

## **WORKING PAPER**

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### **Odyssey Healthcare**

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## **Odyssey Healthcare**

### **Instructor's Manual\***

#### **Abstract**

Since its inception in 1995, Odyssey Healthcare, Inc., a publicly-held hospice organization, had enjoyed a meteoric rise in fortunes. Operating in an industry dominated by non-profit entities, Odyssey Healthcare had grown its base of business through organic growth, acquisition and de novo operations to be one of the largest hospice organizations in the US. However, in February of 2004, Odyssey Healthcare's management advised investors that their earnings estimates for the fiscal year 2004 would be lowered due to higher than anticipated operating costs.

This gave rise to a chain reaction of events that included 1) a precipitous drop in stock price, 2) class action suits alleging inappropriate insider selling ahead of the news, 3) an unflattering article in a major investment publication in regard to patient recruitment, care and discharges, and 4) an investigation by the Department of Justice, prompted by two separate whistle-blower complaints. These troubles all came to a head in the fourth quarter of 2004, when Odyssey Healthcare announced that CEO David Gasmire had resigned from the company. In addition, guidance on earnings was again lowered. Odyssey Healthcare's stock plummeted 47% in a single day. Odyssey Healthcare's senior management team faced the challenge of dealing with allegations of fiduciary and ethical malfeasance, not to mention the day-to-day challenges of operating their rapidly growing enterprise.

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\*This case is intended to be used for class discussion rather than to illustrate either effective or ineffective handling of the situation. This case was written entirely from published sources, including books, newspaper and magazine articles, and Odyssey Healthcare annual reports, quarterly reports and transcripts from quarterly conference calls. Only direct quotes are attributed in endnotes. Submitted to the Southwest Case Research Association (SWCRA) for its Workshop March 2006, Oklahoma City, Oklahoma. All rights reserved to the author(s).

#### **Teaching Objectives**

This case provides a fairly unique context for business ethics issues, since Odyssey Healthcare is a for-profit hospice operating in an industry still dominated by non-profit entities and largely controlled by the regulatory oversight of the US Medicare system (CMS). The primary objective of the case is to highlight the special considerations of operating as a larger, for-profit entity in an industry where non-profits organizations have primarily focused on meeting the needs of all of their stakeholders--particularly their patients. In particular, the case pits the stakeholder perspective, which has long dominated this largely non-profit sector, against the shareholder perspective of management, with its focus on company profit and shareholder wealth maximization. At issue is whether for-profit companies such as Odyssey Healthcare should meet the needs of all stakeholders, particularly their patients, instead of just fulfill their duties to shareholders, particularly top managers.

#### **Courses and Levels**

This case is suitable for both undergraduate and MBA courses in management, strategy, and business ethics. The case has enough detailed information to support specific analyses, but also promotes the discussion of broad strategic and ethical issues.

## Discussion Questions

**1. What is the shareholder perspective of management and why is it theoretically antithetical to the purposes of the hospice industry?**

The classical or common-law view of the fiduciary responsibility of management is that officers and directors are primarily fiduciaries for shareholders, who are the legal owners of the corporation. Therefore, the main responsibility of officers and directors is to operate the corporation in the interest of those shareholders. Thus, any social responsibility of corporations is narrowly defined in this perspective. Highlighting this historical perspective of management's fiduciary responsibility to shareholders, Nobel Prize-winning economist Milton Friedman once noted that the one and only social responsibility of business is to make as much money for shareholders as possible. Of course, Friedman qualified his assessment by noting that each business must operate within the confines of the law, and engage in free and open competition.

In the hospice industry, where the needs of patients must be paramount, the rise of for-profit companies, such as Odyssey Healthcare, could tilt the focus of management strategy and attention from maximizing patient care to maximizing shareholder wealth, which theoretically could be antithetical to each other. This could particularly be the case when top management, as in the case of Odyssey Healthcare, receives a significant portion of their annual compensation from stock options. Since the earnings are a major contributor to stock price appreciation, could Odyssey Healthcare's top management be tempted to skimp on patient care, in order to reduce the company's cost structure, so as to inflate earnings?

**2. What is the stakeholder perspective of management and why is it a natural fit for the largely non-profit hospice industry?**

The classical view of management fiduciary responsibility is criticized by those holding to the stakeholder perspective because all emphasis is placed on one stakeholder—the shareholder. Thus, the interests of stakeholders are subordinated to the interests of shareholders. In contrast, the stakeholder perspective of management, as popularized by R. Edward Freeman, argues that every group with a stake in a corporation has claims that rival those of shareholders. As such, management's fiduciary responsibilities are expanded to include serving the interests of employees, customers, suppliers, the community and the environment.

In the hospice industry the needs of the patients must be preeminent. If a rigid adherence to the classical perspective of management were embraced in this industry, then patient care could be subordinated to the rights of shareholders to maximize their profits. Some anecdotal evidence and preliminary empirical research appears to indicate that patient care is indeed less robust under for-profit hospice care than under non-profit hospice care. As the percentage of for-profit hospice providers increases, the concern that patient care will erode grows more acute. Because the stakeholder perspective brings parity to the interests of all stakeholders, it has been the natural management approach in not only the non-profit sector as a whole, but also in the hospice industry in particular. According to these non-traditionalist thinkers, only the stakeholder perspective gives patients a voice in management decision-making process to prevent undue subjugation of their interests to those of shareholders.

**3. If Odyssey Healthcare's top management operated the company based on a stakeholder perspective, how would its decision-making be different? Do you feel that shareholder and stakeholder perspectives of management are antithetical to each other?**

First, the strategic plan of the corporation would reflect greater focus on patient care. Thus, performance metrics, by which the company measures its effectiveness, would change from a stock market, profit-maximization orientation to a customer-satisfaction driven orientation. In addition, long-term investment

in patient care would not be validated on return-on-investment standards, but instead on patient quality-of-life issues.

Finally, caregivers in these facilities would not be evaluated not the impact of a company's cost structure, but instead on the experience and care that they can bring to bear on their patient's needs. In short, the stakeholder perspective would balance the scales between sometime competing needs of stakeholders, providing the most benefit to the maximum number of people.

Although the shareholder and stakeholder perspectives are often seen as antithetical, some argue that these two positions can be reconciled. Critics of the classical perspective argue that management is often forced to make decisions to please Wall Street, which invariably leads to short-term, myopic decision-making. The net result is that other stakeholders--particularly employees--are disproportionately hurt by the poor performance that often resulting from such decision-making. If, however, management were to take a long-term, strategic perspective, similar to the approach embraced by Japanese firms, then the two perspectives can be reconciled. With a long-term, strategic perspective, it is argued, management can maximize the benefits to all stakeholders, including shareholders.

**4. Can non-profit corporations in the hospice industry compete effectively with their for-profit counterparts or are they destined to fail? What impact would the departure of a significant percentage of the non-profit corporations have on the hospice industry and patient care?**

Competitive strategy posits that firms gain and sustain competitive advantage through the effective use of resources. For-profit corporations have a natural competitive advantage over non-profit corporations because they have access (i.e., capital markets) to more resources. In addition, because for-profit business processes have been honed through competition, they typically perform better than their non-profit counterparts, all things being equal. Finally, salaries for executive talent are considerably higher in the for-profit sector, giving this sector access to superior human resources that can be channeled into a competitive advantage. In short, for-profit corporations can usually gain and sustain a competitive advantage over non-profit corporations, provided that they leverage the superior resources available to them.

For-profit corporations have gained substantial market share in the hospice industry over the last decade, given their natural competitive advantages. If this trend were to continue, then the majority of hospice care in the United States would be provided by for-profit entities, in the not too distant future. Given the concerns that some have expressed about the potential subjugation of patient needs to the profit maximization needs of shareholders, patient needs may suffer as the shift to for-profit status continues. This begs the question of whether for-profit entities are the best alternative in the hospice industry, given the expected preeminence of patient needs.

#### Teaching Suggestions

This case is best taught in the standard case format. It is probably best to address the questions in sequential order. Since there are two competing management perspectives in view, you may want to force several students to defend one of the perspectives against another group of students who will defend the other. To enhance learning, force the students to defend the position opposite of the perspective that they currently hold.

Epilogue and Odyssey Healthcare website:

In addition to discussing the implications of the new information provided in the Epilogue, student should be encouraged to visit the Investor Relations section of the Odyssey Healthcare website to see how the industry and Odyssey Healthcare have evolved since the case was written.

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## Epilogue

To date, there has been no resolution of the class-action lawsuits or the Department of Justice investigation. Odyssey has maintained its strategy of aggressive growth. Odyssey has implemented a new IT system to help with internal controls and reporting.

In October of 2005, Odyssey named a new President and CEO to replace the departed David Gasmire. His name is Robert A. Lefton. Mr. Lefton joined Odyssey from Select Medical Corporation, a privately-held operator of acute care hospitals. Mr. Lefton is expected to spearhead Odyssey's operational initiatives as well as contribute to the partnering efforts of the firm. Richard Burnham retained his position as Chairman of the Board.

In January 2006, Odyssey announced the creation of a new position: Senior Vice President of Strategy and Development. Mr. Woodrin Grossman, a former member of Odyssey's Board of Directors, was named to the post. Prior to serving on Odyssey's board, Mr. Grossman was Chairman of PricewaterhouseCoopers Global Healthcare Practice.

The stock price, which had been around \$40, has remained around \$20 through 2006.

# Odyssey Healthcare

## INTRODUCTION

Since its inception in 1995, Odyssey Healthcare, Incorporated had enjoyed a meteoric rise in fortunes. Operating in an industry dominated by non-profit entities, Odyssey had grown its base of business through organic growth, acquisition and newly constructed operations to be one of the largest for-profit hospice organizations in the US. With headquarters in Dallas, Texas, Odyssey Healthcare, Incorporated operated 74 hospice care facilities in 30 states and employed over 4,000 healthcare workers in 2004. However, roughly half of those operations were located in California, Texas and Arizona. With an average daily census of 7,700, they were the second largest hospice organization in the US.

Odyssey was founded by Richard Burnham and David Gasmire, both former employees of another large, publicly held hospice organization – Vitas Healthcare. Burnham was a former regional manager for Vitas and Gasmire a former hospice manager. Both saw opportunities for growth in the hospice industry which they felt that Vitas was not pursuing with enough vigor.

An IPO in October of 2001 saw Odyssey debut at \$15. Strong revenue growth, accompanied by handsome profits, catapulted the stock price to above \$30 by October of 2003, with two stock splits in 2003 alone. The number of Odyssey hospices had more than doubled from 2001 – 2003, from 30 to 74.

However, as Burnham and Gasmire navigated into 2004, the Odyssey joyride began to experience some turbulence. In February of 2004, Odyssey released its earnings for the fiscal fourth quarter of 2003. While the numbers for 2003 came in on target, Odyssey management advised investors that their earnings estimates for the fiscal year 2004 were being lowered. The primary drivers of Odyssey's reduced profit outlook included: 1) higher than anticipated costs in the form of newly acquired hospices, 2) greater pharmacy and salary expenses, and 3) greater than anticipated costs in the form of Medicare cap accruals (give-backs to Medicare, their primary source of revenues). Based upon this news, the stock price dropped 26% in a single day. (Yu 2004)

At the earnings conference call, one analyst called into the question the fact that 10 senior executives and directors at Odyssey had engaged in insider selling in the months ahead of the announcement with total proceeds of around \$16 million. This selling was going on at the same time that management was expressing confidence in the future prospects of the firm. (Odyssey Healthcare 4Q 2003 Earnings Conference Call Transcript)

In April, 2004, Barron's, a widely-read financial newspaper, wrote an article about Odyssey which strongly hinted at Odyssey engaging in less than ethical practices related to patient admissions, patient care and patient discharges. The events of February – April, 2004 gave rise to several class action lawsuits. In general, these suits alleged that senior management at Odyssey had failed to fairly disclose the true situation at the firm in a timely manner. In addition, the suits variously accused the firm of admitting patients to their programs which were ineligible, and that the company's levels of care for patients were substandard. (Bernstein et. al 2004, Geller Rudman 2004, Milberg Wiess et al 2004)

September 2004 brought more turmoil. Prompted by allegations in two separate whistle-blower complaints, the Department of Justice informed Odyssey that they were investigating the operations and charges to Medicare of some specific Odyssey sites. While the Department of Justice did not elaborate, they indicated they would be examining Odyssey's practices of patient recruitment and care, as well as some billing practices. (Freudenheim 2004)

These troubles all came to a head in the fourth quarter of 2004. On October 18 2004, Richard Burnham presided over another tumultuous conference call related to the earnings announcement for the previous quarter. For those listening in on the call, the first surprise was the announcement that the CEO, David Gasmire, had resigned from the firm, and that Burnham was now acting as both Chairman and CEO. In addition, Burnham informed investors of the Department of Justice investigation. Finally, Odyssey announced that they were lowering their earnings estimates for the full year 2004, based upon a slowing rate in overall admissions and continuing issues with Medicare cap accruals. The market response to this “triple-whammy” was even more pronounced than was observed in February: Odyssey stock plummeted 47% in a single day. (Freudenheim 2004)

In October of 2004, Burnham and his senior management team faced the challenge of dealing with allegations of fiduciary and ethical malfeasance, not to mention the day to day challenges of operating a rapidly growing enterprise. Top management at Odyssey was likely wondering what steps they may have taken to avoid the negative publicity of the Department of Justice investigation and the class action suits. Their chief conundrum may have been how to balance the ethical issues facing their firm with the need to run a profitable firm that is attractive to shareholders.

## **OVERVIEW OF THE HOSPICE INDUSTRY**

### **Hospice Care**

Hospice care is defined by the Hospice Association of America as:

“...comprehensive, palliative medical care (treatment to provide for the reduction or abatement of pain and other troubling symptoms, rather than treatment aimed at cure) and supportive social, emotional, and spiritual services to the terminally ill and their families, primarily in the patient’s home. The hospice interdisciplinary team, composed of professionals and volunteers, coordinates an individualized plan of care for each patient and family.” (Hospice Association of America website 2005)

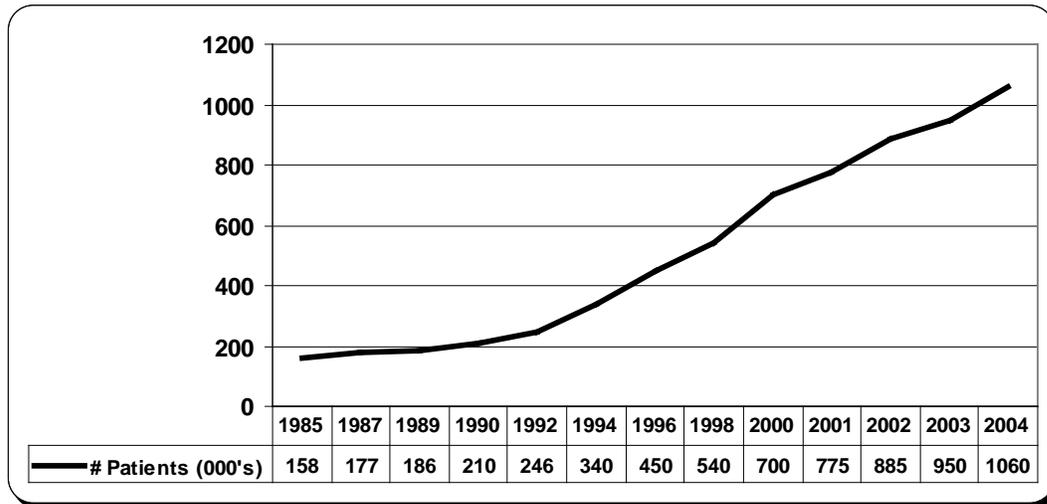
The palliative care provided by hospices differs from curative care which is traditionally provided by hospitals. A broad range of services, from traditional nursing care to respite care for family caregivers to bereavement services for family members is traditionally offered.

### **The Institution of the Medicare Hospice Benefit Spurs Industry Growth**

The hospice industry in the US is a relatively small and fragmented component of the overall healthcare industry, generating aggregate annual revenues of about \$4.5 billion in 2003. This amounts to less than one half of one percent of the \$1.4 trillion annual US healthcare spending and only 1.5% of annual Medicare spending (Shattuck Hammond Partners 2004).

In 1982, Congress enacted the Medicare Hospice Benefit on a provisional basis. In 1986, the provisional law was made permanent. Each state was given the option of including hospice care in their Medicaid program. In addition, hospice care was made available to terminally ill patients in nursing homes. A significant jump in usage of hospices occurred at this time.

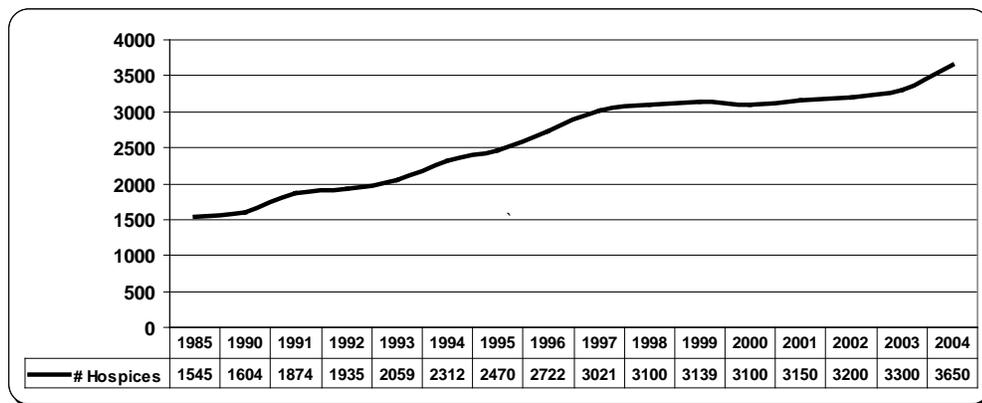
**Figure 1: Number of Hospice Patients: 1985 – 2004 (000's)**



(NHPCO 2005)

In 1996, the federal government initiated a program (“Operation Restore Trust”) focused on preventing Medicare fraud across all provider groups. This increased level of regulatory scrutiny, while probably needed, likely inhibited referrals of patients and reduced average and median lengths of stay industry-wide. The Balanced Budget Act of 1997 further negatively impacted reimbursement rates, further dampening the growth rate of hospice sites.

**Figure 2: Number of Hospices: 1985 – 2004**



(NHPCO 2005)

**Factors Driving the Increasing Acceptance of Hospice Care Services in the US**

There are several factors driving growth in the hospice industry. Foremost is the overall aging trend in the US and the increasing size of the over 65 population. In addition, there has been an increasing role of advocacy groups in promoting hospice care over other end-of-life alternatives. Finally, The Center for Medicare and Medicaid Services (CMS) appears to be promoting hospice care through its liberal policies for reimbursement. The CMS’s favorable treatment of hospice care in their reimbursement policies is

thought to be at least in part because hospice is viewed as a lower cost alternative to traditional, hospital-based end-of-life care.

### **The Medicare Hospice Benefit**

In 2002, Medicare and Medicaid accounted for 86% of all hospice industry payments. Private insurance pays for an additional 11%. The rest is covered through Medicaid, self-pay, or other alternative payment methods (NHPCO 2004)

Medicare has 3 key eligibility criteria for hospice care. First, the patient must have Medicare A coverage. Second, the patient's doctor and the hospice's medical director use their best clinical judgment to certify that the patient is terminally ill with a life expectancy of six months or less, if the disease runs its normal course. Third, the patient must choose to receive hospice care rather than curative treatments for their illness.

Medicare then pays the hospice a per diem rate, which is intended to cover virtually all expenses related to addressing the patient's terminal illness. Because patients require differing levels of care as they progress in their diseases, Medicare provides for four levels of care to meet their changing needs. Typically, each October, Medicare adjusts its base hospice care reimbursement rates for the following year based on inflation and other economic factors.

Medicare reimbursements are made along the following guidelines:

- 1) Medicare beneficiaries must pay limited coinsurance: the smallest of 5% or \$5 for drugs and 5% of hospice payments for respite care.
- 2) Total annual co-payments for respite care cannot exceed the Medicare hospital deductible.
- 3) Medicare caps reimbursements to hospice programs in 2 ways:
  - a. Inpatient care days may not exceed 20% of all patient care days per provider. If the cap is reached, reimbursement continues, but at a reduced rate. This is referred to as "The 20/80 Rule".
  - b. Annual reimbursement per beneficiary is capped at \$19,635.67 for FY 2004. This rate, which is updated every year, is multiplied by the number of new beneficiaries enrolled by the program during the fiscal year. If actual Medicare reimbursements to a program during the period exceed the total, the provider must repay the difference to Medicare. This aggregate reimbursement cap effectively serves as a corrective mechanism to programs with very long lengths of stay.

This version of the cap is applicable on a site to site basis, not for hospice operations overall.

- c. Prior to 1990, Medicare per-patient payments were limited to a 210 day maximum. From 1990-1997, payments were limited to a maximum of 4 6-month benefit periods, or roughly 720 days. Rules for maximum reimbursement have been further slackened: There are currently no limits to the number of days of care for which Medicare will pay. However, in order to continue to receive reimbursement a patient's prognosis must be reaffirmed at 90 days, at 180 days, and every 60 days thereafter.

## Hospice Patient Trends

The typical patient in a hospice tends to be an older Caucasian who is most likely suffering from cancer. They are just as likely to be male or female. According to the National Hospice and Palliative Care Organization, 54% of all hospice patients were female, over 80% were Caucasian, and 63% were 75 years of age or older (NHPCO 2004).

In recent years, the greatest increase has occurred in the number of beneficiaries with non-cancer diagnoses and those living in nursing homes and rural areas. Though cancer patients accounted for 49% of hospice admissions in 2003, this is down from 76% in 1992. Other ailments such as heart disease, dementia, lung disease, kidney disease, and liver disease are becoming more common among patients admitted to hospice care.

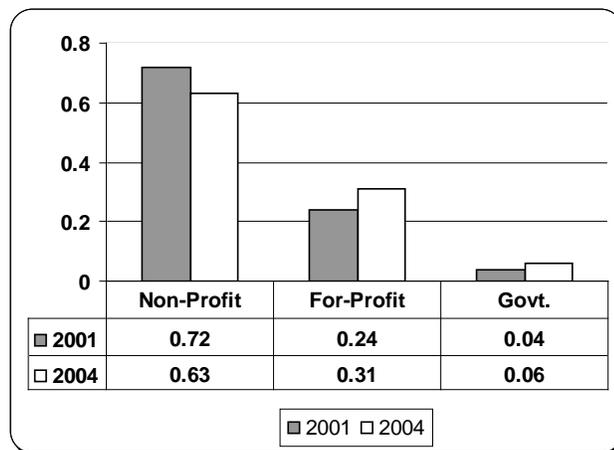
### Trends in Medicare-Certified Hospice Operations

To be certified by Medicare, a hospice must be able to provide a wide range of both core and non-core services. Core services, which include nursing services, medical social services, and bereavement, spiritual and dietary counseling, must be provided by employees of the hospice. Non-core services, including home health aide or physician services, may be provided by hospice employees, or the hospice may contract to provide them. Medicare also requires certified hospice programs to recruit and train volunteers to provide patient care or administrative services. Unpaid volunteers must provide a minimum of 5 % of total patient care hours provided by all paid hospice employees and contract staff of a hospice program.

Medicare regulations specify that hospice providers may not make admission conditional on executed advanced directives, such as a do not resuscitate order, a living will, or a description of treatment desired or not desired. Beyond this specific stipulation, Medicare provides no other mandatory admission guidelines; hospice providers may provide care (or deny admission) to Medicare patients according to their individual philosophy of palliative care. A hospice may refuse care to patients when the program is not equipped to provide the necessary services. For example, not all hospices have the ability to care for ventilator patients or to operate pediatric programs. Once a Medicare patient is admitted, the hospice may not discharge the eligible beneficiary at its own discretion, even if the care for the patient promises to be costly or inconvenient.

The hospice industry has traditionally been comprised of non-profit operations with an average of less than 50 patients at any given time. Currently, 63 % of all hospices are non-profit, with for-profit operations comprising 31%. However, as Figure 3 below shows, the trend has been toward growth in the for-profit area.

**Figure 3: Trends in Hospice Profit Status (2001 – 2004)**



(NHPCO 2005)

As of year-end 2003, 48% of hospices are free-standing entities, 30% are affiliated with hospitals and another 22% are affiliated with a home health agency or a nursing facility. The trend has been away from free-standing toward affiliation (NHPCO 2004). The strategic rationale for a hospice to be a part of an integrated healthcare system is threefold. First, hospice is a critical and growing piece of the healthcare continuum and enables acute care providers to offer patients an alternative to traditional end-of-life care situations. Second, hospice programs can act as a strong link to the community, given the large number of volunteers and the high level of emotional attachment. Finally, affiliated hospices offer “hard-wired” opportunities to transfer patients from high-cost acute care situations to the relatively lower-cost hospice environment, enhancing the financial performance of both entities.

## **ODYSSEY’S BUSINESS STRATEGIES**

Odyssey Healthcare’s business strategies revolved around the following three imperatives: 1) Rapid expansion into new geographies with the ultimate objective to establish a broad geographic footprint, 2) Strict cost control and attention to the bottom line, and 3) A focus on marketing directed at increasing the admissions rate and average daily census (ADC), including the extensive training of their marketing, sales and operations personnel.

In 2004, as their strategy evolved, Odyssey initiated an emphasis on developing a fuller range of services that would make them more attractive to referrers from their hospital partners and skilled nursing facilities with patients requiring more acute care. Odyssey embarked upon a strategy of establishing dedicated inpatient services and continuous care services, and extended their operating hours. Odyssey also recognized the need for more locally-based strategies for patient recruitment. Instead of a broad, one-size-fits-all approach to admissions programs, Odyssey now studies the local conditions at each site and tailors the recruitment targets to fit the business situation and local referring parties encountered by the local programs.

### **Rapid Expansion into New Geographies**

In organizing for rapid growth, Odyssey has established 8 regional territories. Each territory is headed by a Regional Vice President, who, in turn, manages teams of District Managers. At headquarters, Odyssey maintains a dedicated acquisitions team, as well as a dedicated expansion/startup team for de novo operations. With each new operating estimated to cost around \$1.6 million, Odyssey management indicated that a full 25% of that cost is dedicated to marketing expenses.

### **Increasing Scale and Geographic Breadth**

The hospice business model is also highly sensitive to scale. Once the average daily census (ADC) breakeven point is reached (between 30 – 40 patients per month), operating margins in the 10% range are achievable and increase as the census rises. VistaCare’s specific experience with scale effects are summarized in the chart on the following page.

**Figure 4: Odyssey Average Daily Census and Net Margins: Q3 2004**

<u><b>AVERAGE DAILY CENSUS</b></u>	<u><b>NET MARGINS</b></u>
51 - 100	14.7%
100 - 200	27.3%
Over 200	31.9%
Overall	25.2%

(Odyssey Earnings Conference Call Transcript, Q3 2004)

Hospice providers who achieve significant scale are able to negotiate volume discounts on the purchase of pharmaceuticals, durable medical equipment and medical supplies. In addition, they are in a better position to enter into favorable contracts with private insurers HMOs and pharmacy benefit managers. Finally,

large hospice operations are able to spread certain fixed costs (corporate overhead, IT infrastructure, and marketing spending) over a large patient population.

Having a broad footprint in a particular geography aids large for-profit hospices in receiving referrals from similarly broad-based health care providers. National and regional nursing home and assisted living communities often seek the administrative and service consistency benefits resulting from working with a limited number of broad-based hospice service providers.

### **Controlling Operating Costs**

In 2003-2004, Odyssey struggled to adequately control their pharmaceutical costs. In many locations, they were paying local rates. In 2004, Odyssey completed an extensive project whereby a national formulary plan and an electronic drug adjudication system was implemented. This system provides better visibility and control over the drug side of the business. From the first quarter of 2003 to the fourth quarter, daily drug costs were reduced from \$9.85/day to \$7.86/day – more than a 20% drop. (Odyssey 10Q Reports 2003). Odyssey has also recently completed a switch-over to a new internal management IT infrastructure. The new software and hardware system, obtained from the McKesson healthcare consulting firm, and dubbed the Horizon system, is intended to improve the clinical and billing systems. It provides management at Odyssey better real-time visibility into the day-to-day operations of the firm, such as drug usage rate, patient length of stay and Medicare Cap accrual issues. Perhaps more importantly, the system help prevent errors in claim preparation, thereby avoiding lengthy delays in Medicare reimbursements.

### **Aggressive Marketing**

#### **Driving Admissions Growth through Personal Selling**

By May 2004, Odyssey had added 17 new programs in just the past 12 months. To assist in ramping up the patient counts in these nascent programs, Odyssey dedicated an increasing share of its operational budget to establish personal selling teams to call on the various referring entities. In some cases, the teams specialized by type of client, such as nursing homes and oncology centers. These referral reps are referred to as “Community Education Reps” or CERs. In 2004, Odyssey employed more than 200 CERs. They had over 70 hospice sites, with the number of CERs fluctuating between 2 and 6 depending on the market conditions of each individual site.

In January 2004, Odyssey hired Bill Ward to fill the newly created position of Senior Vice President, Sales and Marketing. In addition to managing the overall sales and marketing function, Mr. Ward also took the lead in establishing strategic relationships with large referring partners, such as regional hospitals and other regional/national healthcare providers.

Compensation plans were geared around numbers of referrals and types of patients obtained. In January 2004, the compensation plan was modified. Base salaries were set slightly higher than market. Bonuses were established to be awarded after every 13 weeks (essentially, each quarter) based upon growth over the previous quarter. A minimum expectation of 4 new admissions per week was established. Bonuses were established to incent CERs to raise their averages as the year progressed, with an incentive awarded at the end of the year if the average admissions/week reached a certain target level.

Odyssey has expanded their training and support staff to include two professionals whose sole responsibility is to educate their field sales team who call on their referral sources. This corporate function is referred to as the Support Center. The primary recipients of the training are the CERs, the local patient care managers, and the general managers of each individual hospice facility. In 2004, faced with a slowing admissions trend, Odyssey accelerated their training schedule for these individuals.

#### **Products/Services Strategy**

In order to be certified by Medicare, marketers of hospice services are required to offer specific core and non-core services. However, marketers at certain for-profit hospices have recognized the value of

differentiating their services to appeal to certain types of referrers. For example, certain national or regional health care providers may appreciate the ability to work with a larger partner who can offer a consistent level of care and administration over a larger geographical footprint. Further, hospices are beginning to differentiate themselves by specializing in services for specific diagnoses.

Some of the larger for-profit hospice operations are attempting to differentiate upon the basis of services offered. As Figure 5 illustrates, Vitas distinguishes itself by specifically going after patients that require general inpatient care and continuous home care. This allows Vitas to attract relatively short length of stay patients (as these patients tend to be cancer-related), achieves higher revenues due to the relatively higher compensation levels called for by these services, and differentiates themselves from their major competitors.

**Figure 5: Patient Mix by Level of Care (2003)**

	<b>INDUSTRY</b>	<b>VITAS</b>	<b>ODYSSEY</b>	<b>VISTACARE</b>
<b>Routine Home Care</b>	96%	68%	90%	94%
<b>General Inpatient Care</b>	3%	16%	9%	6%
<b>Respite Care</b>	<1%	--	<1%	--
<b>Continuous Home Care</b>	<1%	16%	<1%	--

(NHPCO, VITAS, Odyssey, VistaCare Annual Reports)

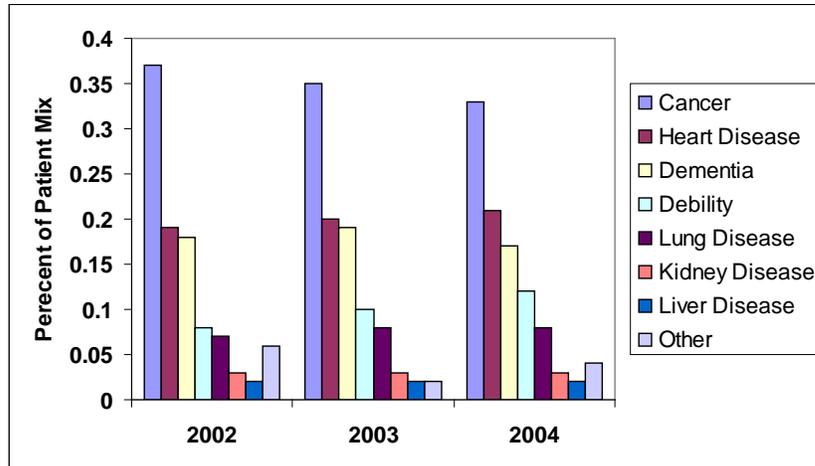
### **The Impact of Fixed Pricing on Target Market Strategy**

With over 90% of the revenues being obtained from Medicare and Medicaid, all hospice operators work under a fixed pricing system. Thus, the revenue function for a hospice operator is linear – a fixed per diem payment over time. The cost function, however, is not linear. The cost of a marginal day of care is relatively high at the onset of care, when there are initial costs of learning about the patient’s background, and when developing a plan for facilitating the move to a hospice environment. Similarly, costs are relatively high in the days immediately prior to death. Between the high costs at the start and at the end of the period of care, costs are lower (Huskamp, et al 2001). This pattern of cost is the same regardless of diagnoses.

In addition, some patients may benefit from relatively expensive types of palliative care or the use of certain types of durable medical equipment. These special needs would only serve to drive the cost function up.

The important implication of the linear revenue function and the U-shaped cost function is this: Longer lengths of stay will yield higher profits. Further, a patient’s diagnosis serves as a predictor of length of stay: Cancer patients tend to be referred late and have relatively short stays. In contrast, non-cancer patients tend to have longer lengths of stay. The cost/revenue dynamic is further complicated by the fact that the non-cancer patients tend to require more and more expensive types of medication and other services not traditionally used on a dying cancer patient. For these reasons, there has been a natural tendency of for-profit hospices to target non-cancer patients for admissions. Figure 6, on the following page, highlights Odyssey’s trend in patient admissions from 2002 – 2004. While Odyssey’s mix of cancer patients approximates 35%, the industry average is 49%

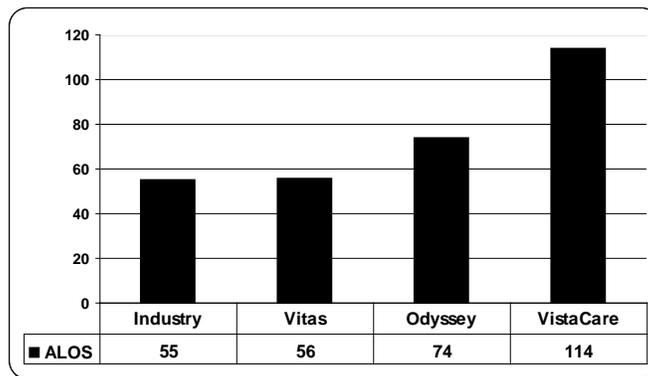
**Figure 6: Odyssey Patient Mix by Disease (2002 - 2004)**



**Managing Patient Length of Stay**

Patient length of stay appears to have the most impact on net patient revenue. Patient care expenses are usually higher during the initial and latter days of care. During the initial days of care, expenses tend to be higher due to initial purchases of pharmaceuticals, medical equipment, supplies, and administrative costs. In the latter days of care, expenses tend to be high because patients require more services due to their deteriorating medical condition. For each patient, if length of stay is only a few days, the high costs are spread over fewer days of care which increases patient care expenses as a percentage of net patient revenue. Consequently, profitability is negatively impacted. Clearly, the ideal scenario for a for-profit hospice is to have each patient stay as long as possible so that the patient care expenses are spread over more days, positively impacting profitability. As a result, it is not surprising to find that Odyssey has a relatively high length of stay compared to the industry, as figure 7 below attests.

**Figure 7: Average Length of Stay (2003)**



(NHPCO, VITAS, Odyssey, VistaCare Annual Reports)

Thus, the marketer at a hospice is faced with a challenge of managing the type and number of patients in an environment where one is expected to take on all types of cases.

This task is approached in the following two ways. First, marketing appeals are directed at the type of patients needed at the time to keep the mix of patients by diagnoses in an acceptable range. At times, this may mean directing efforts at oncology patients, but at other times it may mean directing efforts at non-cancer patients. Second, rapid census growth is viewed as a means of staying a step ahead of the issue by attracting traditionally longer length of stay patients, and mitigating their impact by continuing to attract new patients with their inherently short tenures.

### **Compliance and Oversight**

Odyssey placed heavy emphasis on compliance with Medicare rules and regulations. Kathy Ventre, Senior Vice President of Clinical and Regulatory Affairs reported directly to the CEO and regularly reported to the Board of Directors. She headed up a team of 12 clinicians whose primary objective is to ensure that all of Odyssey's hospices remained Medicare compliant. Of the 12, one clinician was assigned to each of the 8 sales regions. The remaining 4 clinicians monitored activities at all start-ups and acquisitions. In addition to this central staff, each of the individual hospices also employed one full-time clinician. Medicare regularly samples paperwork submitted by its certified sites for compliance to its rules and standards. In the first quarter of 2004, 17 of Odysseys 70+ sites had been scrutinized by Medicare: All had passed.

## **ODYSSEY'S WINTER OF DISCONTENT: OCTOBER 2004**

As Odyssey senior management convened in October 2004 following the earnings announcement, they faced challenges on two fronts. On the business front, admissions growth was slowing. Net income was being squeezed by increasing marketing expenses and reduced profitability due to increasing issues with Medicare Cap accruals.

But perhaps, it was Odyssey's legal and ethical issues which represented the bigger issues that Odyssey must consider. The Department of Justice was investigating the marketing and operating practices at selected hospice operations. Was Odyssey too focused on profitability at the expense of ethical practice? Was the new compensation scheme creating a corporate culture that was not conducive to promoting proper recruitment and care practices at their hospices? Did Odyssey senior management have enough ability to monitor the activities of their rapidly-growing business? Was senior management too focused on their own compensation incentives and stock options to make clear decisions with regard to properly running a far-flung hospice organization? How can Odyssey properly balance the requirements of their shareholders as well as their stakeholders? What are the implications if they cannot?

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