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LHCG - Q2 2019 LHC Group Inc Earnings Call

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PRESENTATION

Operator

Good day, ladies and gentlemen, and welcome to LHC Group Second Quarter 2019 Earnings Conference Call. (Operator Instructions) As a reminder, this conference is being recorded.

I would now like to introduce your host for today's conference, Mr. Eric Elliott, Senior Vice President of Finance. You may begin, sir.

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

Thank you, Norma, and I'd like to welcome everyone to LHC Group's earnings conference call for the second quarter ended June 30, 2019. Everyone should have 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 year-to-date 2019 on the Quarterly Results section of our Investor Relations page. The supplemental deck as well as a copy of our 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; Josh Proffitt, Chief Financial Officer; and Don Stelly, President and Chief Operating Officer.

Before we start, I would like to remind everyone that statements included in this conference call and in our press release and in 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 2019 and beyond. Actual results could differ materially from those projected in forward-looking statements because of a number of risk factors and uncertainties, which are discussed in our annual and quarterly SEC filings. LHC Group shall have no obligation to update information provided on this call to reflect subsequent events.

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

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

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

Before I begin, I want to take a moment to directly thank our 32,000 team members serving at locations around the nation. Your collective efforts reflect our unwavering commitment of providing the highest quality and service in our industry, a true hallmark of our LHC Group family.

Collectively, you fulfill our commitment to being a 24/7/365 health care organization that never sleeps and is always there for those who place their trust in us. Please know that your efforts are noticed and greatly appreciated.

For 25 years, LHC Group has been a clinically driven company, and we reinforced that commitment with a strong addition to our team when Dr. Tricia Nguyen joined us in July as Chief Medical Officer. As a physician and business leader with experience in health systems and managed care, she is already influencing how we think about our care models, our ACO business and other initiatives that should have an impact on revenue and earnings.

We value people here at LHC Group as our greatest asset along with the culture we have intentionally created. It shows in the high level of quality and patient satisfaction that has consistently outpaced the industry. And it shows in our voluntary turnover rate. The turnover rate at legacy LHC stands at 15.5%, another record low for us.

Our second quarter story is mainly about building on this strong reputation for clinical quality and an exceptionally deep team of clinicians, operators and other professionals, who go out and execute on organic growth, M&A, integration and managed care initiatives. The work we did in the quarter and to date in the third sets us up for a very successful year in 2019 and to continue thriving in 2020.

With a national platform that now extends across 35 states and the District of Columbia, reaching 60% of the population aged 65 and over, we have many opportunities to capture market share through organic growth, de novo and acquisitions. With organic growth and legacy LHC performing ahead of our usual annual targets, we believe once we're past the Homecare Homebase conversion, we will be able to drive organic growth with Almost Family as well.

Our target for M&A volume for 2019 has been between $100 million and $150 million. To date, we have announced 6 transactions which totaled approximately $81 million in annualized revenue. These transactions include more hospital joint ventures, several tuck-in acquisitions that fill out our tri-level of care strategy in existing markets, and a strategic acquisition of Visiting Nurse Association of Maryland with approximately $35 million in annual revenue.

We've accelerated our pace of acquisitions post the final stage of Almost Family integration and following the completion of the 2-phase joint venture with Geisinger in April and June, which included home health and hospice locations in Pennsylvania and New Jersey.

We announced VNA home health of Maryland in late July and expect this transaction to close on September 1. On August 1, we made several more announcements: First, we closed the previously announced joint venture with Capital Regional Medical Center to purchase from SSM Health the assets of 3 home health and hospice locations in Jefferson City and Mexico in Missouri; second, we completed a JV with Atmore County Hospital to purchase a home health provider in Atmore, Alabama; and lastly, we purchased 2 home and community-based locations in West Union and Waverly, Ohio, from Comfort Home Care. Together these 3 represented approximately $7.5 million in annual revenue.

Our opportunity pipeline managed by our in-house corporate development team remains robust. We have the experienced corp dev infrastructure in-house to be able to capitalize on increased industry consolidation likely on the horizon in 2020. Particularly among the smaller providers, this component of our growth story could potentially take on greater importance in the months to come.

We have been saying for some time but it bears repeating in the context of the focus on PDGM, we expect and believe that any shift of care into the home and any payment models built on delivering value will be a net winner for LHC Group. Delivering high-quality care in the privacy and comfort of the home, our primary place of residence, is the most appropriate and most efficient setting. Our partners, payers and policymakers recognize this. We've seen it directly in our ACO business as we manage large patient populations and analyze the claims [data]. Our many hospital and health systems partners recognize this, as do the many payers we work with and again policymakers at Washington, D.C. Health care service delivery is moving to the home at a pace that will continue to increase.

When we connect our joint venture strategy, the new payer models and the new value-based environment we're headed to, we're at a vastly different place than before. Whether it's with partners such as Ochsner that are on the full capitation, or partners such as Geisinger that have their own health plan, the conversations we are organizing and the solutions we are presenting are more strategic than they've ever been.

We've always been known for the highest level of quality. Where these conversations are going is how we look at unnecessary hospitalizations, ED usage and recertification and focus on total cost of care, and sharing in those savings in the form of bonus payments. These relationships create more upside for us in the future, and we are very excited about where we sit in this environment with national scale, leading quality scores and a differentiated value proposition.

Now turning to PDGM. As many of you know, the new payment model for Medicare Home Health Services, PDGM, which Congress enacted in 2018, is set to begin January 1 of next year. Our preparations for this change are well underway and ahead of schedule. At the same time, our constructive dialogue with CMS and our work with Congress continues to develop ways to improve PDGM in its current form for the benefit of Medicare beneficiaries, more specifically to avoid the unintended consequence of forcing patients back into higher cost settings to access care that could be provided in the home at a fraction of the cost.

In July, CMS issued its proposed rule implementing this model, increasing to 8.1 -- 8.01%, I'm sorry, its proposal on budget neutral payment adjustments based upon assumed provider behavior. While we are well positioned and well prepared for this change at LHC Group, we do not agree with the prospective cuts and the use of assumptions as opposed to evidence to adjust payment.

As Founder and Chairman of the Partnership for Quality Home Health Care, and as a long-standing active member and formal Board member of the National Association for Home Care & Hospice, I have been heavily involved in the industry's lobbying efforts. I'd like to add some more commentary on PDGM and our collective efforts.

Both the partnership and NAHC are in lockstep, I should say, and with behind priority legislation to refine PDGM, and we're generating strong bipartisan support in both houses. Leading into resource -- recess, there are 45 house cosponsors and 27 cosponsors for H.R.2573 and Senate Bill 433, respectively. Among the cosponsors are significant and crucial support from key constituencies and many members of the committees of jurisdiction.

The bill's momentum is building. The lead sponsors of the PDGM bill, Collins, Stabenow, Sewell, and Buchanan, are home health champions with a strong track record and personal knowledge and support for home health. The bill is well positioned with sponsors who are motivated to deliver for the home health community. This is evidenced by their statements about the bill.

Our strategy is simple: build broad congressional support for our targeted legislative approach to eliminate the most onerous component of PDGM; use all of the muscle of the industry collaboratively; share data on the potential impact and likely consequences of PDGM; and be ready and positioned for a legislative vehicle as it develops.

Again, the entire home health community is working collaboratively to build support for the PDGM bill. The national associations are working together with every state association in the nation, and nonprofit investor-owned urban, suburban, rural agencies are all speaking with one voice. This effort mirrors the successful HHGM effort that resulted in CMS slowing down and redoing its original plan for payment reform of home health. The intensity of the advocacy includes a heightened push to remove any technical barriers to passage of the bill, especially pressure at all levels to secure a score which determines the physical impact of the bill. Health care leaders have committed to accelerate a CBO analysis of the bill, which would remove a significant process obstacle that can affect any legislation. Congressional sponsors have been assured that PQHH and NAHC are ready and able to pivot quickly to make refinements needed to ensure budget neutrality.

In addition, an extensive grassroots advocacy effort during the August recess to communicate by e-mail and social media to Members of Congress, make personal visits to Members of Congress in their district offices, attend town hall meetings and community forums and invite lawmakers on home health visits to experience the power of care in the home.

Both the partnership and NAHC also continue their grassroots media strategy by encouraging independent voices in the field to write letters to the editor and use other social media means to build support for the bill.

While the PDGM bill is well positioned, the focus of Congress immediately after recess will likely be dominated by policy decisions to address tragic events of recent days.

However, the business of Congress and the followup must also incorporate actions on other must-pass initiatives, continuation of many provisioned budget items that conclude at the end of the fiscal year. For this reason, it is very likely that PDGM will have potential vehicles on which to ride along before the end of the fiscal year or certainly before Congress adjourns in December. Hill staff has also forecast the availability of a Medicare bill this fall that would be a vehicle for the PDGM legislation.

Given bipartisan action earlier this summer on the budget and debt limits, there may be legislative opportunities in the appropriations or other health care extended vehicles that offer our bill the chance for legislative action. Despite these opportunities, Congress camp, as it has in the past, delayed its budget process by passing a continuing resolution, flatlining expenditures temporarily, all for a series of months. Should this happen, other legislation in the health care space may still provide good vehicles to advance our bill.

So the bottom line is, we have strong bipartisan support, growing momentum, data and strong policy argument to support our calls and a unified and engaged home health community. I cannot be more pleased with our unified industry advocacy efforts. I believe that our coming together as one voice with reasonable evidence-based policy recommendations, supported by the majority of providers in the industry and supporting data from reputable third-party firms, is a recipe to success in our current and future policy efforts on behalf of the industry.

And now, here is Josh to provide some color on our financial results and 2019 guidance. Josh?

Joshua L. Proffitt - *LHC Group, Inc. - CFO & Treasurer*

Thank you, Keith, and good morning, everyone. Thank you all for joining our call. As always, I like to begin my prepared remarks by saying how much I appreciate all of our clinical professionals across the country and what they do each and every day. It is a privilege to serve you as you tirelessly serve others. I would also like to thank our home office support teams, whose level of commitment and service to the field is greatly appreciated. I am so proud to work alongside and support you all. It is because of all of your hard work and execution that we are able to once again report another strong quarter of results.

Our supplemental financial information posted on the website provides more detail on the breakdown among sector performance, guidance and assumptions. I will reference that supplemental deck in my summary remarks this morning.

For the second quarter financial results, here are the big takeaways: First, our guidance for the year is for 21% growth and adjusted earnings per share at the midpoint, and we are on track with that outlook with $1.07 of adjusted EPS in the second quarter at the significant improvement of 27.4% year-over-year and also up 9.2% sequentially from the first quarter; second, we realized a total of approximately $7.8 million in pretax cost synergies in the second quarter, which now brings the realized cost synergies to an annual run rate of $31.2 million from the Almost Family acquisition; next, incremental margin improvement has continued across all of our segments on a year-over-year and sequential quarter-over-quarter basis; fourth, with organic growth of 9.1% in home health and 9.6% in hospice for the quarter, our organic growth was strong in both home health and hospice yet again, as we maintained our industry-leading quality and patient satisfaction scores; and lastly, revenue across all segments for the quarter met or exceeded our expectations.

Turning to Page 9 of the supplemental deck, I would note that our adjusted consolidated gross margin of 37.6% in Q2 was a 130 basis point improvement year-over-year, and a 50 basis point improvement over the first quarter. Consolidated adjusted G&A expense as a percent of revenue was 27.3% in the second quarter, which was down 50 basis points from 27.8% in the same period a year ago and in the first quarter of this year. Our adjusted consolidated EBITDA was 10.2%, which is up 160 basis points year-over-year and 100 basis points from Q1 of this year.

As part of our ongoing strategy to optimize the portfolio, we also closed 13 locations that represented a total of $11.2 million in annual revenue. In addition, we incurred some severance costs, lease termination fees and impairment costs related to these closures. All of these costs were accounted for in our adjustments. The details of those adjustments are on Page 10 of the supplemental deck. However, in addition to optimizing the portfolio through certain closures, we also continue our strategic growth efforts through not only same-store organic growth and new joint ventures and acquisitions that Keith described, but also through the opening and planning for opening additional de novos across the portfolio.

So far year-to-date, we have opened 5 de novos, 2 in home health and 3 in the HCBS segment. And we are currently underway in process or evaluating an additional 30 de novo locations to open throughout the balance of this year as we head into 2020.

Our improvement across all metrics continues to be broad-based. Pages 8 through 15 of the supplemental deck highlight the results and Page 7 notes the key stats by segment.

Turning to Page 21 of the supplemental deck, we've outlined a number of our debt and liquidity metrics, including the fact that adjusted free cash flow was $61.9 million for the 6 months ended June 30, 2019. DSOs have improved to 48 days, down from 51 days in the second quarter of 2018, as we continue to improve our collections on managed care receivables and receivables from the Almost Family acquisition. Recall that we are expecting DSOs to remain close to this range, if not slightly below, for the balance of 2019.

Our balance sheet remains strong with a net leverage at 0.94x adjusted estimated EBITDA for 2019. With $248 million available on our credit facility and an accordion feature that can provide an additional $200 million of capacity, we are well positioned to remain in growth mode on the joint venture and acquisition front for the foreseeable future and to take advantage of the M&A momentum we have year-to-date and the opportunities we are currently evaluating in our top line.

We are reaffirming our guidance issued on May 9. The details of this guidance are on Page 17 of the supplemental deck. At the midpoint of this range, we're expecting adjusted EPS growth of 21.1%, net service revenue growth of 16.9% and adjusted EBITDA growth of 34% as compared to 2018.

In summary, the quarter's results reinforce our growth thesis built on strong organic growth, differentiation in quality and patient satisfaction scores, the ability to move from cost to revenue synergies with Almost Family as we complete the Homecare Homebase integration by year-end, incremental margin improvement with additional levers yet to be pulled, and significant momentum on the M&A front. Should there be a disruption among smaller providers due to PDGM in 2020, we will be well positioned to gain market share, both organically and inorganically.

That concludes my prepared remarks, and I am happy to further answer any questions during the Q&A section.

I am now pleased to turn the call over to Don.

Donald D. Stelly - *LHC Group, Inc. - President & COO*

Thank you, Josh, and good morning, everyone. As both Keith and Josh alluded, we are where we are today because of the hard work and commitment from our team, a team that cares for patients and families that we truly are privileged to serve each and every day. I too sincerely thank you.

I do want to focus my time this morning on some quick updates on the Almost Family integration, our growth, quality scores and how we prepared for PDGM. First, on Almost Family. While our KPIs continue to trend in the right direction, contribution margin increased and the Quality Star ratings of Almost Family agencies up, the patient improvement is going to accelerate further when we are past the Homecare Homebase conversion and around our modeling, both which will happen by year-end.

Turning to organic growth for the quarter, we were well above our usual 5% to 7% annual target range with home health admissions up 9.1% and hospice admissions up 9.6%. In hospice, in particular, we clearly are seeing the benefit from the sales and operational leadership changes that we made and discussed last year.

In that similar vein, you can see the early benefits in our home and community-based services from the changes in the structure we made last quarter. From our segment results on Page 15 in the supplemental deck, you can see that our home and community-based service segment-adjusted EBITDA margin was up 200 basis points from last year and up 150 basis points from the first quarter. We expect more improvement in this business as the year progresses as we drive both gross margin and G&A efficiencies.

Our quality, our quality scores, which are outlined on Page 19 of the supplemental, we continue to see improvement with same-store LHC quality scores, up in July from (sic) [to] 4.65 from 4.61 in April. Almost Family improved as well with a quality score of 3.78 in July as compared with 3.76 in April.

As a reminder, CMS did change the calculation for patient satisfaction from April to the July release, where we again continue to outpace the industry on those scores as well.

Looking ahead to the balance of the year and to 2020, of course, PDGM is front and center on everyone's mind. At LHC Group, we have fully incorporated the new reimbursement model in the work streams, clinical staffing models and our operating reviews. We also have several pilots that are going on which have allowed us to test, and we're pleased with these responses. Even if we assume the behavioral assumptions ultimately remain, which operationally we are, we are ready with adjustments to offset the higher reimbursement cuts.

Now I don't think you heard anyone from our business at this point who believes they can fully offset these behavioral assumptions on day 1; that could adversely impact patient care. But we believe firmly that PDGM is manageable, just as all other reimbursement changes we've seen the industry give us. For instance, there are modifications that have been made to care delivery where we could achieve more patient touches that use a different skill mix of clinicians in the field to do that more efficiently.

More larger providers like us who believe PDGM has the potential to accelerate an industry consolidation unlike any we've seen in recent memory. We will be ready.

Thank you again to all of my fellow colleagues around this country and company, and thank you for listening in on our call today. Operator, we're now ready to open the floor for Q&A.

QUESTIONS AND ANSWERS

Operator

(Operator Instructions) Our first question comes from Brian Tanquilut of Jefferies.

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

Keith and Don, thanks for all the color on the operations. I wanted to ask Don on the AFAM side first. As we think about the rollout of Homecare Homebase, and what that's doing to the agencies, I mean if you can just give us some more color on the disruption, clinician turnover? And then where do you think the same-store growth for that portfolio of assets actually inflects?

Donald D. Stelly - *LHC Group, Inc. - President & COO*

Great question, Brian. First of all, let me just give a little color on where we're on completion. And even before that, Homecare Homebase in the conversion to the one instance is really the mainstay, but there are tangential things that happened. For example, we're 88% complete with putting one instance in the portfolio. We're 64% complete putting the payroll processes that coordinate with Lawson and actually track the time and attendance.

So I just wanted to give you that example and color to talk about the disruption. When you use the word disruption or how it affects it, the first thing is you're running a parallel for essentially all new admits and resource -- and re-certs. So that takes that clinician going into 2 systems. So quite candidly, when you look at the flatness of that growth, and you also look back on pre-merge at AFAM wasn't growing at all, considering this disruption, while it sounds maybe a little oxymoronic, we're very pleased with where we are with that. We see it as a win because we're really putting this into place with the model of STI, short-term incentives, some of the other parameters of how we route plan. We're building this out to get to that same -- and I would, I would come out with a 5% to 7% annual number next year. We're in the middle of budget process right now. I'm going to color that in on the next call. But I would look at the last half of 2020 being extremely similar to what we're seeing inside of LHC Group right now. That's what we're going to budget and that's what we're going to hold our team accountable for.

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

Got it. And then, Keith, you talked about the partnerships you have with some of these very innovative or progressive hospital systems. I saw that Ochsner, for example, is rolling out a home hospitalization program. I'm guessing you guys would be the partner there. So if you don't mind just talking to us about what that does or where do you see that going and your ability to roll that out with other partners going forward?

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

Sure. That's a great question. So let's start with Ochsner. So that is very much in the developmental stage, I would say. I mean we've been involved with them in this initiative for probably a little over a year now. Don, you can probably get a little more specific, but really incorporating nurse practitioners and moving patients out of the hospital into the home quicker is what the whole initiative is. They refer to it as hospital at home. So we are doing the piloting now. We're creating the value. Obviously, the next step for us before we roll that out is to discern -- is to determine what the economic models are going to look like. How do we share in those savings as their partner? And I think that's going to be our reality for the next several years as we move to value-based care with payers or with hospitals is -- and by that, I mean piloting a specific product and a model that's well documented and that can be replicated. And then determining how we score it and then determining how we share in the savings that are created, because there are obviously additional costs that go far above and beyond what we provide in traditional home health, i.e., nurse practitioners, telemonitoring, and those type things. Don, maybe you can expand a little bit on that.

Donald D. Stelly - *LHC Group, Inc. - President & COO*

Keith, I think you framed it up well. The add-on there, well, there is the reason nurse practitioners are so important is because then you take the burden of the homebound and the medical necessity inside of Part A benefit away because, candidly, the hospitals don't care if that patient can drive sporadically or they don't exactly meet that criteria. But there's a huge cost of that because you can only build Part B and it doesn't offset the whole cost. That's why Keith is alluding to how does the economics work. It's a little bit more complex, but I got to tell you, I think Josh would echo later, our partners are really starting to "get that." And so, Keith, you laid it out very well.

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

Got it. And then just last question from me really quickly, Josh. As I think about the Innovations business, there was a notable sequential drop in revenue. Is there anything to call out there and how should we be modeling that going forward?

Joshua L. Proffitt - *LHC Group, Inc. - CFO & Treasurer*

Yes. Brian, great question. And thanks for the questions up to this point. HCI, really the revenue reduction is around the closure of the asset that was formerly referred to as Ingenios. If you recall, in the HCI segment that we acquired from Almost Family, there were 4 different really completely separate books of business. You've got Imperium, which is the ACO business; you've got the nurse practitioner business; you've got a long-term payer business that does primarily assessments for long-term insurance companies; and then you had Ingenios. We sold the Ingenios asset back earlier this year, so that would explain it. And then as far as the run rate goes, I would factor in the same that you saw for this quarter on a go-forward

basis, with a little bit of incremental growth, because we are bringing in some new revenue on the PMPM side for Imperium, and we have a few new opportunities with the LTS business. But don't forget, in Q3, we get the MSSP, the Medicare Shared Savings Payment, from Imperium. That will give a little bit more revenue in the third quarter that would be out of the normal run rate.

Operator

And our next question comes from Joanna Gajuk of Bank of America.

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

So you sounded quite confident in the -- in your ability to still -- to grow next year in talking about the PDGM and also this other -- these avenues of growth in terms of AFAM and the specialties. But in terms of the PDGM, I know I understand that you are saying -- you are not saying that you can offset all of it, but can you just maybe flesh out a little bit in terms of your ability to attack that 8% in terms of the different avenues of hospice? And how quickly you can kind of act upon those?

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

Sure. Don, do you want to take that?

Donald D. Stelly - *LHC Group, Inc. - President & COO*

Yes. Keith, I'll take the first part and then turn it over to Josh to talk specifically about the numbers. But, Joanna, it's a very good question. Remember, I also alluded to in my prepared comments about the initial rate that we've got to do that in the first quarter will look quite differently as we model it out going forward specifically into Q3 and 4 of next year, and let me explain that briefly. But of course, the biggest component is, how you take the restorative diagnosis in PDGM and work through providing therapy-type services with a different skill mix. You can't just flip a switch going between November and December. So we expect the first quarter to have a little less steam in moving that way as we go through the year, of course, Q3 and Q4 being fully modeled. Josh will talk about the way we think through that in the offset on the financials, but I would fully expect that by Q3 and Q4 that any of those effects go away because we're fully deployed into our model, which can -- again, just can't be pushed out there January 1. Josh?

Joshua L. Proffitt - *LHC Group, Inc. - CFO & Treasurer*

Yes. Great frame up, Don. And Joanna, to get more into the details of the financial implication, so as I think we said previously, just to reground everyone, base PDGM has about a 1.9% reduction to LHC Group, which is almost entirely offset by the market basket adjustment. So I would refer to base PDGM as flat for us going into 2020. Then you've got the 8% behavioral adjustment that Keith mentioned and Don just referred to. I want to maybe take an opportunity to describe it in dollar terms that I don't think we've done before, which is when you look at the new 30-day rate for a new 30-day payment period within the 60-day episode and you apply the 8%, that represents about $140 per 30-day period. So when you think about all the things that Don just described and the operational preparedness efforts that were put into place and some of the learnings that we've already obtained through the pilots, that's where we get our confidence, Joanna, that we feel like throughout the balance of next year, we should be able to offset and mitigate the majority of that $144 every 30-day period. So therein lies kind of the financial side of it, if you will.

Donald D. Stelly - *LHC Group, Inc. - President & COO*

And Joanna, I have not said this before, but I think I need to, the coloring what I just told you. We have out of, of course, of the 432 different diagnostic groups, our preparedness in the aggregate of the patient population mirroring next year's patient population, if we were able to flip that switch I alluded, no doubt we can mitigate that effect. But what I cannot predict right now until we get further into our pilots, which I also alluded, is what

is the effect on quality rehospitalization. And so as this year meanders through, I would expect us to give you a lot more clarity even on the next call because we'll have those pilots fully matured.

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

Right. So on those pilots, what are some of the things you're testing out? So I guess you mentioned, you're watching the quality and rehospitalization rates, but are you testing out things like labor and the utilization of, say, visits per episode? Are you already making these changes across the board? Are you first kind of testing it out in some centers to see how you can calculate a PDGM payment versus the current payment? Any color there in terms of what kind of adjustments you are trying to make?

Joshua L. Proffitt - *LHC Group, Inc. - CFO & Treasurer*

Sounds like you've been in my meetings, Joanna. Absolutely. We are kind of pretending, if you would. We're outlaying the financial aspects by different episode right now to see that if we actually drop again on the PDGM, what it would look like. We're also looking at VPE, skill mix as well as the quality on our SHP. And that's exactly what we're doing. And that gives us the confidence, [brand] , we just started it, so we haven't been through a full 30 and 30 yet. We are also looking to see how the different LUPA rates would be affected based on our visit patterns our clinicians have made and really starting to bake that in into a product that bakes into quality, the financial parameters and honestly employee satisfaction, because they've got to really understand that we're going to provide greater touches, greater satisfaction and a greater quality product under this new rule.

Operator

And our next question comes from Kevin Ellich of Craig-Hallum.

Kevin Kim Ellich - *Craig-Hallum Capital Group LLC, Research Division - Senior Research Analyst*

Just wanted to continue on PDGM, 2 questions here. As you do your preparation and you've gone through your pilots, wondering how much cost savings you might be able to attain from using extenders like PTAs and COTAs? And then the second part, maybe for Keith or Don is, with the changes to wrap payments, what sort of impact do you think that will have on your business? And what opportunities do you think that could drive from how much it will hurt some of the smaller home health providers?

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

All right. Kevin, that's 2 good questions. I think, Don, you take the first part, and Josh, I think actually you should take the wrap piece.

Donald D. Stelly - *LHC Group, Inc. - President & COO*

Okay. So Kevin, I will jump in. You mentioned the extenders, specifically PTA and COTAs. We're going to actually take that a step deeper. We have been very prescriptive in analyzing roughly 850,000 episodes on in that patient diagnostic group that maps over 1 of 432. What was done? And that's what we looked at first and said, just for a second, forget what discipline did it. What intervention, what actual procedure, what teaching and training was done by that person? And who now in the new world could do it? And some of those can be done by nurses, some can be done by CNAs. Of course, we will have used the lower cost disciplines on PTAs and COTAs. But it's what I just kind of described in that scenario as added to what I was talking to Joanna about that these pilots are doing. So no doubt we call it, practicing at the type of your license. No doubt, we will see the extender use be a real big lever to pull. But again, it has to be based on the interventions which lead to the quality, and that's what I am testing right now with our teams in these pilots.

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

JP?

Joshua L. Proffitt - *LHC Group, Inc. - CFO & Treasurer*

Kevin, I want to maybe take some of what Don has described and put some numbers around it for you that might be helpful. So when you think about the current regulatory parameters around providing -- and I will just use therapy as an example because I know Don just referred to PTAs and therapy techs. In the current home health environment, you've got to send either a physical therapist or a physical therapy assistant out to make those visits. And that runs anywhere, call it a PT somewhere around $80 a visit, give or take, and a PTA of somewhere in the $55 to $60 a visit of direct cost of just the labor, right? In the new environment, under PDGM, you are now allowed to provide services through a therapy tech or a much lower cost delivery. And a lot of the pilots and the models that Don and Tricia and the team are working on from a clinical perspective are again ensuring equal or higher quality outcomes in patient satisfaction, but those therapy techs will likely be half the hourly cost of a PTA, for example. So you can really see just on a per visit level when I refer to the $144 roughly on average per 30 days that the 8% would represent, how many visits that you might even be able to modify from a PT or a PTA to a tech and still generate the outcomes that reduce that direct cost infrastructure. So kind of wanted to give you that framework.

Donald D. Stelly - *LHC Group, Inc. - President & COO*

And Kevin, one more thing that I would hope everybody sees, and I know I'm trying to do today, that is the framework Josh has alluded to beginning in January. But we still have expectations that we put out for all of you and our shareholders for this year. So we've got to operate within this environment. And then you've got to have those 32,000 people that we talked about. You've got a short window to make sure that they understand how to get this done. And that's why I am trying to make sure you all really grasp the full effect will begin to consummate somewhere around Q2 -- late Q2, early Q3 next year, because we've got to get all of this kind of cascaded almost like a wave across the United States.

Kevin Kim Ellich - *Craig-Hallum Capital Group LLC, Research Division - Senior Research Analyst*

Got it. And what about the wrap payment?

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

Yes. Josh, on wrap?

Joshua L. Proffitt - *LHC Group, Inc. - CFO & Treasurer*

Yes. Kevin, I guess from our perspective, it's not that big of an issue. You'll have some slower cash flows from the way we're doing our cash flow modeling, Don referred to our budget process already underway for next year, the cash flows are slowing down from January through March and then kind of correct themselves April, May. So kind of call it June forward for the rest of the year, you won't see really any difference than what we've experienced historically. But I will say, although the larger providers like ourselves that are in the situation that I just described, when we refer to market opportunities and consolidation, the impact on cash flow of a smaller, more regional player is going to be much more dramatic. And that's one of the reasons why the industry is fighting it so hard because those folks that are in the smaller, more regional size are going to have a much more burden caused by the wrap disruption.

Kevin Kim Ellich - *Craig-Hallum Capital Group LLC, Research Division - Senior Research Analyst*

Got it. That's helpful. And then Keith, just going back to M&A, we saw the deal that you guys announced with VNA, just wondering does that kind of open the door for further discussions and maybe more opportunities, given the size of their network and presence nationwide?

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

Sure.

Kevin Kim Ellich - *Craig-Hallum Capital Group LLC, Research Division - Senior Research Analyst*

Hello?

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

Okay, I am sorry.

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

Keith, we've lost you.

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

Okay. Now I'm here. So with regard to VNA -- I am sorry I hit mute, that was on me. With regard to the VNA, I think, it certainly opens the door. VNA was started -- I don't know if everyone is aware, this was started back in 1895 as a group of civic leaders got together to provide for the needs of the community and that's what started this whole movement. And when we -- there was a separate VNA association and there was almost no connection back when we started in this business between VNAs and what we'll refer to as "for profit agencies." Now with all of the changes, the lines have been blurred, especially with LHC and our culture and our history of joint venturing with so many nonprofit hospitals and health systems. That becomes pretty seamless for us. So I mean the short answer is, yes. And I have to say that a couple of weeks ago when I was there with the rest of the team for the announcement and the initial integration, it was amazing how much of an immediate fit there was between our team and their team culturally. And so really excited about it. The other thing that's, I think, worth mentioning here is, there was no process in that transaction. The current owner of the VNA that's owned it for the last 16 years was an incredible gentleman by name of Barry Ray, he lived in Chicago, but he was -- he felt like he had inherited the mission of the VNA and had been its custodian and shepherd for 16 years and was -- it mattered to him where that agency went. So he hand-selected us and came to the table with us to negotiate a transaction. So it was quite a surprise to others in the market because there was no process and no bankers or middlemen involved. So I think that's a credit to our entire organization, and I do think it opens a lot of doors that we may have previously thought would have been closed to us.

Operator

And our next question comes from Matt Larew of William Blair.

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

I wanted to ask about the comments on de novo. Josh, I think you mentioned as many as 30 planned for the back half of the year. Could you maybe just give us a sense for how the shakeout in terms of home health hospice versus home and community-based service is? Are these all co-location targets? And then in terms of timing, any sense for how those might progress in terms of opening?

Joshua L. Proffitt - *LHC Group, Inc. - CFO & Treasurer*

Yes, absolutely. Thanks Matt, great question. So as I mentioned, we've gone live with 5, 2 are home health, 3 are HCBS. And when I refer to the 30, about 20 I would put in the category of truly in-process. And in-process, we'd refer to seeking and down the road of obtaining whatever legal or regulatory approvals are needed to go live. And then another 10 that are currently in our pipeline for evaluation. And I would say that we've really matured over this last 12, 18 months and developed a real pipeline of activity around de novo growth as we continue to try to optimize the portfolio. The way those spread, Matt, across the segments or across all 3, so about 11 of those, 10 or 11 are in home health, probably 3 or 4, I believe, are in hospice, and the lion's share of those, so call it maybe about 12 to 15, are in HCBS. The real exciting aspect to that is this, delivering on what we've been discussing around the bi-level and tri-level strategy. So the lion's share of the HCBS and the hospice buildouts are in co- or tri-located markets as we continue to put gas to that effort.

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

Okay. And then Josh, just in terms of the Almost Family closure, I think you had mentioned in the past that you weren't closing facilities that they were making money. So I guess were these also a drag on EBITDA? And then do you have a sense now, now that you're a little bit more than a year out from formally closing the deal, as to whether the number of facility closures is going to start to slow down?

Joshua L. Proffitt - *LHC Group, Inc. - CFO & Treasurer*

Yes, great questions. And yes and yes are the answers, Matt. So on your first piece around, was it a drag? For the locations that we've closed year-to-date in 2019, they represented around $1 million, $1.5 million of drag dollar, if you will. So you see that manifesting in our quarter-over-quarter margin improvement. And then on the second piece, the pace in which we've been closing, I think, you'll see significantly decelerate. We've had a pretty good number of closures this quarter and year-to-date. But what I'll tell you is probably, you'll continue to see a couple here and there and then as we do every year, during the budget process and through the fourth quarter, you may see a few more, but I wouldn't say that there is a lot left from the Almost Family acquisition. I will say that's just an ordinary course. The other thing, Matt, I'd like to just highlight on the closures is, several of those closures are not just home health in overlapping markets or hospice in overlapping markets, but we've closed several IPUs that were dragging almost $3.5 million. We closed a legacy DME holdover asset that we had had for years up in North Virginia that was dragging a significant amount of dollars. So we've been real targeted in what we've been closing and that's, candidly, helped us deliver that 10.2% consolidated EBITDA margin.

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

Okay. And then the last one here is just for Keith then. Keith, just maybe if you could address it all, what seems to be maybe a disconnect between CMS and some of the broader support you've had? I think Congress and frankly just throughout the health care space in terms of the move from care into the home, is there a possibility here that CMS makes a change in their final rule? Just given your position throughout the industry, where do you sense the dialogue and thought processes with CMS in terms of the way they're handling PDGM and the behavioral cuts?

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

Sure. That's a great question. Let me start with maybe going in and lead a little bit with recent information. So Joanne Cunningham, who is our Executive Director for the partnership and others -- I don't remember all of the others that were with her recently, but this has been within the last couple of weeks, there was a meeting at CMS. We have a great relationship, sit across the table, I'm there periodically, and we have great conversations. But they are very -- they seem very entrenched and unwilling to move in their policy positions most of the time, more so in the last several years than in the past. It's just my impression. But at the last meeting that I was not present at, they said that there were comments made by the CMS team in Baltimore that they weren't confident that they were prepared to implement, to manage the implementation of PDGM. Granted this is in July that they're saying that, so that doesn't necessarily mean that they are -- they don't think they'll be ready by January. But the team that was there viewed those comments as significant. And there's been quite a bit of discussion among the Board about that.

So I don't really know what that means, and I don't want to -- I don't want anyone to take that further than just a comment that was reported back to me. But what is noticeable for me is the distance between the conversations we have in Baltimore and the conversations we have when we visit HHS in Washington, D.C. The distance is far greater than the distance to drive between the 2 offices. It's as if you're talking to foreign countries. The career people in Baltimore seem to develop policies that current administration doesn't -- isn't in alignment, let's just say. And so that opens the door for us to open questions. And I think it also helps us with our arguments on The Hill. I don't think they're bad people, they're just people that have a career job there and they have a view, and their views are informed by outside parties they contract with to do actuarial work. And they generate a mathematical model with no understanding of how you would practically implement it. I think it just comes down to that and there it's very hard to get them to open up and accept comments and constructive criticism, anything they could use from industry leaders. I think we are tearing those walls down slowly by providing honest, accurate third-party data to push back on their assumptions. But it is a marathon.

I'll just close with this. In our world, especially where many of us -- we're on the phone like this quarter to quarter and we tend to think of progress that way. Chairman Tauzin, who is our lead independent director, said to me when I was in my 30s and started working in D.C., started advocacy efforts, I would get frustrated when I couldn't see results. And I wouldn't -- not even a year, I wanted immediate results when I make a trip up there, to be honest. And he said if you're going to survive in this game, he said, you need to accept that sometimes you have to measure success in decades. And when I look at the home health industry and where we've come from the '90s to today, that's very true. It's not something I liked to hear when I was 30, but -- and I'm not suggesting it will take us decades to move CMS, but that is the truth. I mean that's where the conversation is and there is a definite disconnect between the two.

Operator

And our next question comes from Matthew Gillmor of Baird.

Matthew Dale Gillmor - *Robert W. Baird & Co. Incorporated, Research Division - Senior Research Analyst*

I wanted to ask about the volume performance on the home health side. So overall, volumes were quite strong again. The Medicare fee-for-service volumes were again a little bit softer versus some of the recent trends. And can you provide some sort of color or view in terms of what's driving the recent divergence? And secondarily, are you increasingly indifferent between fee-for-service and non-fee-for-service, given some of the changes you all have made?

Donald D. Stelly - *LHC Group, Inc. - President & COO*

So I'll start. Go ahead, Keith. I'm sorry.

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

Yes. No, let's tag. Let me just start off by saying it depends on the reimbursement model. So today, fee-for-service doesn't mean per visit. We get paid episodically for home health, and we're managing patients for a said amount of reimbursement for the 60-day period today. And we have certain outcomes, expectations we have to hit. So we're very comfortable in that model. We're less comfortable in the preferred historical model of managed care companies, where they want today on a per visit model, which really ties our hands to provide service to patients without getting preapproved to go out and make a visit, not to mention it's incredibly inefficient from a G&A perspective. So those are my comments. And Don, maybe you could elaborate on that in addition to your other comments.

Donald D. Stelly - *LHC Group, Inc. - President & COO*

Keith, you actually -- I guess we've been together so long, you said exactly where I was going with that. Indifferent, no. Certainly with what Josh and the team has done, and he has alluded to it twice already with these contracts, it becomes okay to take that, and we've been able to marginalize that. But the fact is, we all know in this industry that traditional Medicare fee-for-service environment is shifting. You couple that with LHC Group's

quarter-over-quarter, year-over-year, we have been leading in organic growth, that 2% number is what we've factored in so that when we continue to grow that at that clip, add those contracts, that's that 9% to 10% you see in this quarter. Josh?

Joshua L. Proffitt - *LHC Group, Inc. - CFO & Treasurer*

Yes. No, and the other thing that I would add, no doubt agree with everything Keith and Don said. But the non-Medicare growth is the healthiest non-Medicare growth that we've experienced. And my reason for saying that I shared on calls over the last year, our incremental improvements we've been making in the managed-care side, one is just on the rate. So yes, we're not indifferent, and yes, we do not prefer the per visit, but our rate per visit due to a lot of hard work and effort through our team here at the home office that those hand-to-hand combat with the payers to get the new contracts, we have increased our rates by almost 9% on just a rate per visit level. We've also done a lot of things both in the back office, in the field, as well as in our revenue cycle management to reduce our bad debt expense and otherwise where we've reduced our cost per visit by about 200 basis points. So over the past few years, as we've seen this not only mix shift, but opportunity before us, we've really hunkered down here and got more rigorous. And as we get those admissions in the door, we're a lot more laser-focused on getting the right admissions in the door.

Matthew Dale Gillmor - *Robert W. Baird & Co. Incorporated, Research Division - Senior Research Analyst*

That's helpful. And Josh, if I could ask you one more on the revenue performance. I think you mentioned that results were in line with expectations. Did you mention the revenue impact from agencies that you closed? And then also could you give us a sense for where the revenue dollars are for AFAM just so we can model that a little bit better?

Joshua L. Proffitt - *LHC Group, Inc. - CFO & Treasurer*

Yes, sure. So on the ones that have closed year-to-date, in home health, that represents about $17.5 million in annual revenue. So what is that, $4.25-or-so million per quarter. And then on the -- in the LTACH's, where we had most closures, the annual run rate is, call it, $8 million, so about $2 million per quarter. And then Ingenios, which I referred to earlier, in the HCI, I'm just trying to off my head going down by segment, it was about $5 million in revenue annualized. So $17.5 million in home health, call it another $8 million in LTACH in the facility-based division, and another $5 million in the HCI division. And if you take those numbers and divide it by 4, that would give you your quarterly impact. For -- what was your second question?

Matthew Dale Gillmor - *Robert W. Baird & Co. Incorporated, Research Division - Senior Research Analyst*

Yes. And maybe I can follow up if you don't have that number handy. But just curious sort of where the Almost Family agencies are in terms of either quarterly revenue or annual? And I guess I ask as we, I think, the Street keeps probably modeling that number a little bit too high, so if you get to level set us on where sort of Almost Family asset is, that might help us model better.

Joshua L. Proffitt - *LHC Group, Inc. - CFO & Treasurer*

Yes. I got you. I got you. So the consolidated Almost Family on a quarterly basis is, call it, right at $200 million in revenue with about $140 million to $145 million of that in home health, about $40-or-so million in CBS, call it $8 million to $10 million in hospice and around $7 million in the Healthcare Innovation segment.

Operator

And I'm currently showing no other questions in the queue. I'd like to turn the call back over to Mr. Keith Myers for closing comments.

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

Okay. Thanks, operator. And thanks everyone for dialing in this morning for the call. As always, we want to make ourselves available to you. If you have any follow-up questions or need to reach us between earnings calls, please reach out to Eric Elliott and Eric will assist you. And if you need to speak to either -- any of us on the management team, we'll make ourselves available for you. Thank you, again, for joining us, and thanks for your support of our LHC Group family.

Operator

Ladies and gentlemen, thank you for your participation in today's conference. You may now disconnect. Everyone, have a wonderful day.