S&P Global
Market Intelligence

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Presentation

Operator

Good morning, everyone, and welcome to the Enhabit Home Health & Hospice's Second Quarter 2023 Earnings Conference Call. [Operator Instructions] Today's conference call is being recorded. If you have any objections, you may disconnect at this time.

I'll now turn the call over to Jordan Loyd, Enhabit Home Health & Hospice, Director of Investor Relations.

Jordan Loyd

Thank you, operator, and good morning, everyone. Thank you for joining Enhabit Home Health & Hospice second quarter 2023 earnings conference call.

With me on the call today are Barb Jacobsmeyer, President and Chief Executive Officer; and Crissy Carlisle, Chief Financial Officer.

Before we begin, if you do not already have a copy, the second quarter earnings release, supplemental information and related Form 8-K filed with the SEC are available on our website at investors.ehab.com. On Page 2 of the supplemental information, you will find the safe harbor statements, which are also set forth on the last page of the earnings release.

During the call, we'll make forward-looking statements, which are subject to risks and uncertainties, many of which are beyond our control. Certain risks and uncertainties that could cause actual results to differ materially from our projections, estimates and expectations are discussed in the SEC company filings, including the Form 10-K and subsequent quarterly reports on Form 10-Q, each of which will be available on the company's website once filed. We encourage you to read them.

You are cautioned not to place undue reliance on the estimates, projections, guidance and other forward-looking information presented, which are based on current estimates of future events and speak only as of today. We do not undertake a duty to update these forward-looking statements.

Our supplemental information and discussion on this call will include certain non-GAAP financial measures. For such measures, reconciliations to the most directly comparable GAAP measure is available at the end of the supplemental information and earnings release. I would like to remind everyone that we will adhere to the 1 question and 1 follow-up question rule to allow everyone to ask your questions. If you have additional questions, please feel free to rejoin the queue.

With that, I'll turn the call over to Barb.

Barbara Ann Jacobsmeyer
President, CEO & Director

Thank you, Jordan. Good morning, and thanks for joining us. While we continue to make progress with our strategic initiatives, the pace of the progress has not been fast enough in 2023 to meet our initial guidance. As we have consistently noted, the greatest sensitivity to our guidance is episodic volume.

The market is shifting rapidly to Medicare Advantage. Last summer, CMS data pointed to 50% of Medicare eligibles

enrolling in a Medicare Advantage plan by 2030. We reached the 50% mark in January 2023. CMS data now points to 70% of Medicare eligibles enrolling in a Medicare Advantage plan by 2030.

While our payer innovation progress has been strong, it has not been enough to overcome the negative impact of the continued erosion of Medicare episodic fee-for-service volume. To put this in perspective, as we mentioned on our quarter 1 call, every 5% move of non-episodic visits to one of our new national or regional payer innovation agreements improved adjusted EBITDA by approximately $2 million annually.

Meanwhile, every 50 basis points decrease in Medicare fee-for-service volume negatively impacts adjusted EBITDA by the same amount, approximately $2 million annually. We are working diligently to combat the erosion of Medicare fee-for-service admissions. We know referral sources want providers who can serve all of their patients regardless of payer source.

So while we can't slow the transition of Medicare eligibles to Medicare Advantage, we can strategically target referral sources who have strong Medicare fee-for-service market share and those we know send both Medicare fee-for-service and Medicare Advantage patients to us.

We can also collaborate with our primary referral sources to identify other payers; our payer innovation team should focus on to strengthen our preferred provider status with them. Our payer innovation team has demonstrated their ability to successfully prove our value proposition to the Medicare Advantage payers both in terms of the number of contracts we've negotiated and the improved rates within these contracts. Since the inception of the payer innovation team last summer, they have successfully negotiated 37 new agreements.

Let's talk more about our strategic initiatives, especially around payer innovation and recruitment of clinical staff, and the success we are having with them. Our teams continue to provide high-quality care as proven in our outcomes. Our 30-day hospital readmission rate is 370 basis points better than the national average and continues to be our primary value proposition and driver of conversations with payers.

During the second quarter, we continued our progress with Medicare Advantage payers and successfully negotiated 10 new regional agreements. We are also pleased with the results our local Home Health teams produced in moving volume to our payer innovation agreements.

During the second quarter, we admitted over 3,400 patients within these non-episodic new contracts. That's 150% sequential growth under these agreements, and we achieved this with our new national agreement effective for only 2 months of the quarter. We are confident in our ability to make continued improvement in Medicare Advantage pricing and in the shift of our Medicare Advantage admissions to these improved payers.

In addition to our success with our payer innovation contracting, we had continued success with our recruitment and retention of clinical staff with the highest net nursing hires, since we started tracking this metric in 2021. We had 203 net new full-time nursing hires in quarter 2, and we continue to hire for additional growth. With this success, we plan to eliminate substantially all contract labor by the end of the third quarter.

For hospice, the implementation of the case management model has added critical resources driving our positive recruitment and retention. At the end of the quarter, we had only 4 locations with staffing constraints. The new staffing model has also improved our ability to accept patients for more diverse referral sources with admissions from facilities increasing 6.1% year-over-year.

With the rapid shift of Medicare eligibles into Medicare Advantage and the headwinds associated with Medicare reimbursement, we are working to find better ways to use our resources and control cost. For example, the new case

management staffing model in hospice has increased our fixed cost due to the addition of triage nurses and dedicated on-call resources.

With the case management model now fully staffed in all branches, we developed an updated back-office staffing matrix that will allow us to eliminate positions or reduce the hours of certain roles and create annual savings of approximately $1 million to help offset the increased clinical cost. We have also identified opportunities for improved alignment within our home office departments that will reduce annual cost of an additional $3.2 million.

Now let's touch on the Home Health proposed rule. As proposed, the overall impact to 2024 Medicare Home Health spending, including the additional PDGM permanent adjustment would be a negative 2.2%. PDGM temporary adjustments are now calculated at a total of $3.4 billion for the industry, though CMS has not indicated when or how they would collect these clawbacks.

It's important to remember this is the proposed rule with the final rule expected late October or early November. CMS may adjust or update payment components between now and then, including an updated market basket percentage, just as they did in other recent Medicare final rules.

Nevertheless, legal and advocacy actions are underway to mitigate the impact of the proposals. The National Association of Home Care and Hospice, of which we are a member, filed a lawsuit against CMS in the U.S. District Court for the District of Columbia on Wednesday, July 5, challenging the implementation of the PDGM pricing cuts.

The NAHC litigation argues that Medicare is required to implement the PDGM payment model changes in a budget-neutral manner rather than in a way that inflicts rate cuts on providers. And NAHC, along with the partnership for quality home healthcare has already filed a joint preliminary comment letter calling on CMS to not finalize the proposed cuts.

In addition, on the legislative front, on June 22, Senators Debbie Stabenow, Michigan and Susan Collins from Maine introduced legislation titled the Preserving Access to Home Health Act of 2023, that aims to prevent PDGM payment cuts to home health providers. And last week, Companion Legislation was introduced in the House by Terry Sewell, of Alabama and Adrian Smith of Nebraska. We remain active with the industry and our advocacy efforts.

With that, I'll turn it over to Crissy to discuss more details on our quarter 2 results and our updated guidance.

Crissy Buchanan Carlisle
Executive VP & CFO

Thanks, Barb. Consolidated net revenue was $262.3 million for the second quarter, down $5.7 million or 2.1% year-over-year. Adjusted EBITDA was $23.9 million, down $16.4 million or 40.7% year-over-year. We estimate the continued shift to more non-episodic payers in home health and the resumption of sequestration, decreased revenue and adjusted EBITDA approximately $10.5 million year-over-year. Adjusted EBITDA was also impacted by $3.4 million of incremental costs associated with being a stand-alone company.

In our home Health segment, Total admissions increased 3.2% year-over-year as continued strong growth in non-episodic admissions offset a reduction in episodic admissions. In the second quarter of 2023, our non-episodic visits grew to approximately 31% of our total Home Health visits. This represents an approximate 800 basis point increase year-over-year, and an approximate 200 basis point sequential increase over the first quarter of 2023.

While we are making significant progress, demonstrating our value proposition to payers as we negotiate new agreements with improved rates and have success shifting volumes into our payer innovation agreements. It has not been enough to overcome the erosion of Medicare fee-for-service volumes. We estimate the impact of this payer mix

shift was approximately $8 million, net of the impact from improved pricing and payer innovation contracts on both revenue and adjusted EBITDA during the second quarter.

Our Home Health team is managing costs to a level lower than originally expected for 2023. Our cost per visit increased 3.4% year-over-year as improved clinical productivity and optimization offset the impact of contract labor, merit and market increases for clinical staff and increased costs associated with employee group medical claims. We now expect cost per visit to increase 1% to 3% year-over-year rather than the 4% to 5% in our initial projections.

In our Hospice segment, admissions increased 0.1% year-over-year, while average daily census decreased 0.7% year-over-year. Similar to Q1 this year, our average daily census was impacted by an increase in the number of admissions with shorter lengths of stay. This is due in part to our intentional diversification of referral sources and the expansion of the number of our admissions coming from facilities, as patients coming directly from a facility tend to be admitted to hospice care later in their journey.

This diversification of referral sources and increase in short length of stay patients is lowering our hospice cap exposure. In 2022, we had 7 locations with cap exposure, in 2023, we have 3. The implementation of the case management model, which includes additional fixed cost for triage and dedicated on-call resources, was the primary driver of the 11.6% year-over-year increase in cost per day.

While cost per day increased year-over-year, it was flat sequentially from Q1. We now have full-time nursing capacity and are reducing our use of contract labor. The cost per day story for the remainder of the year is dependent upon our ability to increase our average daily census over which to spread our fixed costs.

Our home office, general and administrative expenses increased $3.8 million year-over-year, primarily due to incremental costs incurred as a stand-alone company. Stand-alone company costs totaled $6.9 million in the second quarter and include expenses associated with the transition services agreement we have with Encompass Health, as well as the costs we are incurring to ramp up our team and their resources.

We continue to expect our stand-alone cost to be $26 million to $28 million per year going forward. Today, we have transitioned all services from Encompass Health except for certain technology services, and we expect to complete the transition of those services by the end of Q1 2024.

Let's transition now to the balance sheet. Information on our debt and liquidity metrics is included on Page 15 of the supplemental slides. We exited the quarter with net leverage of 4.75x. In June and with the full support of our bank group, we proactively renegotiated the leverage covenant under our credit agreement through June 2024. Our leverage covenant for the remainder of 2023 is 5.25x.

As of June 30, we had approximately $90 million of available liquidity, including approximately $34 million of cash on hand, which we believe is sufficient to support our operations and financial obligations as well as continuing to grow the company through our de novo strategy. In the second quarter, we opened 1 hospice and 2 home health de novo locations, bringing our year-to-date number of de novos to 5 and putting us on track to open our goal of 10 new locations this year.

Let's turn now to guidance. As noted during our Q1 earnings call, our guidance is most sensitive to 3 factors: episodic admissions; the transition of non-episodic admissions to our new national and regional payer contracts, and improved clinical productivity in hospice.

With the shift of Medicare eligibles into Medicare Advantage happening faster than anyone anticipated, we are trying to forecast a rapidly moving target. In the first quarter 2023, a episodic admissions increased 1.3% sequentially from the

fourth quarter of 2022. We noted the sequential trends in episodic admissions in home health needed to accelerate throughout 2023. And that has not happened.

While our progress with our payer innovation agreement has been strong, it has not been enough to overcome the negative impact of the continued erosion of Medicare fee-for-service volumes. And while our cost per day in hospice was flat sequentially, we have not yet achieved the consistent volume levels that will allow us to offset the fixed cost associated with the case management model. As a result, we revised our full year 2023 adjusted EBITDA guidance to a range of $100 million to $107 million.

Before I turn it back to Barb, I want to comment on our continued strong free cash flow. We generated approximately $39 million during the first 6 months of 2023. Free cash flow generated in the back half of the year is dependent on the timing of working capital needs, specifically around accounts receivable. Based on our revised guidance, we expect to generate between $49 million and $69 million of adjusted free cash flow in 2023.

Now I'll turn it back to Barb.

Barbara Ann Jacobsmeyer
President, CEO & Director

Thanks, Crissy. Before we open the line for Q&A, I'd like to take a moment to discuss the announcement we made yesterday regarding a potential strategic alternatives process.

Our Board and management team continue to take action to enhance stockholder value. We believe the value of our company is supported by long-term secular trends. The aging population, the need to shift more health care into the lowest cost setting and patient preference for care in their home.

Importantly, we believe that the outcomes we generate for our patients will enable us to succeed as the market continues to evolve. With this backdrop, the Board is undertaking steps to satisfy the conditions in our Tax Matters Agreement with Encompass Health Corporation, relating to certain transactions involving Enhabit.

The conditions in the Tax Matter Agreement includes securing a tax opinion of legal counsel, satisfactory to Encompass Health in its sole and absolute discretion that the actions taken by Enhabit would not jeopardize the tax-free treatment of the spin-off of Enhabit. If these conditions are satisfied, the Board, with the assistance of independent advisers, intends to launch a strategic alternatives process.

The Board expects that any potential review would consider a wide range of options for the company, including, among other things, a potential sale, merger or other strategic transactions. That being said, there are no assurances that the conditions in the Tax Matter Agreement will be satisfied that Enhabit will initiate such a process or a launch that a process would result Enhabit pursuing a particular transaction or other strategic outcome.

Our management team remains focused on our mission, delivering exceptional care to our patients in the lowest cost setting in the place they want to be their home. Our team's relentless focus on that mission to drive high-quality care to more patients who need our services will continue to enhance our value.

With that said, I would like to remind you that the purpose of today's call is to discuss our financial and operational results and outlook, and we ask you to limit your questions to these results. I will not be commenting further on the potential strategic review process.
Operator let's open the call for questions.

Question and Answer

Operator

[Operator Instructions] We'll take our first question from Brian Tanquilut with Jefferies.

Brian Gil Tanquilut
Jefferies LLC, Research Division

I guess my first question, as I think about understanding the payer mix shift that's ongoing in the market, but as I think about the ramp of the contracts that you had signed earlier in the year and last year. What does Enhabit need to do to get that accelerated to the level of admissions that you had initially projected?

And then maybe on the cost side of that as well, you've obviously had success in recruiting nurses. But how do we think about your ability to start driving leverage with the cost structure and looking at it on a cost per visit basis as well?

Barbara Ann Jacobsmeyer
President, CEO & Director

Sure. So first, on the Medicare Advantage side, so as you noted, I mean, we have had success in negotiating the 37 new agreements. We were pleased with that 150% sequential improvement because the greatest number out there available is the new national agreement. And so it's continuing to have a team focused on prioritizing those payer innovation agreements.

I think the most critical piece is to get this episodic component stabilized. And so for us, what we've done is look back at -- if you think back to 2022, our total Medicare as a percent of our Home Health revenues was 74%, whereas our largest peers were at 60% to 65%. When you look now June year-to-date, our Medicare percent of revenues is 66%.

So we're certainly getting back -- we're getting closer to where our peers are on that because stabilizing that component is going to be critical so that we can really feel the financial value of moving the past non-episodic into these new agreements.

And then on the cost front, really, the success in hiring is going to help us to eliminate all the contract labor as well as when we are able to have increased staffing it helps you really be able to leverage that optimization and productivity that we have. We've done a good job with the optimization and the productivity as it relates to therapy. We do have some potential to continue to improve the optimization for nursing and that's about getting LNs added now where we have RNs that are fully productive.

Brian Gil Tanquilut
Jefferies LLC, Research Division

Got you. Okay. And then maybe shifting gears to the hospice side. Obviously, admissions are still on the soft side. So what do you think -- is this just more of a market issue still in hospice? Or is there something more specific to Enhabit that we need to be thinking about that -- or what catalysts that you need to work on in order to inflect admission trends in hospice?

Barbara Ann Jacobsmeyer

President, CEO & Director

Sure. I do think that there is an element of this that is market that is -- it's just the softness out there in general. I would say the things that are -- that we're focused on that we think could help really aid us is this case management allows us to say yes faster to our referral sources. It's why we've seen an uptick in those admissions coming from facility settings.

So being able to say that quick, yes, it's the critical part to be able to pull the market share component, as well as now that we are fully staffed, we need to get back increasing our sales headcount. We're down about 5% on our headcount for direct sales year-over-year. And so it's about getting staffed up so that now that we have the ability to say, yes, we have the sales teams out there promoting Enhabit.

Operator

Next, we'll go to A.J. Rice with Credit Suisse.

Albert J. William Rice
Crédit Suisse AG, Research Division

First, just to make sure I understand the dynamic of what's going on in the mix between non-episodic and episodic. Is any of this being driven by the fact that you signed all these new MA contracts and therefore, get you're getting more volume pushed to you that way from those contracts, and that's the dynamic here? Or would you say the significant drop, which accelerated seems like this quarter in episodic, is just the market dynamics? It seems more pronounced than what we're seeing, although we don't anymore have full visibility on the rest of the industry as much, but it seems more pronounced than what we've seen elsewhere.

Barbara Ann Jacobsmeyer
President, CEO & Director

So it's a great question. And I would say what I would start with is that our peers have certainly been at this a lot longer. When you look at their payer mix shift has happened pretty gradually over about a 6- to 8-year period, ours kind of has been more of a cliff, if you will.

I do think that actually, we are holding on to the number of episodic that we have because of the ability to offer more -- a longer list of payers that we're able to take, I think absent the success of our payer innovation thing, I frankly think we would have seen actually even more erosion from our fee-for-service Medicare.

So I think going out there and being able to be more of a full-service provider is actually aiding us. We just have unfortunately done in about an 18- to 24-month time what our peers experienced over about a 6- to 8-year time frame.

Albert J. William Rice
Crédit Suisse AG, Research Division

Okay. And then I guess on the hospice cost per day, up 11.6%, I understand the move to the case management model, should we think that you're running excess costs right now? And as you implement that, and then it will step down? Or is the way you're going to get at that is just growing the revenues faster over time?

Crissy Buchanan Carlisle
Executive VP & CFO

Yes, A.J., so it is a fixed cost of these dedicated on-call resources. One way to look at it is our hospice costs are running about $8 million per month, and that seems to be kind of leveling off. So it is about eliminating the use of contract labor,

and then the real difference maker being the volumes. We've got to get those volumes to offset the fixed cost associated with it and spread that out over the number of days.

Operator

Next, we'll go to with -- Mayo with Leerink Partners.

Benjamin Whitman Mayo
Leerink Partners LLC, Research Division

Crissy, I'm kind of curious what the fee-for-service admissions look like when you decompose referrals from the institutional versus the community setting? Are you seeing more of this MA pressure on the SNFs assisted living, hospitals, physician referrals, maybe where do you see the pain points more than other places?

Barbara Ann Jacobsmeyer
President, CEO & Director

Sure. So this is Barb. I'll mention it first. So obviously, one of the big pain points have been the IRF. Certainly, we've seen an impact. I would say about half of our fee-for-service impact has been from the IRFs. The others have been more from these assisted living facilities.

What we found is historically, there were many assisted living facilities where we provide what we call our community care program and those assisted living facilities had fee-for-service Medicare patients in there. One really strong Medicare Advantage salesperson goes in and literally in a matter of a few months, the next thing you have is everyone in that building is -- or the majority of people in that building are Medicare Advantage.

So it is about really knowing where that volume is and the shifting volume so that we can do similar shifts.

Benjamin Whitman Mayo
Leerink Partners LLC, Research Division

Can you elaborate maybe a little bit more, Barb, on the comments around the IRF? I presume that's from Encompass and the concentration that you have there. Just any additional color would be helpful.

Barbara Ann Jacobsmeyer
President, CEO & Director

Sure. So when you look at -- on the IRF side, we don't have their detail like we used to have. So I think it's probably a combination of some payer mix shifting on their side. It used to be we would know the discharges coming out of there in that mix. We don't know that at this point. So what we do know is that we have about half of our settings where we have overlap, where we have seen a pretty significant decline in the fee-for-service referrals.

We do have some settings where we actually have seen a growth. What we're focused on now is making sure that we are reminding them our quality, particularly our claims base quality metrics because they are using a new system now to -- an electronic system to do their referrals. And in that, there's a star rating component of it, and we are asking them to take into consideration not only the star rating component, but our low rehospitalization readmission rates as they are presenting their choice to their patients.

Benjamin Whitman Mayo
Leerink Partners LLC, Research Division

Okay. Maybe one last one and maybe a little sensitive, but just thinking about proactive cost reduction opportunities in light of some of the pressure on earnings over the next year or so sort of what are you guys evaluating?

Barbara Ann Jacobsmeyer
President, CEO & Director

Sure. So we continue to evaluate opportunities for -- on the cost side. I will tell you though one of our greatest opportunities we've mentioned in the past that we've been piloting the MetaLogics Pulse in 17 of our branches. Our team is very data-driven. And so I know it seems like a long time to have a pilot that goes over 9 months, but we needed to do that where we could start getting claims-based outcomes data, and we are pleased now that the data from this Pulse pilot shows that using the tool and managing to a patient-specific care plan, some patients need more some needs less has allowed us to maintain our high quality in these branches and reduce our visits per episode by about 5%.

So a big focus for us is getting this rolled out to all of our branches by the end of the third quarter, so that we can see the benefits of that visits per episode. And that's going to be a big lever for us.

Operator

Next, we'll go to Jason Cassorla with Citigroup.

Jason Paul Cassorla
Citigroup Inc., Research Division

I just wanted to ask about leverage, just following your amended credit facility. The covenant was brought up to 5.25. I should give you about $5 million to $10 million of legal room on EBITDA, assuming the free cash flow you're expecting to generate in the back half of the year.

I was just hoping if you could help frame any levers you might have either help on whether it's working capital or on the spending side that just gives you confidence you don't trip the covenants in light of your guidance and since the max leverage ratio falls in each of the first few quarters of next year? Anything on that would be helpful.

Crissy Buchanan Carlisle
Executive VP & CFO

Yes, sure. So we've been monitoring the covenants, and we knew it would be tight, and that's why we took that proactive approach with our bank group in June. A few things to remember. The term loan does naturally deleverage $5 million per quarter. We do generate a significant amount of free cash flow and we're able to fund our operations through that as well as potentially make some additional debt pay downs and on top of those required pay-downs.

But it does come down to execution. This business was built on Medicare fee-for-service. And the market shifted rapidly, and we've had to make a lot of changes and adapt in the past 12 months, while the peers made those over the last several years. And we did all of that during a time with Medicare reimbursement uncertainty, the resumption of sequestration, staffing challenges, rising interest rates, and then just an increased debt load from the spin.

The long-term value remains. And our bank group understands that, and that's why it was an easy approach to them to ask for the covenant relief. And again, it's an execution story going forward in regards to our ability to meet that covenant.

Jason Paul Cassorla
Citigroup Inc., Research Division

Okay. Got it. And maybe just the Home Health and the cost per visit up a little north of 3% in the quarter. It brings you to about 2% to 3% range so far year-to-date. You lowered the outlook there. Now only 1% to 3%. I know last quarter; you had talked about potential market adjustments this year.

Just curious if that's being offset with better productivity, what's driving the better cost per visit outlook and maybe just your confidence in the visibility that you have of that trend kind of sustaining for the rest of the year would be helpful?

Crissy Buchanan Carlisle
Executive VP & CFO

Yes. So when I look at the Home Health cost per visit in the quarter, a lot of that increase, half of so of the 3.4%, that was contract labor. And as Barb mentioned in her comments, we do expect to eliminate that in the back half of the year. So that's one driver.

And yes, the biggest driver of how we're able to offset the merit markets that we've given so far in 2023 is based off of improved productivity and optimization of our staff.

Operator

Next, we'll go to Joanna Gajuk with Bank of America.

Joanna Sylvia Gajuk
BofA Securities, Research Division

So if I may, just following up on the comments around the Home Health proposal, right?

So you're talking about potentially maybe a little bit better at the market basket improvement. But I guess if it's still, call it, negative 2%, I guess you indicated there will be some additional optimizations you will be pursuing in preparation or in response to that. But I guess if it's finalized at that level, call it, negative 2% rate update, can you grow Home Health EBITDA if rates are down year-over-year?

Crissy Buchanan Carlisle
Executive VP & CFO

Well, Joanna, it's a little early to start talking about 2024. That is the proposed rule, not the final rule. If it -- the proposed rule were to go into effect today based on kind of our current volumes and with that negative 2.2%, that would be about a $12 million to $15 million headwind just off again that rate alone.

Now the hospice final rule with the positive reimbursement rate adjustment that would offset that and be a positive to us for about $4 million to $5 million. But you are, again, talking about a negative proposed rule. And if we want to give a, let's call it, 3% merit market adjustment in 2024, then yes, we would be starting in the whole.

Joanna Sylvia Gajuk
BofA Securities, Research Division

And I guess, also in the proposal, you mentioned, right, CMS is talking about recoupment for $3.4 billion for payments and that was up prior estimate. It seems like it could even increase when they included their estimate, obviously, of the [indiscernible] so just based on that, it's like a 20% rate cut right there, right? So I know CMS kind of left it open. But kind of what is your expectation. Like what's realistic there, I guess, for how this recruitment will be finalized in terms of the size and also the timing of the cut.

I know also you mentioned that there's also the industry is pursuing all the available options in Congress and in courts. But I guess, let's say, those things take time, or they don't materialize before next year proposal. Like what would you expect CMS to say in the proposal -- 2024 proposal for '25 when it comes to that particular overpayment recruitment?

Barbara Ann Jacobsmeyer
President, CEO & Director

Yes. I think that -- I don't know what to say for the 2024 proposal for '25. I would say that because there was no comment about how or when they would collect those in '24. We're confident that, that would not be included in the final '24. I think also it's important to know that CMS does have the authority to reduce the impact of the cuts even for our final rule this year, for example, like they did last year.

Last year, they cut it in half so that there was an element of positive left for the industry. They do have the authority to reduce the impact of the proposed cuts again for 2024. So I think that's important to remember. And then again, as you already noted, we do anticipate a little bit of an uptick on the market basket.

Joanna Sylvia Gajuk
BofA Securities, Research Division

But then in terms of the recoupments going forward, like how would you think they will try to go about? I mean, given the size, I would think that they would try to spread it out, right?

Barbara Ann Jacobsmeyer
President, CEO & Director

Right, for sure. There's no way they could do that all at once. They would definitely look to spread it out, but I think there's still a lot of comments coming in. And as you noted, there's a legislation and the legal action that's being taken as it relates to all of it, including those cuts.

Joanna Sylvia Gajuk
BofA Securities, Research Division

And if I may, I guess, related on the hospice side of things. So yes, the rate average is positive, but I guess there's more language in the regs, both home health and hospice. On the hospice scrutiny, and audits and things like that, so how do you think the company is positioned in light of those actions?

Barbara Ann Jacobsmeyer
President, CEO & Director

So yes -- so there's certainly always a team focused on. A lot of that comes down to documentation and making sure that we feel confident that we have strong documentation as it relates to patients' eligibility, particularly your longer length of stay patients.

And so we have a team that's always focused on that, on education, auditing and getting back directly with clinicians on how to make sure that they're focused on accurate and good documentation.

Operator

We'll go to Jamie Perse with Goldman Sachs.

Jamie Aaron Perse
Goldman Sachs Group, Inc., Research Division

I guess I'm still struggling a little bit to understand what's going on with the episodic volume trend. I know the market is shifting, but I don't think it's down high single digits, and that's sort of the range you guys have been in the last couple of quarters.

I know you've been behind on MA contracting and are catching up. Is it just as simple as you're losing market share to providers that have more lives covered in your respective markets? And at what threshold of lives covered in incremental MA contracts, can you kind of start to stabilize the episodic referral volume?

Barbara Ann Jacobsmeyer
President, CEO & Director

Well, I think it is a big market shift, right? In our markets alone, there was a 9% increase in MA enrollees and an actual 4% decrease in fee-for-service enrollees. So we are actually seeing shifts directly happening in our markets as it relates to what's available to pull from a market perspective.

It's why there's such a focus for us on our primary referral sources saying, what other contracts do you need and want us to try to negotiate to be on so that we can come to you as a full-service provider. I do think that we kind of came out of the gate slow on this because our peers had a longer list. So they could say, I can be your full-service provider, which means send me your fee-for-service and all of these other payers.

With the success that our payer innovation team has had, we do now have a longer list to bring into the provider so that we can get more of their fee-for-service in addition to the other payers that are on our list. But there's been a lot of work in the 9 to 12 months' time to have that longer list of who we can take as we go in and talk to every referral source.

Jamie Aaron Perse
Goldman Sachs Group, Inc., Research Division

Okay. And then just -- I imagine you'll be a little tight lift on this topic, but can you remind us just what percent of your MA volume is now with the United contract? And I think that renews at the start of next year, can you just help frame kind of range of potential outcomes and how you feel about the renegotiation process and in light of your competitive positioning at this point?

Crissy Buchanan Carlisle
Executive VP & CFO

Yes. So the volumes under the United contract have -- are on their way down. We have certainly made a concerted effort to balance use of that contract with our referral sources and noting which referral sources provide both attractive types of patients in regards to reimbursement along with the United and having to balance that.

That's a very unfortunate position to be in because we recognize that a patients at the background of every decision we have to make in regards to that. But unfortunately, that payer has put us in that position. So it is certainly trending downward again as we continue to get more contracts and improved contracts at better rates.

Jamie Aaron Perse
Goldman Sachs Group, Inc., Research Division

And just on framing expectations for the rate negotiation process with that payer.

Barbara Ann Jacobsmeyer
President, CEO & Director

I mean we continue to be at the table, and we continue to talk about the quality metrics that we bring. We do -- we have extended an offer to move away from a national to more regional, if there's markets that they're struggling to have more member access. And if we need to move in that direction, we would be happy to do that. So there are discussions that are ongoing.

Operator

[Operator Instructions] Next, we'll go to Andrew Mok with UBS Financial.

Andrew Mok
UBS Investment Bank, Research Division

Maybe just a follow-up on that last topic, and I hate to belabor this. But I still don't fully understand the magnitude of the guidance revision relative to what's going on in the market. I understand that your fee-for-service mix is structurally higher, but that's always been the case.

And when you take a step back and look at MA fee-for-service industry growth, it seems relatively in line with industry expectations. MA, I think you said it was down 9% or up 9%, fee-for-service down 4%. You've always meaningfully outperformed the MA penetration in your market. So it does seem like there's something more unique to you. Is the competition for fee-for-service members intensifying?

And anything else to point to, I think you also said episodic admissions were expected to accelerate. Just wondering why that was the assumption in the first place?

Crissy Buchanan Carlisle
Executive VP & CFO

I don't believe we said that the assumption was that it accelerated. I think it was we needed it to accelerate in order to be within that initial guidance range.

I think that the payer mix shift and that whole payer innovation strategy is at the -- one of the key assumptions. And if you recall back when we provided the initial guidance, and we talked about the $40 million of headwinds, one of those headwinds we provided for 2023 was a $14 million expected payer mix shift impact for the year.

That $14 million was spent in the first 6 months of 2023. We now expect that to be at least double that. So that is one of the largest driving factor of the initial guidance range. It has been challenging, again, as we balance the historic contracts that we have and continuing to service those patients in order to maintain the relationships with those referral sources that provide both. It's -- you have to take all of my patients. You can't just come here and pick and choose. And so that is a struggle.

And then we continue to, again, work with our payer innovation team and with other referral sources, including IRFs as well as primary care physicians, to determine what contracts do we need in each market, and it does vary by market in order to maintain those relationships and to continue to get the Medicare fee-for-service in addition to the Medicare Advantage.

Andrew Mok

UBS Investment Bank, Research Division

Got it. Okay. And most of the color on the guidance revision is focused on the home health side and the mix shift there. But I'm also curious to just hear what's going on in the hospice side. We haven't seen a lot of meaningful progress there. And you mentioned diversifying your mix into shorter length of stay patients. Does that also have a negative profit mix component to it?

Crissy Buchanan Carlisle
Executive VP & CFO

It does, Andrew. Hospice is paid, it's a revenue per day, whether you make a visit or not. And as we diversify those referral sources and we have those shorter lengths of stay patients, it means in those markets that if you thought -- I'm going to make up the numbers here, if you needed 5 admissions based off your clinical capacity, as your length of stay goes down, you have those shorter length of stay patients, you now may need 8 or 9 or 10.

And so making all of those shifts and working with your business development team to say, hey, historically, we needed 5, now we need, again, the higher number. All of that is in process and working strongly together with both operations and business development to ensure that happens.

Operator

There are no further questions at this time. Jordan Lloyd, I'd turn the call back over to you for any additional or closing remarks.

Jordan Loyd

Thank you, David. If anyone has additional questions, please feel free to call me at (469) 860-6061, and thank you again for joining this morning's call.

Operator

This concludes today's conference call. You may now disconnect.

Jordan Loyd Thank you again for joining this morning's call.