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PRESENTATION

Operator

Thank you for standing by, and welcome to the LHC Group Q1 2020 Earnings Conference Call. (Operator Instructions)

I would now like to turn the call over to Mr. Eric Elliott. Senior Vice President of Finance and Investor Relations. Please go ahead.

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

Thank you, Takila, and good morning, everyone. I'd like to welcome all of you to LHC Group's earnings conference call for the first quarter ended March 31, 2020. Hopefully, everyone received a copy of our earnings release last night.

I would also like to highlight that we have posted some supplemental information on the quarter and the impact of COVID-19 on the Quarterly Results section of our Investor Relations page. 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. Our supplemental deck includes all of our reconciliations and breakdowns of adjustments. We will refer to the non-GAAP measures during our call today.

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

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

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

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

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

Thank you, Eric, and thank you, everyone, for dialing in and participating in this morning's call. Let me begin with a special thank you to all LHC Group family members at every level of our organization for the courageous work you are doing during these unprecedented times. Your energy, enthusiasm, support for one another and desire to care for others is nothing short of amazing. I am humbled and honored to be part of your team.

I would also like to say Happy National Nurses Week to all of our LHC Group family nurses and nurses throughout the country who are on the frontlines fighting this COVID-19 pandemic.

Rather than focus on the usual upfront highlights in this earnings call, I want to direct comments to 2 distinct periods of time. The first is the period January 1 through March 14, 2020, where we experienced double-digit organic growth in home health admissions; strong year-over-year growth in earnings and EBITDA trending above guidance; and key quality and patient satisfaction measures for Q1 2020, showing overall improvement from Q4 2019; all together, validating that our PDGM care model is exceeding expectations.

But let's turn to what I expect most of this call will be about, the second period. Although we began our internal COVID-19 preparations in earnest on March 2, I will refer to March 15 as the beginning of the second period of 2020 for LHC Group as it follows our first COVID-19 patient admission on March 13 and relates to the period where we began to see an impact from the pandemic.

With regard to our COVID-19 preparedness efforts, we began by creating a multidisciplinary task force. We replicated the basic framework of the proven work stream model that worked well for us in the recent past with the integration of Almost Family and our PDGM preparation. We held our first COVID-19 task Force meeting on March 4, and since that time, we have held either daily or twice daily task force meetings. From our early preparation at the beginning of March until today, I am pleased to report that we have taken necessary steps to position us well and to be part of the frontline solution to the national pandemic, working closely with our many hospital partners, payers, referral sources and governmental partners at the local, state and federal levels.

As Josh will discuss later, it took us a few weeks to fully understand the impact COVID-19 was going to have on our census, admissions and revenue. But as it relates to our patients and their family members and our employees, we knew from the start that we had to move quickly to source adequate inventory levels of PPE to protect our clinicians and the patients we serve throughout the country. The 2 top priorities of our PPE work stream were to: one, source adequate PPE to allow us to provide full PPE kits for every in-person patient encounter by a clinician caring for a COVID-19 suspected or positive patient. These PPE kits include, among other items, an N95 mask, isolation gown, face shield, gloves, head covering and shoe covering. And two, to provide every clinician with the clinically appropriate face mask and pair of gloves for every in-person patient encounter with patients that were not COVID-19 suspected or positive.

Although we experienced the same reduced allocations of PPE from our primary supply chain vendors as our peers throughout health care, our PPE work stream was able to successfully identify alternate suppliers of PPE, both domestically and abroad that allowed us to achieve our goals of accepting and treating COVID-19 patients at all locations and to implement our universal mask and glove policy for all patient encounters throughout the organization. We remain well-stocked at this time at all locations and bearing any unseen setbacks in production or availability, we have good sourcing in place for subsequent orders.

Our first phase of response to COVID-19 also included a prescreening of our entire work force based on current CDC guidelines, a tremendous effort that put us a step ahead. Immediately following our task force meeting, we completed an initial prescreen of all LHC Group employees. Shortly thereafter, we initiated a daily prescreening of every employee every day of the week prior to beginning the workday.

As it relates to ADC, or average daily census, we saw a 5.6% decline from a high point of 100,030 on March 9 to a COVID-induced low of 94,476 on April 18. Our ADC has already begun to rebound from that April 18 low point and as of Wednesday, May 6, was back up to 96,182, which represents a 1.8% increase in ADC from the April 18 low to May 6.

Last but not least, we made it a priority focus to support our greatest asset, our employees. While taking care of our patients, we made sure from day 1 that we were intensely focused on taking care of employees. We often say that our people-first employee-focused culture at LHC Group is one of our greatest differentiators that sets us apart as an organization. Well, I can humbly say, I believe this COVID-19 pandemic has pressure tested that core foundational principle in an unprecedented way. In addition to ensuring the safety of our employees through the 2 main PPE initiatives I described earlier, we've put in place several initiatives to help relieve the financial burden some of our employees experienced due to the COVID-19 pandemic. These programs include: first, the addition of a new COVID-19-related criteria for our LHC Group Purpose Fund, which is our 501(c)(3) charitable arm, which was founded in 2005 in response to Hurricane Katrina and continues to help LHC Group employees receive support when they experience financial or other hardships in their lives. The Purpose Fund is funded from contributions from fellow employees to help one another. Members of our executive team, Board of Directors and others throughout our LHC Group family have generously stepped forward to fund this new COVID-19-related criteria for the Purpose Fund.

Second, we afforded our employees an opportunity in the month of March for a special PTO cash-in for 100% of a certain amount of an employee's PTO value.

Third, we made enhancements and modifications to the loan and disbursement parameters afforded to our employees under our 401(k) program.

Fourth, we expanded the offering of benefits provided by our employee assistance program.

Fifth, we announced a make-whole wage supplement for frontline direct caregiving employees designed to protect and restore gross wages for employees who have experienced lower gross wages due to the temporary effects of COVID-19 on patient volumes.

And finally, we continue to provide resources for all employees to be better prepared and informed through daily communication update to all employees on directives, policy and procedural changes related to COVID-19 and are manning a special COVID-19 e-mail inbox to answer questions that arise from our employees in a timely manner.

Turning to growth. We could not be more pleased with the execution of our overall growth strategy. To date, we've received referrals from over 5,000 new referral sources in 2020, defined as a referral source with no history of referring to LHC Group in the prior 12 months. We believe this is largely driven by improved execution of our growth strategies and market consolidation resulting from implementation of PDGM. We fully expect home health market consolidation, both organic and inorganic, to continue throughout 2020 and for the next several years.

With regard to M&A, understandably, we've experienced delays in LOI executions and closings in our hospital JV pipeline over the last couple of months. On the other hand, during COVID-19, we've experienced our existing joint venture partners more fully leveraging our capabilities as an integral part of their health care delivery team than ever before. As a result, we fully expect even greater joint venture interest from hospitals and health systems in the future. That said, our pipeline of potential M&A growth opportunities remains robust and is well balanced between home health and hospice. When we add that to the historic organic growth opportunity from market absorption that lies ahead in home health, these are very powerful sources of growth for the remainder of this year and into 2021 and beyond.

Before turning the call over to Josh, let me conclude my prepared remarks by expressing my appreciation for the support that has been provided by the White House, both Chambers of Congress, CMS, HHS and the CDC during these very unique and challenging times. In addition to areas of financial relief and support Josh will cover, which includes receipt of traditional recovery funds for expenses and lost revenues attributable to COVID-19 and the temporary suspension through year-end of the 2% Medicare sequestration cut. I want to acknowledge a few policy related highlights that are extremely helpful during the COVID-19 pandemic and will hopefully lead to better home care policies going forward.

The first notable highlight is that nurse practitioners and physician assistants are permanently authorized by Congress in the CARES Act to order and certify home health services. For the first time, without regard to the emergency, nurse practitioners and physician assistants can order and

follow a home health plan of care and conduct face-to-face business. We also were pleased the CARES Act directed HHS to encourage the use of telecommunications, including remote patient monitoring in the home during the time of the emergency. While not yet a separately reimbursed benefit, this is a step in the right direction and has resulted in an emergency rule from HHS, giving us increased flexibilities to use remote technology in the home.

One of these flexibilities include the authority for us to conduct initial assessments, recertifications and make homebound determinations remotely or by chart review during the emergency period. Policymakers should consider making this temporary change a permanent one as its value to patients and families become evident. Further, the CARES Act now permits a physician or nurse practitioner to conduct a face-to-face recertification for hospice benefit eligibility via telehealth during the period of the emergency. These provisions, along with other regulatory flexibilities realized from CMS in recent weeks, we think, will lead to greater benefit over time to our patients in the home and inform future policies.

In closing, I want to once again recognize and thank my more than 30,000 LHC Group colleagues for their unwavering commitment to excellence in all that we do and our many health care partners throughout the country without whom, our consistent performance and opportunities for continued growth and development of our founding mission of service would not be possible.

Now here is Josh to provide some color on our financial results and our outlook. 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'll begin my prepared remarks by saying how much I appreciate all of our clinical professionals and the support personnel across the country and what they do each and every day. You have truly gone above and beyond during these historic times in our country to put others above self and to be an integral part of flattening the curve of COVID-19 and being a part of the solution for our country during this pandemic. It is a true privilege to serve you as you give so much of yourself serving others. Again, we are humbled and honored to be a part of your team.

I want to continue with how Keith framed his comments with the distinct periods as it relates to our financial results and provide some additional color on the trends we saw between January to mid-March; and then from mid-March to mid-April; and finally, the extremely positive trends we have begun to see since mid-April; and the implications for all this activity going forward. Consistent with past practice, our supplemental financial information is posted on our website with detail on the breakdown among sector performance. I encourage you all to review the supplemental financial deck as it provides additional details to my comments this morning. We are happy to answer any questions on the quarterly results, but I'm going to focus most of my prepared comments on the context and the stats to help understand the trends.

I'll also address the steps we are taking to balance managing costs in the short-term during the pandemic, with ensuring we remain well positioned to take full advantage of both the historic growth opportunities as well as the new opportunities to accelerate the innovation of the delivery of care in the home that lies before us.

First, a few housekeeping items. Starting with this quarter, it is important to recall that our organic growth is now being calculated and reported across all agencies, legacy LHC and legacy Almost Family combined. Also, our current period, as noted in our earnings release, was impacted by expenses associated with COVID-19 for purchases of PPE, additional supplies, and wage adjustments of approximately $2.9 million in the aggregate or $0.07 per diluted share. We also benefited in the quarter from a tax benefit of $2.2 million or $0.07 per diluted share related to the CARES Act, which lifts certain deduction limitations for tax purposes. Specifically for us, we are now able to fully utilize and offset taxable income with some net operating losses associated with Almost Family prior to the acquisition.

Even amidst the challenges of this coronavirus pandemic, we reported revenues above the top end of our projected guidance range and EPS and EBITDA within our range. For the period January 1 through March 14, 2020, we were actually on pace to exceed the top end of our first quarter guidance in admissions, organic growth, revenue, EPS and EBITDA.

Certain stats of note for that period included Home Health organic admissions for the 2-month period of January and February was 12% as compared to the 2-month period of January and February last year. Although we were really hitting on all cylinders with high single-digit to strong double-digit

organic growth in all of our regions, I'm excited to specifically call out that the state of Florida was pacing at 15.2% organic growth for that 2 month period. If you break down those first 2 months separately, you will not only see incredible organic growth, but you will see building momentum prior to COVID-19 with Home Health organic admissions growth of 10% in January followed by 14% in February.

If you expand the period to the full first distinct period that Keith alluded to, which is January 1 through March 14, we still experienced double-digit organic admission growth in Home Health of 10% over the same period in 2019. Coming off all of that admission growth momentum, Home Health average daily census hit the highest mark of 79,752 on March 9, 2020.

Turning to Hospice. Hospice organic admissions January 1 through March 14 was 2.4% over the same period in 2019. Hospice census continued to remain strong and steady, remaining at levels between 4,242 and 4,311 from the pre-COVID-19 period and throughout the entire COVID-19 period to date.

Turning now to the period from March 15 through April 14, we experienced a number of headwinds that have recently begun to lessen. Due to the pausing of elective procedures and various lockdown orders and visitation restrictions at hospitals, skilled nursing facilities, ambulatory surgery centers and many physician's offices across the country, we had less direct access to referral sources and care coordinators. Some patients and families were also apprehensive of allowing clinicians in their home due to fears of a potential exposure to the coronavirus. We were, however, able to maintain our patient encounters and our relationships with referral sources through telehealth and other remote means of communication. But with CMS not specifically reimbursing for telehealth visits for home health or counting them towards the LUPA threshold, our LUPA percentages increased during this distinct period, thereby reducing our revenue per admission at the end of Q1 and to start Q2.

A few data points might help quantify how impactful this period of March 15 through April 14 was. First, Home Health admissions were averaging around 8,800 per week from January 1 through March 14. On April 13, we hit our low point in Home Health admissions of 6,169. I am pleased to report that we are currently seeing that number rebound with week-over-week improvement in Home Health admissions of 6,634 the week of April 20. And last week, we were back up to 6,700 for an 8.6% improvement over the week of April 13.

At the outset of the coronavirus pandemic, we created a new code in our electronic medical record and immediately began to monitor and track missed visits due to COVID-19. The number of home health visits missed related to COVID-19 started to become evident the week ending March 14, when we had 412 missed visits. It quickly increased and hit its highest point the week ending March 28, resulting in 8,585 missed visits during that week. As with admissions, though, we are starting to see week-over-week reductions in missed visits due to COVID-19 with missed visits down to 1,937 last week, for a 77.4% improvement over the week ending March 28.

Our normal LUPA rate is between 8% and 9% of total Home Health admissions. We saw this number spike to 12.5% during the week ending April 4, but it is now trending back down to single digits with us expecting to return to pre-COVID-19 levels of around 8% last week.

We also implemented a new code in our EMR and began to monitor and track the number of patients that declined admission due to COVID-19. The number of patients that declined admission to home health due to COVID-19 hit a high of 336 patient refusals the week ending March 21. As with other key stats, we are seeing that trending in the right direction as well with the number of patient refusals due to COVID-19 being down to only 52 last week, or an 84.5% improvement over the week ending March 21. Home Health average daily census went from a high point of 79,752 on March 9 to a low point of 74,463 on April 18. We are now seeing that number growing again with yesterday's Home Health census back up to 76,435 for a 2.6% improvement since that April 18 low mark. While this is a positive sign, we have much ground to regain before we get back to the high point in March, depending on the lifting of stay-at-home orders and the elective procedure volume returning to normal.

With regard to lifting of restrictions on elective procedures, 21 of our 35 states of operation have taken steps to begin allowing elective medical procedures from as early as April 27 in Texas to as recent as this Monday, May 4, in Florida. These 21 states represent approximately 88% of our Q4 Home Health admissions volume.

Our number of telehealth and remote patient visits averaged around 10,000 per week prior to March 14 and are over 18,000 since March 14. Post-March 14, our LTACHs continue to be a bright spot with an occupancy rate of 68.3% from January 1 through March 14 to a now current occupancy rate of approximately 80%. Also important to note for our LTACHs, from January 27 through the end of the public health emergency

period, which is now extended to July 25, we are receiving full LTACH reimbursement for every patient admission which has resulted in an increase in revenue per patient day from around $1,200 per patient day to $1,500 per patient day due to this reimbursement relief.

To recap, barring no material spikes in coronavirus cases or a second round of shelter-in-place orders throughout the country once the current orders that remain are lifted, it appears as though we hit the bottom in Home Health census the week ending April 18. And from that point through this week, we've seen incremental weekly improvement in all of our key operational and growth stats. And with regard to resuming our growth momentum that had us pacing at a 12% organic growth for Home Health admissions the first 2 months of the year, I would like to expand a little further on the new referral sources that Keith mentioned earlier.

The breakdown by month so far in 2020 of new referral sources is as follows: 1,547 new referral sources in the month of January, 1,334 in the month of February, 1,191 in the month of March, 1,249 in the month of April and already 242 new referral sources thus far in the first week of May alone. This trend in new referral sources is a very solid early indicator of the market share gain potential we were expecting as we entered 2020, and we believe our industry-leading quality scores, combined with how we continue to receive positive satisfaction feedback from these new referral sources bodes extremely well for regaining this growth momentum, fueling our exit velocity into 2021. While we were clearly on pace to well exceed our previous guidance for the first quarter and had a strong start to achieving or exceeding our previously issued guidance for the year, we believe it is prudent to withdraw formal guidance for 2020 due to the inability at this time to reasonably estimate the impact the COVID-19 pandemic will ultimately have on our operating and financial results for the year.

Many factors are beyond our control and difficult to predict, such as whether or not there will be a further flattening of the curve throughout the markets we serve, the pace at which shelter-in-place orders are lifted, whether or not there will be another spike in coronavirus cases causing a second wave of such orders later in the year, the pace at which elective procedures begin to ramp back up and many other factors. While balancing and prioritizing our people pillar during this pandemic and ensuring we remain in a position to exit 2020 with maximum velocity, we continue with our cost reduction initiatives associated with PDGM. We have also implemented a number of cost containment initiatives to help offset some of the impact of the COVID-19 pandemic-related costs and the lower volumes.

In March, we began eliminating all nonessential travel and discretionary spending. We enacted select employee furloughs while also moving to increased flex time throughout our home office staff and throughout our G&A support positions. Additionally, our executive team, all other members of our leadership team and all home office leaders are flexing a minimum of 10% and up to 30% of their salary during this time. In total, we estimate all of these cost containment initiatives will be able to save us approximately $15 million for the balance of the year.

As you are aware, on March 27, the CARES Act was passed and signed into law by President Trump. The CARES Act contains provisions related to health care providers' operations and issues caused by the coronavirus pandemic. On April 10, LHC Group without application, received $87.5 million from the CARES Act provider relief fund as a formulaic calculation applied to LHC Group's Medicare fee-for-service revenue. While specific granular details of the program are still being evaluated, funds are specified to be used, prepare for and respond to the pandemic and shall reimburse the recipient for health care-related expenses or lost revenues that are attributable to the coronavirus.

The ability of LHC Group to retain and utilize the full $87.5 million from this provider relief fund will depend on the magnitude, timing and nature of the economic impact of COVID-19 within LHC Group as well as the guidelines and rules of the federal relief program itself. In addition, we also received funds totaling $307.6 million under the Medicare accelerated and advanced payment program as provided for by the CARES Act. The accelerated Medicare payments are interest-free, and the program currently requires that the centers for Medicare & Medicaid services recoup the accelerated payments beginning 120 days after receipt by the provider, by withholding future Medicare fee-for-service payments for claims until such time as the full accelerated payment has been recouped. The program currently requires Medicare Part A providers to repay the funds in -- within 210 days of receipt.

The CARES Act also permits employers to defer the deposit and payment of the employer's portion of social security taxes that otherwise would be due between March 27, 2020, and December 31. The law permits employers instead to deposit half of those deferred payments by the end of 2021 and the other half by the end of 2022. We estimate the positive cash benefit to us of approximately $50 million in 2020.

The CARES Act also temporarily suspends Medicare sequestration for the period of May 1 through December 31, 2020. As a result, health care providers can expect to receive an increase in fee-for-service Medicare payments by approximately 2%, which we estimate to be approximately $15 million to $20 million positive impact to revenue for us during this period.

Turning now to Page 20 of the supplemental deck, we've updated all of our debt and liquidity metrics for the quarter end. We have over $385.4 million of liquidity with cash, availability on our credit facility and an accordion feature for up to $200 million of additional capacity. Our leverage at quarter end was 1.4x. You will note that free cash flow was negative $38.9 million for the 3 months ended March 31, 2020. The main driver of this was an increase in accounts receivable of $68 million for the first quarter due to PDGM and reduction RAPs, which was expected.

Also as expected, DSOs increased by 13 days to 62 days in the first quarter compared to 49 in the fourth quarter. We expect this to settle in at a new normal rate of 55 to 60 days in the remainder of 2020.

In the first quarter, our facility based segment experienced lower EBITDA margin. We had a low occupancy rate of 65% in the quarter. As I mentioned earlier, we are currently at approximately 80% occupancy. The other issue that affected Q1 was approximately $380,000 of costs associated with a start-up facility on the Northshore of New Orleans as we expanded our post-acute presence and partnership with Ochsner Health.

Our community-based segment reported modest losses after home office and overhead allocations. The weakness in HCBS is related to our recent conversion from the old Almost Family system to a single third-party billing and operational platform across all HCBS locations. We discussed this late last year and earlier this year and how the Almost Family wide conversion would cause temporary headwind but would bear fruit in the long term. During the quarter, we also had about $500,000 of negative impact to revenue associated with prior year revenue adjustments and also experienced an impact related to COVID-19 in much lower billable hours. January through March 14, we averaged around 180,000 billable hours per week. That number dropped to 170,000 from March 15 to April 14, with a low point of 167,000 the week of April 13. We continue to see this number improve and are currently pacing back over 170,000 this week.

With the conversion and those headwinds behind us and barring no unforeseen digression in the service line from COVID-19, we should see the HCBS service line begin to gain momentum throughout the year and enter 2021 the strongest it has ever been.

These last few weeks have been a historic opportunity for LHC to demonstrate how well we work with our partners across the entire continuum of care, how much more attractive in-home health care is to all stakeholders in times such as these, and how vital we are to delivering the highest quality of care in the most cost-effective setting. When combined with the growth we have continued to experience from integrating new partnerships and extensions of existing partnerships, we sit here today with a much larger opportunity for joint ventures than we did even 3 months ago.

As Keith mentioned earlier, we will also most likely experience delays in finalizing new joint ventures due to the justified focus of our future partners in having the pandemic in front of them. But suffice it to say, we believe the momentum will accelerate after COVID-19. Of course, the other historic opportunity we have been describing up until this point has been the expected consolidation in the highly fragmented home health industry due to the impact of PDGM and the elimination of the RAP payments. With our PDGM care model in place and performing ahead of schedule, even in the face of COVID-19, our successful management through this pandemic when the smaller agencies might be struggling, should get us to an acceleration in volumes in the second half of the year and into 2021 quicker than we had even planned. We expect to get there through inorganic growth, as I just described, but also earning the business with leading quality and patient satisfaction scores to drive incremental organic growth and market absorption.

This has been the start to a year unlike any other that any of us could honestly have predicted. There is still uncertainty about the timing of recovery and reopening, but the trends we have seen since mid-April paint an encouraging picture. What I'm pleased to see so far is that we have been able to respond to this pandemic as a team, our culture intact and emboldened, our mission is vital and practice as it is an inspiration and our value proposition stronger than ever before.

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

QUESTIONS AND ANSWERS

Operator

(Operator Instructions) Your first question comes from the line of Kevin Fischbeck with Bank of America.

Kevin Mark Fischbeck - *BofA Merrill Lynch, Research Division - MD in Equity Research*

Great. Just wanted to get a little color on the, your new referral sources as you highlighted. Do you have a sense there? Or is there any indication why exactly they're coming through? Have they indicated that there were issues with their prior supplier? Is it your ability to treat COVID patients? Any color there on exactly why it's been such a big increase?

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

This is Keith. First of all, it's not related to COVID because we saw this in January. And I'm sure there's some impact related to COVID, but certainly not all of the trend. And I haven't -- I honestly hadn't heard any single 1 component of that buildup that's greater than others. I mean, there are new -- there are certainly new physician referral sources. But I don't know how much of it, to be specific, what percentage of it is related to our quality efforts versus what percentage is related to consolidation as a result of PDGM. We don't have anything measured like that.

Kevin Mark Fischbeck - *BofA Merrill Lynch, Research Division - MD in Equity Research*

Well, then maybe is there a way to put that number into context? Like, I guess, you guys are always out there trying to get new referral sources. I mean, is there a way to compare that 5,000 to how many you added at around the same time last year?

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

There would be. We don't, Josh, do you have that?

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

Yes, Kevin, this is Josh. I don't have that number right here in front of me, but I could definitely circle back with you off-line and provide that to you. I'm confident that it's higher, but I just don't have a relative baseline to compare for you.

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

So this is a standard report we run. So we know it's higher, which is what made us pay attention to it, but it is a standard report. But it would be interesting to follow-up with that. I don't know what it was quarter to quarter.

Kevin Mark Fischbeck - *BofA Merrill Lynch, Research Division - MD in Equity Research*

Okay. That's okay. And then when we think about the volume rebound, obviously, you guys are seeing a lot of momentum and you expect it to come back. How do you think about the concept of pent-up demand? And obviously, a lot of unknowns and uncertainty, so clearly, there will be a lot of caveats to this answer. But if you don't get COIVID coming back, I mean, when do you think that volumes return to normal? And do you think that there'll be a period of above-average utilization if there is pent-up demand?

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

Yes, Kevin, this is Josh. Great question. And I alluded in my prepared remarks to kind of the trend that we're seeing now in a lot of states opening back up for elective medical procedures. And I hit the highlight that 21 states of ours, which represents about 88% of our referral volume. That really began late April and is just now starting to happen. So in talking to a lot of our hospital joint venture partners, it's pretty evident that a lot of the elective procedures that did not occur during the, what I'll say, lockdown period are now being scheduled and looked at being placed on the schedule over the next few months. So I do believe you're spot on that there is a pent-up demand, and we should see that flow back out into Home Health referrals and admissions as those procedures are occurring. And I think I've mentioned in the past that we typically get anywhere from 5% to 8% of our admission volume, post selective procedure. So as that pent-up demand manifests into discharges from the hospitals, we will see a nice pop from that, probably back half of Q2 going into Q3.

Operator

Your next question comes from the line of Justin Bowers with Deutsche Bank.

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

Congrats on firing up growth this quarter and really appreciate all the detailed disclosures that you provided related to this. Just had some higher level questions kind of on D.C. and the policy area. And Keith, was wondering, on the partnership. What are some of the bigger issues or conversation points that you're having with some of your peers and their constituents? And then secondarily, in terms of COVID-19 patients, how should we be thinking about the reimbursement for those under Home Health. It wasn't clear to me if they were getting an add-on payment as well. And if there was any difference between Part A and Part B patients? I'll stop there.

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

Sure. I'll take the first part of that as it relates to D.C. I think our efforts in D.C. have been well balanced in 2 buckets of short-term versus long term. In short term, the staff there and the consultants have spent roughly 50% of their time trying to keep us up-to-date on opportunities for relief that are in discussion and in-process and helping to make sure that those are -- that we have input and so that they're positioned in a way that is clear to us and beneficial. And some of that initial funding that came forth, there was a lack of clarity, at least on -- from an understanding perspective of providers about what strings were attached, if you will, and clawback and all. So they spent time clearing that up. And all that's been important to track. I'm probably being -- trying to always stay balanced thinking about the long-term. And having been in the partnership so long, I wanted to make sure we didn't so completely focus on that, that we take our eye off the long-term strategy in D.C. and things like the doors that we've opened with regard to telehealth and extender utilization. Now we're appropriately keeping that top of mind to hopefully encourage that to be something that's a permanent part of policy going forward. Josh, maybe you can take the...?

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

Yes. Great question, Justin, and thanks for listening. The second piece of your question, I want to hit it head on and then maybe add one little wrinkle to it. With regard to reimbursement for COVID-19 patients, there is no additional reimbursement for the home health benefit. So you're still getting paid under the PDGM model for a new 30-day payment period for whatever the PDGM related reimbursement would be with no COVID-19 add-on. What I will say that one of the regulatory changes that was intended to ensure the treatment of patients in the home during the pandemic was for purposes of the pandemic time period an additional element to the homebound criteria that if a patient is medically contraindicated to leave the home as advised by their physician, then they now meet homebound status. So that would be either for COVID-19 suspection or positivity as well as underlying health conditions that would make you medically contraindicated to be susceptible to COVID-19. So although that's not reimbursement related, I did want to make that clarification as well.

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

Got it. And then just one quick follow-up. How -- can you help us think about the cost structure a little bit in G&A, like fixed versus variable? And just trying to marry that with what we -- how we should think about the run rate for the rest of the year or the quarter? And we're thinking about like home health specifically.

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

Yes. So another good question. On the home health side, you've got probably, right now, in Q1, about 30% of our cost as G&A so that kind of puts that into perspective. We typically run down closer to 28%, 28.5%, I would say. Part of that depression in the quarter was some of the reimbursement and revenue per episode, headwinds that we experienced with some of the crossover revenue from the old pre-PDGM world as well as some of the PDGM headwinds. So I think you're going to see that continue to improve and get back to normal levels throughout the year, but for COVID, I should always qualify. And then I would tell you, even in my prepared remarks, some of the things that we are doing as it relates to flexing and some of the other cost initiatives I lined out that aggregate up to about $15 million across the whole organization is primarily in that G&A line.

Operator

Your next question comes from the line of Scott Fidel with Stephens.

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

First question, just wanted to get some more insight for you just on the corresponds. And I know there's a lot of discussion right now in terms of the accounting for that and the treatment and that CMS is expected to give a bit more guidance on that. Interested if you can maybe just give us a look into the second quarter in terms of whether you've been able to figure out sort of how much sort of lost revenue or increased costs for 2Q do you think you may be able to apply towards the CARES grant funding? And obviously, since we're still only a certain part into the quarter, maybe if you had -- if you run those numbers for April, for example, and have any type of insights on that?

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

Yes, Scott. Great questions. So I'll start with kind of in the middle of your question you alluded to getting some more clarity. And maybe one of the benefits for us having our call today is we have some of that additional clarity that was issued yesterday by the Department of Health and Human Services in conjunction with CMS. There were some new FAQs that were published that really give some of the open questions that were out there lingering around the provider relief fund specifically and how that is going to be able to be tracked and reported back as well as the way in which it will be able to be retained by the health care providers for the items you mentioned, which are both lost revenues and increased expenses. And they specifically put in one of their FAQ answers that HHS does not intend to recoup funds as long as the providers lost revenue and increased expenses exceed the amount.

So from a -- I guess, from an internal perspective, I'll tell you about what we're doing from a controls environment and then what we're thinking from an accounting side because as you can imagine, when you receive funds like this from the government, Day 1, we immediately pull together one of those sub task force work streams that was led by our Chief Accounting Officer, our Chief Revenue Officer and our Head of Internal Audit to develop very specific internal controls around the receipt of the funds, the tracking of the funds by provider number and the allocation of expenses and lost revenues so that as we go forward report back up to CMS, the retention of the funds, we will have utmost confidence in the integrity of that decision.

As far as the accounting around it, really don't have that finalized yet. I know there's a lot of discussion around it. Is it other income? And do you pull it into the P&L at the time you have lost revenues and at the time you have heightened expenses. There's other discussion that you pull it all in at one time in the month of April or in Q2. We are actively digging into all of that, and we'll have those decisions finalized by the end of Q2 before we report out.

And then the piece to your question around how much of the lost revenues do we believe we can attribute to it, without quantifying a number for you, what I would tell you is, based on the guidance that was just released yesterday and the additional color in the terms and conditions in the FAQs, we feel very confident that the lost revenues in the month of April will qualify and be able to be allocated for use of the funds.

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

Got it. That's very helpful. Then just my follow-up question, and I understand you with your guidance, understandably around all the uncertainties of COVID. Just interested, though, I guess, more conceptually, how you're thinking at this point relative to the confidence just around that performance ramp that you had guided to over the course of the year, just as it relates to more of the underlying trends in the business. And just thinking -- you've talked about how you were running nicely ahead of expectations through the first 2 months of the year, so that probably signaled that you had a lot of confidence around achieving that ramp. Obviously, we now have these COVID dynamics that create uncertainty, but I'm just interested in additional thoughts around that ramp that you had been talking about pre-COVID.

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

Yes. Absolutely. Great question, Scott. And I've got to say, the confidence level, we had high confidence coming into the year as we signaled and continue to communicate around because of all of the efforts of our clinical team and our operations teams throughout the country of being PDGM prepared prior to January. But the tale's in the tape, so to speak, in the results. So the pre-execution confidence was one thing, but I've got to tell you, now our confidence level is much higher than it even was back then. If you take out the effect of the census disruption from COVID, we were marching well ahead of schedule under all of our key measures of success under our PDGM implementation model. And that led to kind of how good of a start we were having coming out of the gate in January and February in the first half of March.

We continue monitoring all of our PDGM metrics daily, and we have our internal support infrastructure that works with our operations leadership each and every day that has not, in any way, pivoted from concurrently managing and monitoring against those metrics. So I'm pleased to report that even with COVID, the continued ramp is ahead of schedule for the underlying business around PDGM across the entire home health portfolio. So really, the only variable, Scott, in my mind toward where we start off in 2021 versus the originally kind of guided to ramp is where is our census level at the end of December. And if all of the things that we've talked about here about growth momentum get our census back up to where we had projected it to be in December, then I've got to say that the ramp would be even higher because of the execution.

Operator

The next question comes from the line of Frank Morgan with RBC Capital Markets.

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

Appreciate the color around Almost Family and the details about the conversion that's going on there. But just curious beyond that, are there any remaining tweaks in terms of the integration that you have to complete there? And as you look at that really impressive 15% same-store growth in Florida, any color around what specifically was driving that?

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

Yes. Frank, this is Josh. Great questions. With regard to Almost Family, I would say that there is no additional integration remaining. The conversion to a single billing and operational EMR system for just the home and community-based services segment was the last piece to the overall puzzle of the integration efforts. I would highlight the kind of the one remaining area of improvement that we're continuing to watch and concurrently monitor from an operational metric is the extender utilization for the AFAM agencies.

So as you know, we've been saying that once we got all of Almost Family converted to our instance of Homecare Homebase and fully educated and trained and kind of pass the PDGM education and implementation headwind that we would start to see the AFAM home health agencies LPN utilization start to climb more closely to LHC Group standards. I'm pleased to report even there, Frank, that from a LPN percentage standpoint, the AFAM locations are now up to 40%. You may recall, they started out at 30% LPN utilization and then we've got another 10% to 15% still to improve there to get it up to LHC's 50% to 55% LPN percentage. So I wouldn't say that, that's integration. I would just say that's core operations. But we're going to continue improving in that area. So feel really good about that.

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

And then the 15% same-store growth in Florida, anything you call out there?

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

Yes. I was pleased to highlight it. We mentioned it coming out of year-end that we were starting to see such positive signs in Florida and now pleased to report where they were. And I mean, all credit is due to the folks there that are running the business in the state of Florida for us, both from our Division President of Operations and her counterpart. We did toward the back half of last year. I think we announced this. We added a separate Division President of Sales just for the state of Florida. So previously, that was combined with some other geographies. And Florida was such an important initiative for us. We doubled down and added a division president level resource there. We've also really added some much higher producing feet on the street and really just have armed them with not only better quality results to go out and sell and better information, but better daily metrics to go out and route plan off of and do the things that they do to go grow the business. So could not be more pleased with the efforts going on there.

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

Josh, I might just add to that just to make sure everyone is on the -- for us, Florida, it's really not a surprise. We said this numerous times last year, we -- Florida was one of those specific markets that we intentionally did not want to push growth during integration. It's so competitive in Florida. We didn't want to -- we wanted to make sure quality scores. We're trending in the right direction. We want to make sure we're fully completed with integration. As you said, we have really strong operator in Florida in Lynne. But I'm really -- I feel it's very confirming that we waited until the fourth quarter of '19 to begin the push with a new Division President there in sales as a partner. And we're seeing the results. But it's -- when I say it's not surprising, really, we didn't put in a big sales effort in 2019. I think we said that, didn't we?

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

Yes.

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

Does that help, Frank?

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

Very good. And my follow-up question. I mean it sounds like a lot of really good things on here. But just on the long shot, let's just say, we did have a 2.0 come back on this COVID. Based on what you know now, is there anything significantly incremental that you would need to do? Or any other thoughts around kind of how you would address this if we are so unfortunate to have seen it spike again?

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

Frank, this is Keith. I mean I'll take that. The only -- I think this was a half of a spring training camp. I mean I think about PPE and all of the things we have to put in place to manage fluctuations in census that are not an arm for us in home health. I think all those were put in place. It would certainly -- we would have to believe it would affect the ramp back up and caused some wobbling volume. But I think it would be -- our response to it would be much quicker. And I think we'd be much better prepared, not just LHC, but just the whole space. I don't know. Josh.

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

Yes, Keith. I couldn't agree more. And maybe one thing I would add to that is whether or not there is a 2.0, as you said, Frank, one of the real encouraging pieces that we here have been talking about for the past few weeks is this COVID-19 pandemic, as terrible as it is, and we remain intensely focused to care for those that are affected by it, it has really sharpened us. And it has made us even stronger in some of our core operational areas that will bear fruit even once the pandemic subsides, some of the ways that we have learned for it. So as with anything, whether it's a joint venture partner that pushes us a little bit further into innovation or a health care pandemic, it really has made us stronger.

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

Let's call it deeper. Dr. Doga, can I ask you to weigh in because there's specific clinical things involved?

Benjamin N. Doga - *LHC Group, Inc. - Lead Medical Director*

Certainly. Thank you, Keith. Yes, we began seeing COVID-19 patients in March, as Keith mentioned, and we went nationwide, all locations with PPE on April 1, taking care of 3,214 COVID-19 suspected or confirmed patients to date in over 423 of our local agencies throughout the country in 33 states. So I mentioned those numbers specifically to talk about what may happen through the summer, into the fourth quarter and into January of next year.

From a PPE standpoint, completing every visit as mentioned by Keith with gloves and mask and every COVID-19 suspected or confirmed visit with full head to toe PPE that we have on-site and developed a distribution program that is automated based on our codes that Josh has mentioned to identify these COVID-19 patients and ensure that we get the PPE for our employees, for our every patient, for their entire length of stay estimate, not just on each visit productivity model. And so because of that, we're fully prepared and have on hand the PPE available in anticipation of even increased -- significant increase in the number of patients cared for daily into January of 2021.

So if we do see that 2.0 that you mentioned, not only are we prepared from a clinician standpoint and PPE standpoint, but the tremendous effort has gone into the combination of IT with our support team, along with our clinicians, had allowed us to take many things off the shelf that we had in pilot programs or in development and deploy them immediately for the need to meet the needs of payers and our -- and hospitals and physician offices that are currently already in place. Much of that going forward, we'll be able to utilize on a day-to-day basis for common patients or traditional patients from home health care. But that has allowed us to be able to implement those programs, and they are in place and ready to go for round 2 if needed.

Operator

Your next question comes from the line of Brian Tanquilut with Jefferies.

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

Keith, I guess, I'll just start with the usual question I would ask of my management teams right now. It sounds like Josh is really bullish in the 2021 outlook. But overall, I mean, how are you thinking about 2021 based on what you've seen with PDGM? Do you think that it is going to be where

you were thinking it would be? Or I know Josh was saying a little bit better, but if you kind of just walk us through how you're thinking about 2021 right now.

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

So Brian, can you be a little more specific? You're talking about...

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

Earning power, sorry, is what I was asking.

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

What's that? Say again.

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

2021 earnings power.

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

Earnings power. Yes. So -- yes, so I don't -- my view of 2021 if I were modeling it again today, rather than modeling it in the fall, I would be more positive because we're -- we now have 4 full months of PDGM under our belt. Well, 2 full months, I guess, with all patients, with no transfer patients. The -- and so I would say more so. I mean to Frank's point, I mean, with -- if we're not facing a COVID situation every 3 months but the PDGM model is working incredibly well at every level, not just quality scores and all, but the receptivity of the clinical staff, and I'd give much credit on that to Dr. Doga and the entire clinical team because there's a lot of work that they did with regard to that before they pivoted to PDGM on March 13. But -- so I'm really bullish on it. And I don't go out there on a limb very much, but I think Josh is right. He's living in those numbers, and he's looking -- Josh is looking at more and more real-time basis projected versus actual. So I think that's right.

On the consolidation part, I think that's going to continue. And as I said, we spent a lot of our time working with, well, 50%, the numbers would say, working with hospitals and health systems. And our joint venture strategy was very important to all of our partners from a financial perspective, meaning that for years, we would go over and take over a home health agency that they struggle to manage and not be losing money on them, much less quality. But now they're leveraging that home health -- the home health boots on the ground in ways that we could have never imagine. So I think that's going to lead to more volume there. So super bullish on it.

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

I appreciate that. And then I guess my follow-up question for you is I'd like to think about Medicare, organic Medicare ADC was down 9.5% during the quarter. It was also down in the previous quarter. So are we at a point where you're kind of agnostic between Medicare admissions -- traditional Medicare versus MA? Is that a good way to be thinking about the view on the strategy in terms of payer mix, patient mix?

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

Yes, that's a really good question. I wouldn't go so far as to say agnostic, but we're less concerned about it. Right now, I mean, seriously, we're less concerned about it. There's -- the working relationship we have today with most -- well, most of the payers, especially larger payers, looks more

like a partnership than it ever did before. And we feel less like a vendor than we did 5 years ago. And so we're still making improvement, but I think that's the best way to describe it.

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

I appreciate it. And then I guess my last question for Josh. So as I think about revenue per episode, down 8%, how would you break that down between the impact of LUPA, PDGM and then just mix of patients or COVID, for that matter?

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

Yes. So it's -- as you pointed out, you said it in terms of percent. I'll do it in terms of dollars. It's down about $200, roughly. And about half of that is PDGM headwind on rate pressure as we continue to implement that model. So that leaves you with $100 left to try and figure out and explain. It's hard to break the other pieces out, but I'll tell you the contributors are, as we described coming into the year, the crossover episodes from pre-PDGM into January and February's revenue per episode were negatively impacted because of our, I'll say, early adoption efforts to be prepared for PDGM. As we alluded to, that was going to have a little bit of a drag in the first quarter. And then you've got just the LUPAs and the COVID-related pressure in the last really 2 weeks of the quarter. And if you look, I think at Slide 8 in our supplemental deck, that kind of lines out the LUPA percentage ramp up and now ramp back down. That would be the other piece to it. I'd say about 3% to 4% is PDGM headwind and the other remainder, 3% to 4%, if you will, is due to crossover episodes and COVID-19.

Operator

Your next question comes from the line of Matt Larew with William Blair.

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

You have a unique spot amongst your peers in terms of the relationships with hospitals and health systems through joint venture partnerships. Keith, you just alluded to this. So I'm just curious, over the past 6 weeks, you have some volume trends. Did the volume trends with those joint venture partners look differently in the sense that you were maybe better equipped or better positioned to help them create hospital capacity? And then as you're thinking about the rebound, what are you hearing from those health system partners in states that are opening up about how they're prioritizing cases and reopening them?

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

Yes. That's a good question. I'll just give you high level observations. Josh, maybe you have some data to back that up. First, as it relates to the referral numbers from hospitals, obviously, as hospitals -- census in hospitals were down, so our referrals coming as discharges from hospital partners were down as well. We made much of that up with patients, obviously, being admitted from the community as opposed to discharge in the hospital. But a lot of -- and I don't have that number. I don't think we have it -- many of the patients that came directly to us and from the community may have been patients that would have gone to the hospital because we were definitely seeing diversion. And they're being much more conservative about which patients got put in the hospital. And many of the physicians that refer to us are affiliated with the hospital partners. So I think that offered some benefit. With regard to the -- the second part was about -- the second part of the question...

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

Just about what you're hearing from those same partners in the early days of reopening and thinking about getting elective procedures back online.

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

Yes. So we're hearing the -- Josh, I'll let you take that -- most of that part. But we're hearing the same thing everyone else is saying. They're opening back up for procedures. And there is -- I mean there is data that we see there is some -- there is pent-up demand, if you will, but our needed procedures that have been delayed. And I just -- this gets quite personal, but my wife made this public, so I'll put that out there. So we experienced this personally in the -- right in the middle of this -- of everything COVID related. And Gin just shared this publicly, so I'll share this now. Ginger was diagnosed with breast cancer in February and had a surgery scheduled at Ochsner in New Orleans. And the surgery was scheduled on March 11. And she had surgery there, and she was discharged on 12th, and we came home, had -- and Ginger was DCIS. So it wasn't an emergency. It wasn't an emergency surgery. Had she not had that surgery on the 11th, she would still be waiting in queue now. It would be one of those people that we're talking about right now. So Josh, do you want to --

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

Yes. Matt, I would maybe point you to Slide 8, just for some of the macro trend data on institutional versus community, and we tend to run 65%, 70%, and that has gotten down to 55% here recently. And so that's, in large part, because of everything that Keith just described and the basis of your question, I would give you just maybe some more anecdote, which is in some of our rural more urban market settings, where we are partnered with the hospital and health system in that market. Keith just alluded to Ochsner. That's a great example. New Orleans has been one of the very early on hotspots for the coronavirus pandemic. And we have been working really round-the-clock with those hospitals that are -- not every hospital has the same situation, not every market has the same situation. But those hospitals like in Ochsner in New Orleans and some others and some of the larger markets, we've been working with them to not only decompress and be ready for a potential surge but also to do some patient monitoring and some other things for their patients that would be outside the typical scope of what we do. So again, when I say this is refining us and making us sharper, it really is giving us opportunities to yet again prove ourselves to our partners.

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

If I could add just one piece as well. As we work with our both JV partners as well as hospitals that are not JV, but we still do a lot of business with, if you go back to the beginning of the COVID outbreak, they tended to focus in nursing homes. And so the traditional proportion of patients that would go to SNFs, post-acute, all of a sudden had to look for another side of care. And that's where our cooperation with these hospitals really came in. We designed clinical protocols as well as relationship protocols to be able to take patients that would have otherwise gone to the SNF. SNFs were a combination of not taking patients out of the hospital. Families and patients, were preferring, in many cases, not to go to the hospital or not to go to the nursing home after the hospitalization, and we've been working closely with our hospital partners to be able to take them. We believe that that's a trend that will likely exist far into the future, maybe for an entire generation about rethinking about the need to go to the SNF post-acute the same way as we did last year. And we're prepared to be able to work with our partners to take those patients.

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

Yes. And just my follow-up, actually, I was going to ask Bruce and Keith for some perspective on perhaps long-term takeaways. And one thing you referred to was (inaudible) in your expectation has been able to refer -- of course, refer to the temporary homebound change. And then Bruce, you just discussed and Keith sort of diversion from hospitals or SNFs into the home. Of those things, and there's a lot going on there, what are you most encouraged about? What do you think is the most staying power in terms of really broadening what -- the role that home health can play in sort of both the pre and post-acute patient care?

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

Bruce?

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

Yes. There's been a dramatic recognition that the home is the site of the safest and most preferred care to get, both in a combination of preferring not to go to other institutions after the hospital as well as the increased use of telemedicine from other caregivers, we've shown that the home is just the perfect place to be able to deliver care for those that are maybe on the low end of their acuity, and that would be for, say, monitoring a patient that is suspected to have COVID and not quite home health qualified. And then on the deeper end, where we're seeing patients that would have otherwise gone to the SNF before, and now we've designed programs to divert patients that would have otherwise gone to the SNF to bring them home.

So when we think about overall, something that Keith has been saying for quite a long time, home is the preferred place to go. We see home as the site of care rather than think about it as a place that you go after getting other health care. Instead, we think about it now as the place to get your health care, and home health is really that central quarterback in being able to run myriad plays that involve many other parts of the health care economy. And as we assist both specialists and primary care physicians to do their telemedicine visits with our nurses in the home there as well as designing the new programs that both health systems and payers are asking us to do to monitor patients, so they don't have to come to the emergency department or to the physician's office, if they're suspected to have COVID and being able to monitor and manage their health needs and hopefully, they recover and get better or if they need to seek care for a COVID-related symptom, then we can direct them to the right place as well.

Operator

Your next question comes from the line of Bill Sutherland with The Benchmark Company.

William Sutherland - *The Benchmark Company, LLC, Research Division - Senior Equity Analyst*

The revenue per episode decline, Josh, what are you thinking that returns? I mean when do you kind of bounce back from that as you look at your -- like the progress here quarter-to-date?

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

Yes, Bill, that's a hard one to answer for you. And not that I'm trying to dodge it. It's just -- if it wasn't for COVID-19, I would be able to give you a real clear answer because...

William Sutherland - *The Benchmark Company, LLC, Research Division - Senior Equity Analyst*

I guess, I should say ex-COVID, I'm sorry.

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

Okay. Okay. Ex-COVID, then I think we are still on the trajectory and the ramp that heading into Q3, there would be no real measurable PDGM impact from a rate pressure standpoint. So that 3% to 4% that we projected that did impact Q1 will be lessened in Q2 and then neutralized by Q3 forward. So if you take COVID out of the mix, the other piece that dragged down was the crossover episodes in January and February, which obviously you won't have any more of those. So that's how I would think about it.

William Sutherland - *The Benchmark Company, LLC, Research Division - Senior Equity Analyst*

Okay. That's great. And then one quickie on your extended utilization. Do you have the percentages for assistance for PT or tax?

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

Yes. So for PTAs for Almost Family, we're up to about 45%. And they had been more in the 35% to 40% before. So that was about 45%. And the LHC benchmark there is anywhere between probably 55% to 60%.

William Sutherland - *The Benchmark Company, LLC, Research Division - Senior Equity Analyst*

Great. On your missed visit statistics, as a percentage of total ADC, they're lower than I was seeing elsewhere. And I'm just kind of curious you have color on the reasons for the missed visits as you study that.

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

I do. And it's a great kind of intuitive question. So the missed visits being lower than your expectation, if I heard you right, is attributable to the urgency and the real kind of real-time reaction that this organization had in securing adequate PPE and getting our clinicians fully equipped, whether it was with N95 masks, ear loop surgical masks, gloves and all the other pieces and parts to it. And we implemented extremely early on in the process, a company-wide mask and glove policy for every visit. So I mean you could see the numbers change as soon as that got rolled out. So I think that early adoption of that was really the telltale sign. Ben, do you want to add anything to that?

Benjamin N. Doga - *LHC Group, Inc. - Lead Medical Director*

Sure. Well said. Two other points was, as Keith mentioned, once we did a deep dive and questionnaire on all of our employees in very early March for risk, we also implemented a screening program for all of our patients prior to the visit. That gave us an opportunity to educate the patient and the family on when we were coming, what we're going to be using gloves and things of that nature. And assuring them that we were also going through the screening process as well as the patients gave them some comfort. So that will be number one. And the second one was there was much talk early on about concrete living facilities, residents and patients and the programs there, limiting access to our health care clinicians.

We went with a plan of availability at all times. That put some pressure on those that we're carrying for the patients in those facilities. But we've made it known that you could contact us by phone at any time to help you with the process of the medical care, sociological standpoint, psychological standpoint included, especially through our hospice programs, that created that we are available to help you to continue to care for those patients within those walls. And so in many areas, we were seeing as some of the first clinicians that were asked to come back and help care for those patients. So I think we want to get on the front end of the screening of both the employees and the patients and then the plan of just availability at all times to those that were caring patients' families and those workers that were inside those walls gave us that opportunity.

William Sutherland - *The Benchmark Company, LLC, Research Division - Senior Equity Analyst*

Great. That's good color. And I guess last one, Keith, on the telehealth reimbursement. You hear what's going on in the grapevine. And just kind of curious if you think there's any move there to get it reimbursed by CMS? And then how much is happening as far as other payers, the MA, especially for telehealth reimbursement?

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

Yes. I'll ask Bruce to tag team on that. With regard to Washington, D.C. on telehealth reimbursement, I'm quite optimistic that -- let's just talk about it being recognized as a service rather than specific reimbursement for it. But I think it would be recognized within an episode. And we -- it could be -- it could stand in place of a billable visit in certain situations and maybe with some limitations or what percentage of the encounters would be telehealth. Anything like that would be an improvement. And if that's what we're talking about, I'm highly confident that we're going in that -- that we're moving in that direction. And the question earlier about what was the focus of our team in Washington, D.C., specifically about the

partnership that this would also include not, I think they would tell you the same thing. We feel quite positive about that. I mean do I think it's going to happen in the fall of this year? Probably not. But I definitely think we're moving in that direction. And Bruce, you're probably the best person to answer the other payers' conversation.

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

Well, so there's 2 sides. Let me just to say from what Keith said in terms of where we stand on the administration to telehealth directives. We're quite thankful. We're very happy that CMS has recognized the use of telehealth. They are paying for it differently for other providers. We think that they struck a very good balance for home health. They made policy very quickly. They recognize that what we do is home health, and it can't all be done via tele mechanisms. But they did allow for, and we're explicit about the methodology to be able to use tele in the context of a visit. And that directive was quite helpful.

They also relaxed some of the methods that which you can carry out televisits in a March 16 or 17 letter that gave some flexibility on HIPAA requirements. And so we deployed very quickly telehealth across the company in several business lines, and that's working well. We feel like the benefit of this is we're both training our employees. We're training families. We're training physicians' offices, how to make that complement the high quality of care that gets delivered in the home. So we're quite pleased. And we do expect to continue the dialogue we're having with HHS and CMS. It's been very productive so far. And we feel like we're in a good position today, and we're in a good position moving forward with Washington.

For private payers, we're also seeing some progress, and we're quite pleased. Payers made a lot of decisions very quickly. One great example is United Healthcare that is allowing a tele visit to be recognized the same as an in-person visit and paying the same for it. We call it parity. They're requiring both audio and video for that. And again, we're prepared. We're being approached by several payers to stand-up programs that involve remote monitoring. And this is something we're also pleased about. And in some cases, it's for monitoring a suspected COVID patient before they would qualify for home health. And in other cases, they want patients that have multiple chronic disease or are dealing with COVID itself, and they want to have remote monitoring. Think for those patients, the importance of temperature and a pulse ox to be measured often.

So what -- again, what has been great is the recognition of the use of telemetry of tele visits, both for the phone and video. We believe that this is something you can't unlearn. The genie will not be put back in the bottle, and this health care system has changed for the rest of our lives. The use of telemedicine and tele monitoring from primary care, from in home care and specialty care will be changed forever. And again, the meta point for me is the home is the most desirable site of service for health care moving forward. I don't think we'll see a change in that forever. And there's no better industry to be able to help patients where they want to be than home health treating patients in the home.

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

Okay. Well, if that's the last question, okay. Well, thanks, everyone, for dialing in. And thanks for giving us so much time. We look forward to catching up with you next quarter. And as always, in the meantime, if you have any questions for us, Eric Elliott is the contact, and then he can put you in touch with any member of the management team if you need to take a deeper dive. Thanks so much.

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

Thanks, guys. Stay safe.

Operator

Thank you. This does conclude today's conference call. You may now disconnect.
