service lines. We've had 2 consecutive quarters in which we have hired a record number of frontline employees while our turnover has continued to decrease. In home health alone, we hired 1,916 new frontline employees this quarter compared to 1,225 hired in Q1 last year. These headcount statistics have a direct correlation and validation with our differentiated culture, continued census growth and unwavering focus on patient satisfaction and quality outcomes.

Turning quickly to our inorganic growth levers, I want to focus on our JVs and acquisitions. As Keith mentioned earlier, we remain very bullish in delivering or exceeding against our target of $150 million to $200 million in acquired annual revenue this year. Our M&A pipeline is now over $500 million with several exclusive deals in various stages of negotiation and due diligence.

The last topic I want to briefly touch on is our value-based strategy, which continues to benefit us as well as our partners, as the payers we are engaged with. We have the unique assets and the right mix of quality-based program innovation and rigorous clinical protocols to create care plans that deliver what payers need to reduce re-admissions lower length of stay and episodes, while improving the patient experience and outcomes. We continue to be the only one of our peers with an ACO management business and the unique insights that experience brings. The value we

are delivering is also evidenced by the approximately $14 million in value-based awards we earned in 2020.

One other point I'd like to make on our ACO management business builds on what Keith described earlier. There are over 9 million attributed ACO lives in the markets we serve. Of the ACO attributed lives in the markets we serve, approximately 10.3% received home health last year. As we continue to harvest and educate on the learnings from our value-based arrangements and the learnings from our ACO management company subsidiary, and demonstrate the evidence-based correlation between reduction in total cost of care and high-quality outcomes when appropriately utilizing care in the home, we expect that the size of the opportunity will also continue to grow beyond the current 10.3% utilization with more home health utilized for patients that are appropriate to be cared for with home health.

Dale, I'll now turn it over to you to add additional color on our results and our guidance.

Dale Malken: Thank you, Josh, and good morning, everyone. We are pleased to report first quarter results that were ahead of our expectations. Specifically on a year-over-year comparable basis, net service revenue increased 2.3% to $524.8 million. Adjusted EBITDA increased 61.3% to $61.5 million and adjusted net income increased 86.7% to $43.6 million or $1.39 per diluted share.

Our first quarter performance, coupled with our exit velocity, places us right where we need to be to deliver on our full year projections. Our revenue was above the midpoint while adjusted earnings and adjusted EBITDA exceeded the top end of the range. These are all the more impressive when you consider the significant headwinds we faced from the post-holiday COVID surge, the percentage of our staff on quarantine, the impact of the ice and snow storms and the related closure of 218 of our agencies for multiple days during February.

With the detail we have provided in our earnings release and supplemental deck, I will spend most of my time on the key metrics and trends supporting our guidance and growth initiatives, and then turn to our raised guidance along with our strong capital and liquidity position.

I would first like to call attention to Pages 14 and 24 in the supplemental deck where we've broken out the key revenue factors for our home health, hospice and home and community-based service segments. For home health, the sequential improvement in our revenue per Medicare episode continued through the first quarter with March exceeding pre-pandemic levels and April trending ahead of March.

While the percentage of institutional admits was down this quarter due to the resurgence of COVID, which caused softer hospital volumes, we've seen this percentage start to climb back in April and believe this momentum will continue due to elective procedures starting to open up again. Our (inaudible) percentage on PDGM episodes continues to hold in line with our expectations of 8% to 9% and our case mix, while not yet back to pre-pandemic levels, is improving.

Josh mentioned it a moment ago, but I want to dig in a little more into the hospice performance for this quarter. Similar to other hospice providers, we saw a decline in our length of stay during the quarter from 79.6 days in Q4 to 78.1 days in the current quarter. We attribute this decline to

patients being discharged from institutional settings much larger than in the past, and also to the fact that many patients are not seeing their primary care physicians as regularly as they used to, and consequently, are being admitted to hospice much later in their disease states.

Additionally, admissions from senior living facilities and SNFs continued to lag pre-COVID levels. For hospice, EBITDA margin of 10.5%, while up 60 basis points year-over-year, is down from 13.2% sequentially in Q4, primarily due to 3 factors: one, lower length of stay; two, the 70-basis point seasonal impact of higher payroll taxes; and three, 100-basis point impact from out of period implicit price concessions. As we have communicated previously, we believe the sustainable EBITDA margin target for this segment is in the 13% to 15% range. We expect incremental improvement in the second quarter while returning to the normalized margin range of 13% to 15% in the second half of 2021.

Our personal care business experienced a decline in billable hours of 4.2% versus first quarter of 2020. But we did see a sequential increase in billable hours of 1%, despite all the headwinds presented in January and February. The biggest challenge for the personal care business remained staffing, while stimulus checks continue to be mailed. Demand is very robust and we are working several initiatives to increase labor supply and capture the unmet demand.

Looking at the first quarter compared with our previous guidance, recall that we had called out the following differences bridging sequentially from Q4 to this quarter. The seasonality we typically experience around the holidays and the slower start to the year we had in January, the percentage of our clinicians on quarantine, which reached a high of 4.1% in January, stayed in the range of 2.5% to 4% for the balance of January and February before dipping below 1% in March.

The closure of 218 agencies due to severe winter weather in February affected revenue associated with new admissions, managed care per visit patients and personal care billable hours. The higher payroll taxes compared with Q4, which were approximately $4.5 million higher than Q4 and the lower effective tax rate due to the excess tax benefit from the vesting of restricted stock, which resulted in a tax rate of 21.4% for the quarter.

We also projected we would experience a disproportionate share of COVID expenses in the first quarter relative to the rest of the year. As you can see from Slide 14, we saw a 20% sequential increase in the emission of COVID-19 patients in home health and a 34% sequential increase in hospice. This corresponds directly with the most recent COVID surge, and combined with the higher percentage of clinicians on quarantine, drove higher expenditures for PPE, medical supplies, hazard pay, and an increase in health insurance claims. We had projected $8 million to $12 million of COVID-related expenses for the first quarter and we were right at $12 million.

Looking ahead to the full year, we are still comfortable with our original guide range of $20 million to $25 million for COVID expenditures and as incurred, will be adjusted out of our results. We will revisit our COVID spend view at the end of Q2 and communicate any changes to our estimates if applicable.

Turning to the full year guidance outlined in our earnings release, and on Slide 30, at the midpoints of our new range, we are projecting 8.6% revenue growth, 25.7% adjusted earnings

growth, and 23.6% adjusted EBITDA growth, less non-controlling interest. Our core (inaudible) remain largely consistent with our initial 2021 guidance outlined during our Q4 earnings call and documented in our fourth quarter 2020 supplemental deck. Updates to our full year guidance include our Q1 operational performance and beat on EBITDA and EPS, the sequestration waiver extension through 12-31, and extension of the public health emergency through July 20.

Given we are still early in the year, coupled with ongoing residual uncertainties related to the pandemic, we have allowed for a prudent level of caution in our guidance, as it relates to, one, the pace of elective procedure recovery; two, hospice length of stay; and three, personal care billable hours owing to labor supply constraints.

Lastly, I want to highlight our strong balance sheet. We have $556 million of total liquidity and that's net of the Medicare advance payments and the provider relief funds, the latter of which we previously announced we intend to return to the federal government. On that note, I will mention that on April 13, CMS began recouping the accelerated payments that were distributed last April. Details on the schedule of those repayments are in our earnings release. We intend to fully repay the advanced amounts along with the provider relief funds before any interest will accrue.

Our days sales outstanding increased to 57 days in Q1. While down from 62 days in the first quarter of 2020, DSO is up sequentially from 52 days in Q4. The sequential increase is directly related to the no-pay wrap implementation, which eliminated the remaining 20% of the request for accelerated payment. This CMS payment program adjustment resulted in an impact to cash collections and cash flow of approximately $34 million. Even with the impact of the no-pay wrap, our businesses produced a robust $42 million of free cash flow in the first quarter.

The strength of our liquidity, combined with sustainable and strong free cash flow, gives us significant competitive advantage and the ability to execute on the wealth of growth opportunities at our disposal. We look forward to reporting our progress to you with respect to inorganic opportunities in the coming months.

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

Questions and Answers

Operator: Thank you. We will now begin our question-and-answer session. (Operator Instructions). A.J. Rice of Credit Suisse.

A.J. Rice: First, I appreciate the updated information on the deal pipeline. I just wondered if you would comment on what you're seeing. I know a lot of those deals sound like they're exclusive to you, but in terms of pricing dynamics, competitive landscape, we're hearing about others pursue an activity that may not be new from your perspective. But I just wondered what your latest thinking is on the competitive landscape for deals.

Keith Myers: Yes, thanks for the question, A.J. This is Keith. I'll start by saying from my perspective on hospice, let's start with that. So hospice is competitive, but I do see multiple variation depending on the market; and then just concentration in certain markets and volumes, but for us, we look at it a little bit different. We're building out a continuum of care. So when we look at a hospice, knowing that multiples are going to be high, we're focused in markets where we have a significant amount of home health funds, because we know that we have volume to bring to the table for my home health operations and from hospital partners.

And so everything, obviously, all the acquisitions we look at, we model out, but we'll also build that into our models as we look at it. So multiples are high and in some markets, we can model out the combination and make it work nicely for us. Then others, we just have to walk away from.

Josh, do you want to --

Joshua Proffitt: Yes, Keith, thank you, very well said. Of the ones, A.J., that we're currently working, many of them fit the exact mold that Keith just described. So I would just reinforce our history of discipline, due diligence rigor, all the things that we're known for in the deals that we do close, and then we execute upon. And even with somewhat higher multiples on some of the transactions, we're still going to be ensuring that those deals have growth, potential and upside, and we're not just acquiring a static business or one that doesn't have a lot of upside and growth in it. So I feel really good, A.J., about what we've got going on in our pipeline.

A.J. Rice: Okay. Then maybe for the follow-up question, it seems like referrals -- and this seems like it's for both businesses, home health and hospice or from SNF, senior housing, that's the one area that is still sort of depressed relative to pre-COVID levels. I guess it's probably 2 dynamics there, one being sort of a census in those facilities at this point is depressed and hasn't fully come back and may not for a while. And then there's also just getting access to the facilities.

I wonder which of those can you parse out? Is it really just the census has got to come back, or is there some element of getting access to the patients, as it reopens, you'll see some pickup? And then can you comment on -- I would think in home health, at least, you might see the referrals coming from other sources, all these new referral sources you're getting. So maybe that volume that would have come to you from those sources is coming elsewhere. But is it more of a home health issue or a hospice issue, you would say, what would you're seeing with those senior housing properties?

Keith Myers: Yes, so Josh and I can tag-team that again both together. Let me just start with home health. With home health, we're looking at a lot of data from hospital partners, and we feel that we're getting a lot of patients that were previously gone to SNF that are just coming directly to home health. We can see that we're dealing with a higher-acuity patient population that are being discharged from hospitals. And we assume that these are the patients that were going to SNF and now going straight to home.

Hospice is a little more difficult. I know we're seeing some of that in hospice as well, but I don't know if we have enough data to feel as certain about that as we do with home health.

Josh, what do you think?

Joshua Proffitt: Yes, so I would say, A.J., it's some of both, census and the facilities. It's a diversion around the facilities, which Keith just mentioned and access. On the access issue, I'd tell you, talk with our growth leaders quite regularly just to see how that's going. And I am encouraged that that seems to be getting better and better almost by the week, as we have more adoption of the vaccine throughout not only our workforce, but in the markets where we have SNF relationships. So I am seeing the access get better week over week.

Now, I'll give you a few data points just to really kind of drive home the point you're making. For home health, we're down about 350 basis points of the percentage of our referrals from SNFs. So at Q1 last year, we were about 11.5%, and we're about 8.5% right now. On the reverse, we're up 300 basis points on physician referrals, so a lot of what we've been talking about on the new referrals coming from physicians.

So I think the diversion around some of the congregate settings is not only, as Keith mentioned, coming directly out of the hospital, but also coming from the community from some of those new physicians we've been able to develop. And then on hospice, we're down about 300 basis points there as well. When you look at SNFs, ALS and ILS down from about 11% Q1 last year to right around 8% this year.

So the good news with all that, A.J., is if, as the trends improve, as the census levels increase, as the access improves, then if we can continue the stickiness of those new physician arrangements, our hospital electives are bouncing back. And then you throw in an increased trajectory from SNFs, ALS and ILS, that gives you a lot of confidence in the growth in the last 3 quarters of the year.

A.J. Rice: Okay, great. Thanks a lot.

Operator: Scott Fidel of Stevens.

Scott Fidel: First question, just wanted to go back. In the fourth quarter, you had provided us with a really helpful bridge from 4Q to Q2 2021 in terms of drivers of revenue and EBITDA. Just wanted to just get your sense on you had called out a target to get to $550 million in revenue by 2Q, you had about $9 million worth of headwinds from Medicare sequestration and the PHC that now have been extended.

So just interested in that target you laid out for the $550 million in revenue. And then more specifically, the 3 segment components that you had sort of called out for the home health hospital and HCBS in terms of the growth that you're anticipating, how you're feeling about each of those buckets at this point relative to when you had initially provided that in the fourth quarter.

Dale Malken: Yes, thanks, Scott, for the question. This is Dale. We feel very good about the bridge that we put together from Q1 to Q2, we're still right on that trajectory. The only difference is that would update to it would be the change in sequestration and PAG extension, right? So when you look at that, you look at the bridge we provide and you look at those changes, and you can see now we're looking at on an adjusted basis with that. So I think everything sets up really well for that.

I would say in terms of the 3 segments, feel really good about home health. The exit velocity out of Q1 was extremely strong. And I'd say we're probably looking at some over-performance on them going into this bridge. A little bit of under-performance in hospice because of the length of stay challenge, right? That's been something that's kind of come up with everyone. We're not as directly impacted by it, as we're not as exposed to the senior living facilities from an admissions basis.

But as Josh said, we're from 11% admissions down to 8%, and that affects our length of stay. So I think we still feel good about hospice. We feel like the margins are going to be in the 11% to 12% range for that, but that's probably a little softer than what we had projected.

And then I'd say personal care business, again, I'd say a little change. There may be -- we expected that business to have the most difficult climb back from the pandemic because of the labor supply and things like that. So I think we had tempered our expectations in Q2 quite well for that. So I would say we're pretty much in line with that, but when you put that all together, we feel very solid about the Q2 bridge.

Joshua Proffitt: Yes, Dale -- and Scott, this Josh -- maybe the only other 2 kind of data points I would give you tying back to that specifically on home health, since that's the lion's share of the bridge. We have signaled we needed a home health census to be [87.5] and as I mentioned in my prepared remarks, we're already north of that. And we've been between [87.5] and knocking on the door of 88,000 now for the better part of the last 2 weeks which gives a lot of confidence into that.

And then if you look at our admissions per day run rate, so the sustainability of that census, our admissions per day are higher than they've been ever. So the last Q1 of last year pre-pandemic, we were just under 1,200 admits per day on home health. And now we've had 2 consecutive months of north of 1,200 admits per day in home health. So you've got to really like where we're at, census, and the admission throughput that we're having.

Scott Fidel: Got it. Thanks, good color on that. And then just as my follow-up question, I guess it would be more of a strategic question around positioning around some of the policy dynamics. And Keith, I know you've called out the proposed enhanced $400 billion in HCBS funding and Medicaid that Biden's proposing and some of the other things. And I'm interested for LHCG, how you would think about the best way to position for this?

If that spending ultimately is passed or something even close to that, would the strategy be to ramp up more of your direct PC exposure capability through Medicaid-funded HCBS, or are you ultimately looking at trying to drive more of on the policy side towards ensuring that Medicare providers are eligible for a lot of that funding as well? Just trying to get sort of how you're thinking about I guess those 2 different sort of strategy elements relative to this enhanced proposed funding.

Keith Myers: Yes, that's a really good question. So right now, we're focused on trying to see the -- I'm trying to bring the 2 programs together, Medicare and Medicaid. We know that combination, how that works well, and it's been proven in other state models that we're very familiar with. So it's easy for us to plan in that direction. But with the $400 billion that's

proposed in spending, it's difficult now because there's a number that's out there, but there's not a lot of detail around how that's going to be structured. And it could mean a lot of things; we don't know how much union activity is going to be involved in that. So I think we're taking a conservative approach in everything, so we're staying very close to it from a policy perspective. And we're just going to evaluate it as there's more color around it.

I'm not opposed to, or not ruling out expansion into -- more expansion into personal care services. We think that's a vital service. It's been the most difficult one for us to manage because of how it's delivered, if there's a different program in every state, different rates, or to have stable staffing for it, all of those challenges. And we're not big risk takers, I think you all know that.

So I would say that we're keeping a close eye on it and if there's an opportunity there and the risk profile is good enough for us, we'll move in that direction. But for right now, we're spending the majority of our time trying to work towards the coordination of Medicare and Medicaid services together for patients through this choose home legislation or anything that's structured remotely similar to that.

Scott Fidel: Okay. Got it. Thanks.

Operator: Justin Bowers of Deutsche Bank.

Justin Bowers: I just want to follow up on A.J.'s and Scott's questions and ask it a little differently. But if we take your 2Q bridge and add back the sequestration and the PHE benefit and annualize that, just run that out for the next 3 quarters, we get at about $234 million of EBITDA. You take your 1Q print of 61.5, it takes us to like [295, 296], right in the middle of the current guide. And it sounds like you're tracking now like slightly above the pace for 2Q, or at least feeling good about that. Are we thinking about that the right way?

And is it fair to say if kind of your April census kind of holds for the rest of the year that you're right at the midpoint of the guide, with maybe a little upside if things improve? Is that -- am I oversimplifying things there or --

Dale Malken: Yes, Justin, this is Dale. I don't think you're oversimplifying. I think this is how I would sort of look at the guidance at this point in time, right? So midpoint, the midpoint, we've raised revenue $10 million and we've raised EBITDA to $21 million, right? So let's talk about the revenue context. There's 3 things we're keeping our eye on related residually from the pandemic. And one is pace of elective procedure recovery. So if you think about our guidance from the beginning of the year, right, we had assumptions around elective procedure recoveries. We had hospice length of stay assumptions, and we had personal care billable hour assumptions in there.

I think we're all still seeing some slowness around the pace of elective procedure recovery. Obviously, we all understand the dynamic around the hospital length of stay right now. And that's the one thing that we're keeping ourselves a bit of caution around as we look forward. We expect it to come back, but timing of that is a little variable. And then personal care billable hours, same thing, right, slower to recover.

So when you look at what we originally guided from a revenue perspective, we're pulling back about $10 million to $12 million of revenue around those 3 data points, and letting Q2 play itself out, see how those indicators start to play out for the next 2 to 3 months before we [technical difficulty] our view of that. We think it's an appropriate stance to take.

But when you look at the margin, I think you're right on in the margin, right? Our margin print was really strong in Q1, and that was evidenced by our Q1 results and that's showing up firmly as flowing through in our guidance, right? So we've got the full margin flow-through in there despite holding back about $10 million to $12 million of revenue.

Joshua Proffitt: And Justin, this is Josh. And that was a pretty impressive introduction, so maybe I need to talk to the operator and see if they can introduce us that way. That was pretty good. But what I'll tell you -- what I'll add is I really want to put a fine point on what I said in my prepared remarks around the fact that during what is traditionally a seasonal decline, flatness to decline, over the months of -- toward the end of March and into April, and then as you get into May, June, then you're in kind of that late spring, summer. And I went back and looked every year from -- I stopped looking at 2014 just because it proved us out every year. You've seen that kind of trend.

What we're seeing now, we've had a 2% growth in our census when it historically wouldn't have done that. So I think your point is very well made that if that were to continue -- and now that's an if, because we're living in a new normal. But if that were to continue and census continues to increase throughout those months, then I do think you do have some potential for upside there. I don't want to bake that in just yet, but that's another reason I'm pretty bullish.

Justin Bowers: Got it. And then maybe just I'll follow up on home health and some of the nuances and the volume there. Can you -- one, you're seeing like in April, it's pretty obvious that the acuity is increasing there along with the institutions. Is that more -- is the institutional side, is that all hospital, or is it some of the other modalities? And then is there a way to help us think about the deferred and kind of elective volume, maybe from 4Q to 1Q? And I know it's early, but how it's trending now? And I'll just hop back into the queue after that.

Dale Malken: Yes, so this is Dale. I'll take that. Yes, so when you look at the sort of balance, first of all, what we'd say is the April, we want to give you guys as up-to-date indicators as we can. The caveat and the footnote, as you know, on the page is just an estimate; we're not closed with April at this point, so we'll make that caveat. But obviously, we're very encouraged by what we're seeing during the close process here. But I'd say the uptick in the institutional is probably some of the rebound that's coming around hospital. Their volumes, I think, are starting to recover. So that would make sense and align there.

When you look at your question around the electives, I think this is pretty well known, but I think we view it the same way. We're at about 75% of pre-COVID volumes around electives. And we fully expect that to get back toward pre-pandemic levels over the course of the balance of these 3 quarters, probably a little more heavier in the back half of the year. But for us, about 10% of our admissions come from the elective procedures. So that's about 200, 250 basis points of opportunity for us, that as that process comes back, or those volumes come back, that are additive to us.

Justin Bowers: Understood. Thank you.

Operator: Brian Tanquilut of Jefferies.

Brian Tanquilut: Josh, I'll just follow up or I guess, yes, I'll follow up on the comments on margin. So obviously, pretty strong this quarter. As we've seen visits kind of like bottom out, it feels like at the 12.6 visits per episode, how are you thinking about where that lands once LUPA normalizes? And how are you thinking about that pace of recovery?

Joshua Proffitt: Yes, Brian, good morning. I would say the 12.5 to 13 is now been pretty sustained and pretty consistent, and what we would have expected in our PDG and modeling for the patient population in the acuity that we were seeing, as we see case mix increase, and as we see patient acuity go up, I think you could see -- I don't necessarily want to call it a rebound because I think it's appropriate where it's at. But as you see more post-electives, post-surgery, you might see that go up to 13, 13.5. But as we've said before, when that occurs, case mix goes up and the revenue comes with it. So I still feel very confident about the margin throughput.

Under each of these, we've got some sensitivity analysis that we've done on visits per episode and how it relates to the different HHRGs and the comorbidity stack and what all that looks like. So as the VPE were to pick up, the margin would still be sustainable in that way. So I feel really good about that.

And then the other thing I have to mention as we're talking about VPE is I want to give a cap tip to Dr. Doga and Angie and our entire Clinical Leadership Team, as well as our operators that have just unwaveringly not taken their eye off the ball on our quality outcomes, star ratings, patient satisfaction throughout not only PDGM execution, but the pandemic. And we continue to monitor those results monthly and feel really good how we're pacing there as well.

Brian Tanquilut: And then Josh, just to follow up your point on ADC where census being the driver, right? So as I look at your admissions trends for the quarter versus what ADC trends were, and as I think about pushing that going forward, where do you see the research rate movement going? Will we be able to sustain kind of like this elevated level of research or is this just the new normal post-PDGM?

Joshua Proffitt: Yes, I think, Brian, our [restart] rate is somewhere around 36% or so. I wouldn't necessarily say that's elevated. There was a little bit of elevation earlier on in the pandemic if you go back and look at it quarter-over-quarter. But 35% to 38% or so is about what we would expect and about what we would run. So I think that's pretty solid. So if your length of stay and your restart rate is pretty stable and solid, then you're just looking at the correlation between the admit throughput and the census.

Brian Tanquilut: Got it. Okay. Thank you.

Operator: Matt LaRue of William Blair.

Matt LaRue: Josh, I just wanted to talk a little bit on your comments on the M&A pipeline. I think you mentioned that's largely creating more overlap markets. Maybe could you just confirm that that's where the majority of the pipeline is versus anything you've seen on the footprint

expansion side? And then are you starting to see anything sort of PDGM-related start to pop up in any of your discussions, maybe a return of some of the inbounds you saw before all the CARES dollars started flowing out?

Joshua Proffitt: Yes, Matt, good morning. I'd say on both of those that yes and yes. So the majority of the acquisitions in the pipeline, especially those that were pretty far along in our diligence and discussions are more overlap, either co-location overlap, which is the strategy that Keith described earlier, or just market density opportunities in the states that we currently operate. So there's not a lot of geographic expansion or footprint growth in that kind of a way.

And then on your second question, which was -- remind me again, Matt, the second point that I said yes to already.

Matt LaRue: Yes, sure. Just you had mentioned pre-COVID that you were looking forward to maybe some PDGM opportunities coming. And just curious if any of those are starting coming back?

Joshua Proffitt: I'm glad you did ask that one because if you look at our pipeline right now, and even if you look at the difference between what we reported last call and this call, there is an uptick in home health in the pipeline. So last call, it was 80% or so weighted toward hospice, and now it's 70% or so weighted toward hospice and about 30% of home health. And even this week, we've had 2 inbounds, some -- what I'll call small-to-medium size home health opportunities that we're already kind of modeling and looking at. So I've definitely sensed and seen an uptick in home health specific activity over the last 2 months that we were not seeing in the fourth quarter.

Matt LaRue: Okay. That's helpful. And then just a question on the hiring side. Obviously, you've been sort of hiring record numbers to try to meet record demand. But I'm just curious is the availability of some of these clinicians do you think in any way related to other providers not paying COVID bumps, maybe a reduction in some of the travel payer bonuses that staffing agencies might've been using? Just curious if there's any sort of different supply side dynamics that are [sticking] up with your hiring?

Joshua Proffitt: Yes, Matt, that's a hard one to answer. I could speculate and give you my gut on it, which I think it might be some of a lot of things. I still continue to believe that just the flexibility and the type of work we do is very attractive. And then when you're doing it in a pandemic setting where everyone is just going through fatigue and burnout throughout all levels of settings of healthcare, I think we are a good place for a lot of the clinical workforce.

But I want to spend maybe more time talking about just our processes and what we have really focused on and improved over this last year from the efficiency of our onboarding and orientation process to the way we more closely monitor our speed of hire metrics. We've got daily pipeline reports that go out all throughout our operations and sales teams for their open positions. And the velocity of hiring, we've had back-to-back quarters that just keep jumping themselves in the higher number being historical highs. Last week alone, we have the strongest week in the company's history. So we we're watching this one that closely and had just another record week last week in hiring.

So I'm really -- I didn't know we would be here quite frankly, Matt. We put a lot of process in place; we added to our talent acquisition team both at the leadership and at the kind of tactical level and in hopes of building up capacity for growth, but honestly, we're a little bit ahead of pace from what we would have expected.

Matt LaRue: Okay, good deal. Thanks, Josh.

Operator: Frank Morgan of RBC Capital Markets.

Frank Morgan: I guess I want to stay on the M&A side for just a second. When I hear your numbers of 5-day increase in DSOs and $34 million use of cash from the whole wrap elimination, you just got to think it's going to hurt at some point. So I guess is it the deals, these recent deals, that have come in? Are people talking about that, or are people talking about what happens after sequestration ends? I'm trying to figure out what scares mom-and-pops enough to actually want to actually consider selling assets?

Keith Myers: I think on home -- are you talking about home health primarily?

Frank Morgan: Yes, yes.

Keith Myers: So I think the decisions of home health of mom-and-pops to sell was made in 2019, and then the COVID pandemic and the stimulus money. You heard us say this; I think we're all saying the same thing. I think it's the truth. Provided some relief and postponed that urgency, but there's just so much changing in the way home health is delivered. And I mentioned in my prepared comments about value-based purchasing. That's a really big deal.

And when I look at our data and I see how far we're outperforming the home health agencies that are getting 91% of the business in places where we are, that's just -- that's going to get found out and brought to light. And so to take their home health agencies from where they were, and how they were operating them really as a cash cow, to how they were living out of it, I think that decision to sell has just been made, right? And so now, it's just their long-term view.

Let me just say a couple of other things. This is probably too leading, and I don't want to mention any names and stuff, but there are people that started these like Ginger and I did, and they grew them to a certain level not at the -- and these are real. I'm thinking of really people now that I know, right, that we're talking to, but didn't have the good fortune to end up in an LHC type situation, but they grew a business, starting from something very small. And so they don't have any debt and so it's their nest egg that they're going to retire at. And so, they're late 50s, mid-60s, and just looking to move on. I just think it's that simple.

Frank Morgan: Got you. And the mix of the backlog, is that more a function or the size of the deals in a couple on the hospice side, or are these just like larger deals, and therefore represent a larger percentage? How would you characterize the backlog from that perspective?

Keith Myers: Yes, so the hospices that we have in the pipeline now aren't of that -- aren't the kind that I just described to you. The ones that we're looking at now were more investor-owned or investor-backed and so they've done quite well with them to a point, just in the 5-to-7-year window where they're going to flip out of it and move on. So we're not -- there are some of the

hospices that fit in the other model that I've described that are relationship type deals, but the ones in our pipeline now aren't, Josh, I don't think, right?

Joshua Proffitt: Yes, just a couple, maybe something small, but yes.

Keith Myers: The significant ones aren't.

Joshua Proffitt: Yes, and on the size question, Frank, on the hospice deals, you're right, they are a little chunkier ranging from medium size to pretty good size. Whereas on the home health, those are, I would say, more smaller to medium size as we're consolidating that for PDGM, as we just discussed.

Frank Morgan: Got you. And then the last one here, just obviously, you at management, you'd already commented on Brian's question about the visits per episode. Beyond visits per episode, is there anything in terms of labor mix, substitutional labor between nurses and LPNs or any mix opportunity left in the cost of labor cost structure, or from here is PDGM or just a function of refining coding and more top line?

Joshua Proffitt: Yes, Frank, I would tell you that you know us quite well, and we've been very public with kind of our LPN-RN mix and our PTA-PT mix. And we continue to feel like we are operating very effectively there and efficiently, and have monitored those metrics as the VP had evolved through PDGM. But again, I hate to sound like a broken record going back to all of our preparation work before we executed on PDGM, but we knew what those were going to look like before the calendar flipped to 2020, and the team has executed quite well. So I wouldn't say that there's a lot of upside or further improvement there. We're still 45% or so mix on LPNs and probably 50%, 55% on PTAs.

Dale Malken: And Frank, this is Dale. What I would say would grow the opportunity is around contract labor portion. As Josh mentioned with the strong hiring, strong retention, we're starting to create -- and our clinicians off quarantine or our capacity is starting to get back to where we're very comfortable with it. And so that creates an opportunity to displace some of the more expensive contract labor. We're a little bit overweight in contract labor yet, in home health and hospice, but it's gotten better in [L-Tech], but we feel that we're at a good pivot point where it's starting to -- going to get better for us.

Keith Myers: Yes, Frank, let me (inaudible) a mix, but so we're talking about visits per episode. I think it's time for us to start talking about how the delivery model changed as a result of PDGM and then was also influenced by COVID. So when we think inside LHC Group, just so you know, we don't -- we talk about visits, but our big focus is on patient encounters and minutes of time with patients. So our patient encounters and the time that we spend with patients is at an all-time high, but we're only having this discussion around visits.

And you know what I think would make it easier for all of us non-clinicians to understand is how differently we talk to them today post-COVID, and how we have virtual meetings. If someone would have tried to convince us that there was value in a virtual meeting 2 years ago, not many of us would've thought that made much sense. But today, a significant amount of the time that our nurses spend with patients are through telehealth. And those are all in addition to the visits we're making.

So at some point, we're going to need to bring that up because if you keep talking about just visits, it gives the impression that we are spending less time with patients in this model and we're actually not. We're spending more time, so how are we going to communicate that to the market?

Frank Morgan: Okay. Let me ask one follow-up. So what's the difference between a visit and an encounter? Did you get the count things like telehealth or other things to create the encounter? And then I'll hop off.

Keith Myers: Yes, so these are not things that we put on a cost report and so we've always put visits on, and we've talked about home health in terms of visits. And we honestly didn't do much of this pre-COVID, and pre-PDGM or pre-COVID, they all happened at the same time. But now, we monitor all encounters with patients. So in the past, if a patient at some -- had some issue and spent 30 minutes on the phone with a nurse during the course of the day, let's just say 5 years ago, that wasn't something we would have tracked. And today, we track all of that as part of the encounter time with patients just to learn how the model's working. It doesn't have any financial impact or nothing we can bill for or anything.

Frank Morgan: Okay. Thank you for the insights.

Operator: The last question today comes from Joanna Gajuk of Bank of America.

Joanna Gajuk: So I guess the follow-up is on, I guess, prepared remarks, the choose home legislation that you seem to be even more, I guess, confident it could be introduced this year. So if this is passed, right, which we don't know, like maybe next year, if things go right, or maybe this year, I don't -- if you can talk about kind of the timing of things. And also more importantly, If you can (inaudible) the SNF at home benefit, essentially, how big of an opportunity could this be for the industry and the company? Kind of any way you could frame it for us.

Obviously, you have a decent exposure in personal care, right? But can you -- would you require more of these assets or would you partner to be able to kind of implement this in your market?

Keith Myers: So I'll start with this question about choose home. The model is nothing new. It borrows from the Oregon health plan and the passport program in Ohio, to be quite honest, and then maybe adds a little more skilled side to take higher-acuity patients. But so when we proposed it, I think we were surprised by the receptiveness to it. And I think the reason that we've been surprised by the positive way other reception is because of the COVID experience we all just went through. It shined the light on the need to have an alternative to institutional care for that patient population.

So we're building champions on the Hill on both the House and Senate side, and that is exceeding our expectations, at least exceeding my expectations. I'm pretty conservative, always plan for the worst, but I'm just surprised at the champions that are getting behind this, but I just think it's the right thing at the right time. So I am pretty confident that it gets introduced later this year. Now, where does it go? Does it get passed? I just don't know. So that's where I am on the legislation. Every -- all policy in Washington D.C. right now, if you show up and want to talk about ideas to shift care to the home, everybody wants to talk to you, and I think a lot of it has to do with just the COVID experience.

But I'm sorry, but your second question about if it does pass the home, yes, how big is the opportunity?

Joanna Gajuk: Right, and then would you need more personal care, I guess, coverage to do that, or would you have to -- or no partner?

Keith Myers: So we would have to have more personal care activity because the choose home legislation incorporates an element of personal care with the traditional Medicare skilled benefit. So and I would say in markets where our volume is lower, we would probably contract with a personal care provider if we didn't already have that service in that market. But in larger markets, let's just say like the Dallas market, where we have the THR joint venture, in that kind of market, we would probably acquire or build personal care, just economies of scale, if the volume's there, and of course, how big the market is.

I think in the regular home health model without this combined service, we have proven out that 40% of the patients being admitted to SNF could be cared for at home with just the traditional home health benefit and we were doing that already. So when we look to this benefit, I think we're talking about another 30% or 40%. So 70%, which means 70% to 75% of patients that were going to SNF 2 or 3 years ago could be cared for in the home setting with a combination of services.

Joanna Gajuk: All right. I appreciate the color. I guess I'll end here because we're over time. Thank you.

Operator: This concludes our question-and-answer session. I would like to turn the conference back over to Mr. Keith Meyers for any closing remarks.

Keith Myers: Thank you, operator. As far as closing remarks, just as always, thank you for your questions. Thank you for participating in the call, and know that our management team will always be available to you between calls. Contact Eric Elliott, and if you'd like to speak to myself, Dale or Josh, we'll set time aside and be glad to speak with you and answer any questions you may have.

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