WORKING PAPER

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VistaCare Healthcare

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Abstract

Since its founding in 1995 as a for-profit hospice, VistaCare had enjoyed significant growth in revenues and profits. By the end of 2003, VistaCare operated 40 hospice sites in 14 states. Recent operational issues negatively impacting revenue growth and profitability had left Chairman and CEO Rick Slager and his management team with the unenviable task of informing investors that the firm had recorded a net loss for the third quarter 2004 of $6.2. The previous quarter had seen a loss of $1.8 million. Investors had expressed their displeasure by dumping the stock from their portfolios: In December of 2004, just one year after the stock had achieved its all-time high; it now wallowed at less than half that value.

VistaCare had invested in future growth by implementing aggressive marketing plans geared to spur the recruitment of patients for its ever-expanding number of hospices. But admissions growth had slowed. To make matters worse, VistaCare was plagued by unexpectedly high charges from its primary source of revenue, Medicare, for what was called "Medicare Cap Accruals". In effect, VistaCare had to pay back large amounts of monies they had received from Medicare because they had failed to effectively manage their business to comply with Medicare guidelines.

CEO Rick Slager and his CFO, Mark Leibner, needed a viable operations plan to turn VistaCare's business around quickly. At the same time, they needed to sort through their various marketing strategies to try to understand which were helping the cause and which were only making matters worse.

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*This case is intended to be used for class discussion rather than to illustrate either effective or ineffective e handling of the situation. This case was written entirely from published sources, including books, newspaper and magazine articles, and VistaCare 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.

Teaching Objectives

This case provides a fairly unique context for marketing and operations issues, since VistaCare is a for-profit hospice operating in an industry still dominated by nonprofit 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 government regulations can severely limit operational flexibility and negatively impact profits. In particular, the case brings to light the need for effective operations reporting systems and the need to manage operations on a real-time basis in order to avoid the negative consequences of being out of compliance with government guidelines. A second objective is to discuss a classic situation of investing in marketing activities designed to spur company growth that do not deliver quick results. In this case, VistaCare is investing heavily in personal selling headcount, but the sales process involves a fairly long selling cycle. Hence, they find themselves investing ahead of results.

Courses and Levels

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

Discussion Questions

1. Where is the hospice industry in terms of Product Life Cycle (PLC) theory?

This initial question may lead to a lively discussion. Information provided in Figure 1 regarding the growth in hospice patients points to an industry that is clearly in the growth phase. In addition, many industry factors, particularly the aging of the population in the US, point to continued aggressive growth.

However, when one considers Figure 2, related to the growth in hospices, one could argue that the rate of growth is actually slowing, and that perhaps the industry is entering the mature phase.

It will be very useful at this point to call attention to some of the other industry trends that shed further light on the issue of PLC, in particular:

1) The entry of non-profits into the industry,
2) The trend to larger patient counts (ADCs), and
3) The expansion of the patient base toward more non-cancer patients

All of these developments point toward an industry that is well into the growth phase, and help to explain the relatively low rate of growth in the number of hospices.

It will also be instructive to point out some of the unique characteristics of the hospice industry that make the prediction of future growth relatively difficult:

1) The current growth is highly dependent upon favorable treatment from CMS (Medicare) in terms of both management guidelines and the rate of reimbursement. Here the instructor can point out the tenuous nature of industries that rely on government programs. What would happen if, due to overall government budget cuts, CMS were to cut funding for the hospice benefit? What would happen if the government created more and more management constraints on the for-profit entities, increasing their cost of doing business to the point that it becomes undesirable to continue in business? Developments such as the aforementioned would likely lead to a significant contraction in both the number of patients availing themselves of hospice services, as well as the number of hospices (particularly, for profits) providing services.

2) Much has changed in the nature of patients and hospice services since the overall hospice benefit was established over 20 years ago in 1986. In particular, the mix of patients is changing from predominantly cancer patients to non-cancer patients. The average length of stay of non-cancer patients tends to be much longer than originally comprehended by the hospice benefit guidelines. In addition, the non-cancer patients require different "name-brand" drugs that create challenges for hospices used to budgeting for generic pain–killing prescriptions.

3) Finally, the US stands on the verge of millions of Baby Boomers entering their old age. This wave of patients, whose psychographics tend to lead them to avail themselves of pain-reducing life strategies, may swamp the current hospice infrastructure, creating a crisis in end-of-life care in the US in the not-too-distant future.

2. What is VistaCare's position in the industry? What are the implications for marketing strategy?

Figure 5 shows VistaCare to be the third-largest hospice provider in the US with a 4.3% share of patients in 2004. The industry leader, Vitas, has a 10.9% share – or over two times the share of VistaCare. Relative to the rest of the healthcare industry, the hospice industry is small and highly fragmented. Further, the industry is poised for significant growth. The industry is showing some signs of consolidation as for-profits and non-profits alike expand aggressively and drive up the average size of hospice operations.

Thus, in a highly fragmented market, VistaCare has a modest share position. However, one cannot find much fault with VistaCare management for seeking to grow aggressively in the current environment. Business theory still generally points toward market share growth as a very desirable strategy in an industry in the growth phase. However, to set up the discussion of what VistaCare must decide in 4Q 2004, the instructor may want to

discuss what the appropriate sense of urgency should be for a company in VistaCare's position. To take up the devil's advocate position, the instructor may want to ask the class: What would be wrong with pursuing strategies geared toward maximizing profitability and moderate growth as opposed to maximizing growth and jeopardizing profitability?

Students may examine Chapter 10 of the popular Kotler text A Framework for Marketing Management (2nd ed.) to re-examine appropriate marketing strategies for various points in the product life cycle. Assuming that the industry is in the growth phase, one can compare what the classic theory prescribes and contrast it with the steps that VistaCare is taking. The Table below provides an example of some potential findings for this exercise

Table 1: Implications of PLC for VistaCare Marketing Strategy (Assuming Industry is in Growth Phase)

Prescribed Strategies	VistaCare Strategies	Comments/Discussion
Product Mix tends to broaden to appeal to expanding customer base.	VistaCare implementing segmentation strategies and adding services (e.g. IPUs) to cater to targeted segments	VistaCare appears to be moving in the appropriate direction.
Pricing tends to be at profit-making levels.	VistaCare operating in fixed pricing environment (Medicare)	Pricing strategies not as relevant: Cost control considered extremely important.
Promotion objectives tend to move away from general demand generation into advertising that helps differentiate services for an increasingly segmented market.	VistaCare still involved in general demand generation activities. However, "open Access Policy" is an example of early attempts to differentiate services.	Unless US government engages in social marketing, for-profits forced to shoulder the burden of creating awareness and educating patients. VistaCare on target in actively differentiating services.
Distribution expands to meet expanding demand. Distribution moves from exclusive to selective to intensive.	VistaCare a leader in the industry with vision of large geographic footprint, critical mass in a geography, and "leapfrog" strategy of program development	VistaCare strategy of distribution expansion appears to be on target.

The upshot of this discussion will likely be that VistaCare's marketing strategies are largely on target. It leads to the natural question along the lines of "Gee, if VistaCare strategies are on target, what exactly is the problem?" The answer to this question begins to be revealed with Question #3.

3. What are the unique constraints to strategy represented by role of Medicare as the primary regulator of competition in the hospice industry? How well has VistaCare adjusted to those constraints?

Oversight of CMS brings the following unique constraints:

a) The need to pre-qualify patients to meet the guidelines for admission to the Medicare system for payment, including the edict to take on all types of patients, and

b) The Medicare Cap accrual, particularly as applied to individual sites

The instructor is encouraged to stress the asymmetric nature of these requirements. Hospices are expected to take on any and all types of patients, and are paid a flat rate for care regardless of the diagnosis for the terminal illness. However, it is relatively easy to observe that not all patients are equal in terms of the requirements to provide appropriate care. This represents both operational and ethical dilemmas for hospice providers in terms of which subgroups to target and how to care for them appropriately. The operational issues are the focus of this case. Table 2 below identifies some of the ways VistaCare attempted to cope with these constraints with some comment on the effectiveness of their actions

Table 2: VistaCare Actions Related to Medicare and Their Effectiveness

VistaCare Actions	Comments/Discussion
Undifferentiated approach to positioning enrollment: The "Open Access" policy.	Provided VistaCare with a differentiation from competitors, but did not jibe well with what, in fact, they were trying to accomplish with targeted referral efforts.
Implementation of IPUs	Appears to be a good move. Will make VistaCare more attractive to cancer patients, and at the highest level of reimbursement (inpatient care). Also should ease the Medicare Cap problem by attracting shorter length of stay patients. Finally, provides VistaCare a point of differentiation from other providers.
Aggressive investment in personal selling	Allows VistaCare to take a segmented approach to hiring, training, and targeting for recruitment efforts. Problem lies in the fact that VistaCare did not control recruiting effectively on a site by site basis.
Aggressive geographic expansion.	Strategy appears a bit dubious in light of operational issues on the individual program level.

At the end of the day, VistaCare's operational problems are probably the result of:

1) Lack of specific targeting, and
2) Lack of internal tracking systems sophisticated enough to track patient dynamics at the program level on a real-time basis.

In sympathy to VistaCare, it is difficult to manage one's business when one is forced to accrue for a reimbursement level that is not specified until one is more than 80% through the fiscal year. However, prudent management would likely suggest that one get the internal systems in order before embarking on an aggressive growth strategy under these conditions.

4. VistaCare finds itself spending aggressively on marketing expenses (primarily personal selling) ahead of expected results in the form of increased revenues. Comment on the pros and cons of this strategy. What is required to ensure the success of such a strategy?

Figures 9 through 15 under "VistaCare's Operational Issues" lays out the operational "train wreck" experienced by VistaCare in 2004. VistaCare was aggressive in both opening new facilities and in hiring new personal selling agents, only to see their average daily census stall out in 2004 due to the lack of productivity of a green sales force. Typically, the pros and cons of spending ahead of sales include the following:

Table 3: VistaCare Actions Related to Medicare and Their Effectiveness

Pros	Cons
Investing in future growth is generally a prescribed strategy for a firm in the growth phase of the industry life cycle.	Investing ahead of revenues puts stress on the business model by increasing operating expenses without a commensurate increase in revenues. Operating margins are squeezed.
Investing ahead of demand allows the firm to meet growing demand, thereby capturing market share from lesser-prepared competitors.	For VistaCare, the size of the Medicare Cap Accrual created an additional source of risk in addition to slow revenue growth. This adverse adjustment to revenues calls into question the wisdom of pursuing an aggressive investment strategy until it was determined that the size of the Medicare Cap Accrual could be accurately assessed.

As stated in Question #3 above, superior operational controls, which allow the firm to minimize the size and surprise nature of the Medicare Cap Accrual, would appear to be a strategic prerequisite to pursuing an aggressive marketing investment program. Without strong operational controls, the firm would appear to be doubling its risk of a financial calamity, which is what transpired with VistaCare.

5. Assuming that the operational issues of tracking the operations were solved, what specific changes to marketing strategy would you recommend?

Given that VistaCare has just announced a second consecutive negative earnings surprise, it would likely be incumbent upon the marketing manager to assess each element of the marketing program and 1) retain or increase the elements of the plan that are working,

while 2) eliminating programs that are not working as well. The overall objective would likely be to control or reduce marketing spending in the near future until an effective business model has been demonstrated to investors. Under these circumstances, the most likely marketing strategies for VistaCare are summarized in Table 4.

Table 3: VistaCare Recommended Marketing Strategy

Marketing Mix	Strategy	Comment/Discussion
Product/Services	Adopt bifurcated strategy: Aggressive growth in mature programs, conservative growth in nascent programs.	VistaCare should adopt a segmented strategy that allows them to pursue aggressive growth in programs that are not likely to be subject to Medicare Cap constraints. However, for programs with Medicare Cap concerns, patients with shorter lengths of stay should be emphasized in recruitment efforts. This is where IPUs should be implemented.
Pricing	No major changes	Pricing is fixed for strategic purposes. It is patient mix and services mix that one must modify to positively impact revenues
Promotion	Advertising budgets should be trimmed in lieu of personal selling efforts.	For the sake of trimming operating expenses, general advertising expenses should be trimmed. Personal selling efforts provide VistaCare with more badly-needed control over which patients are being recruited. Additional training of current staff, with an emphasis on improving productivity should be implemented, with less emphasis on additional hiring.
Distribution	Aggressive expansion strategy should be paused until current Medicare Cap issues are under operational control.	In the short run, focus should be placed on improving the operations of existing programs. Perhaps distribution expansion should be limited to organic growth and acquisitions of existing operations (with inherited customers) rather than newly constructed operations. This still provides VistaCare with a profile of growth

Teaching Suggestions

This case is best taught in the standard case format. It is probably best to take a staged approach to the discussion questions:

> First stage: Discussing the unique characteristics of the hospice industry and the role of for-profit entities in a traditionally non-profit industry.
>
> Second stage: Given the milieu, a detailed discussion of the specific business strategies and marketing strategies being deployed by VistaCare and why some of them do not appear to be working well.
>
> Third stage: Based upon an understanding of both the industry and the firm, a discussion of the most appropriate business and marketing strategies going forward should be discussed.
>
> Epilogue and VistaCare 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 VistaCare website to see how the industry and VistaCare have evolved since the case was written.

There is enough specific information in the case to deploy the use of spreadsheets and scenario-based analysis, particularly in support of the discussion of alternative marketing strategies. In particular, the quarterly income statements have been provided in Appendix C with the intention of providing the basis of higher-level financial analysis by graduate level students.

References

Kotler, Philip: A Framework for Marketing Management, 2nd ed; Chapter 10: "Developing, Positioning, and Differentiating Products Through the Life Cycle"; p188-211; Prentice Hall 2003

VistaCare 10 Q Reports: 2003 - 2005

Epilogue

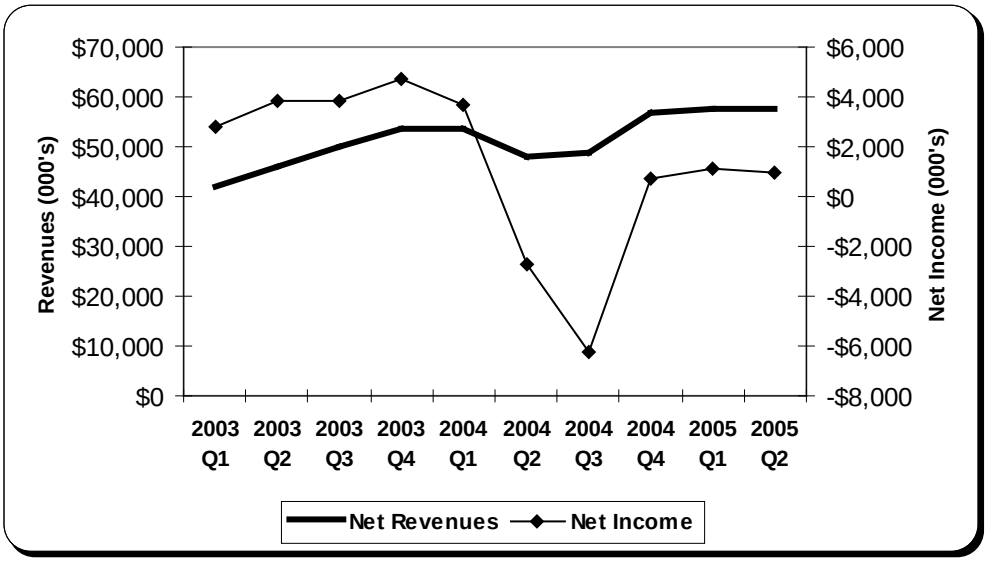
One of VistaCare's main priorities was to improve operational controls and reporting systems. In January 2005, David Elliot, Jr. was hired as President and COO. Rick Slager remained CEO and Chairman of the Board. Mr. Elliot had previously worked at a privately-held medical device company. As President and COO, Elliot's main charge was to refine the operations, with ultimate responsibility for the profit and loss. Carla Davis Hughes, EVP of Operations resigned her position in May 2005.

VistaCare has continued to struggle to control Medicare Cap Accrual issues, but has been able to maintain the "cap hit" at relatively modest levels: $1.5 million in 4Q 2004, 1Q

2005 and 2Q 2005, respectively. The hiring of as personnel slowed, as did the rate of new facilities opening.

Average Daily Census and Revenues remained relatively flat, presumably as VistaCare improved its operational controls. Figure 1 shows VistaCare's recovery in revenue and net income.

Figure 1: VistaCare Revenue and Net Income: 2003- 2005



(VistaCare 10Q Reports, 2003 – 2005)

Mark Leibner resigned as CFO on March 15, 2005. VistaCare is still in search of a replacement.

Question for After Epilogue is Read

It appears that VistaCare has "staunched the bleeding" by implementing more conservative growth strategies and implementing more operational controls. What are the appropriate next steps to renew top line revenue growth?

VistaCare Healthcare

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January, 2006

INTRODUCTION

Since its founding in 1995 as a for-profit hospice entity, VistaCare had enjoyed tremendous growth. In 1997, VistaCare had grown from its initial 2 sites to 7 sites in 4 states. By the end of 2003, VistaCare operated 40 hospice sites in 14 states. And the stock price reflected this growth: From its IPO in December of 2002, where the stock debuted at $12, it had risen to over $40 by December of 2003. Recent operational issues negatively impacting revenue growth and profitability had left Chairman and CEO Rick Slager and his management team with the unenviable task of informing investors that the firm had recorded a net loss for the third quarter 2004 of $6.2 million. In December of 2004, just one year after the stock had achieved its all-time high; it now wallowed at less than half that value.

What had happened in just a year's time? VistaCare had continued to invest in future growth by implementing aggressive marketing plans geared to spur the recruitment of patients for its ever-expanding number of hospices. But admissions growth had slowed. To make matters worse, VistaCare was plagued by unexpectedly high charges from its primary source of revenue, The Center for Medicare and Medicaid Services, for what was called "Medicare Cap accruals". In effect, VistaCare had to pay back large amounts of monies they had received from Medicare because they had failed to effectively manage their business to comply with Medicare guidelines.

Rick Slager and his CFO, Mark Leibner, needed a viable operations plan to turn VistaCare's business around quickly. At the same time, they needed to assess their various marketing programs to ascertain which were helping to grow revenues and which were not. More specifically, Slager and Leibner needed to decide whether or not to continue the aggressive spending on marketing programs in the face of deteriorating company financial performance.

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

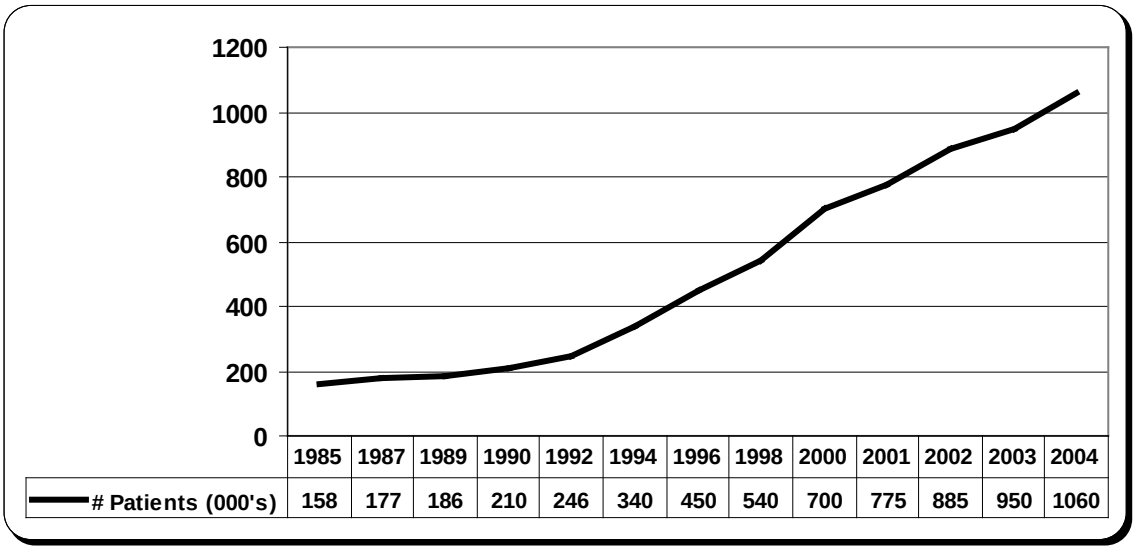
care for family caregivers to bereavement services for family members is traditionally offered.

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 also 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)

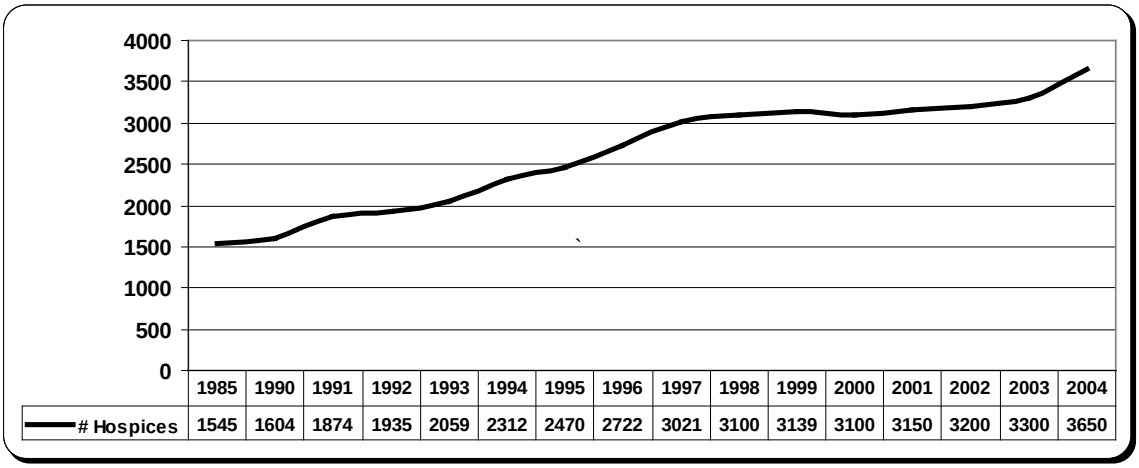


	1985	1987	1989	1990	1992	1994	1996	1998	2000	2001	2002	2003	2004
# Patients (000's)	158	177	186	210	246	340	450	540	700	775	885	950	1060

(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



	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
# Hospices	1545	1604	1874	1935	2059	2312	2470	2722	3021	3100	3139	3100	3150	3200	3300	3650

(NHPCO 2005)

Factors Driving the Growth in 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 2003, Medicare and Medicaid accounted for 97% of all hospice industry payments. Private insurance pays for an additional 3%. 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. These levels are summarized in Figure 3.

Figure 3: Hospice Reimbursement Rates by Service (2005)

LEVEL OF CARE	DESCRIPTION	PER DIEM RATE (2005)	% OF TOTAL MEDICARE PAYMENTS
Routine Home Care	Patient is at own home or nursing facility; hospice-led care-givers provide intermittent services.	$121.98	95%
Continuous Home Care	Patient is at own home or nursing facility; hospice employees are providing care for blocks of 8 – 24 hours per day.	$711.92	1%
Respite Care	Hospice employees relieve family member of certain care-giving duties for short periods of time to provide respite for the family care-giver.	$126.18	0%
Inpatient Care	Patient is at a hospice- run facility being cared for continuously.	$542.61	4%

(CMS 2005)

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 77% were Caucasian, and 65% were 75 years of age or older (NHPCO 2005).

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 46% of hospice admissions in 2004, this is down from 76% in 1992. Other ailments such as heart disease, dementia, debility, lung disease, kidney disease, and liver disease are becoming more common among patients admitted to hospice care. Charts depicting a more complete profile of hospice patients can be found in Appendix A.

Trends in Medicare-Certified Hospice Operations

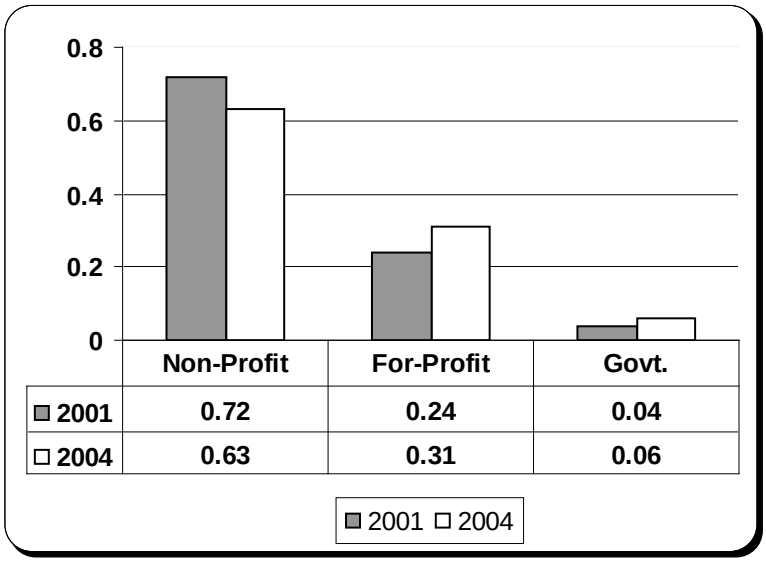
To be certified by Medicare, a hospice must be able to provide a wide range of both core and non-core services. Core services, which include nursing services, medical social services, and bereavement, spiritual and dietary counseling, must be provided by employees of the hospice. Non-core services, including 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, nearly 63 % of all hospices are non-profit, with for-profit operations comprising 31%. However, as Figure 6 below shows, the trend has been toward growth in the for-profit area.

Figure 4: Trends in Hospice Profit Status (2001 – 2004)



	Non-Profit	For-Profit	Govt.
2001	0.72	0.24	0.04
2004	0.63	0.31	0.06

(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.

Hospices have also traditionally skewed towards rural areas, most likely because of the relatively low penetration of other health-care alternatives in those areas. However, much of the growth in hospice care has been in the area of urban environments, where hospices

are complementing other health care providers, such as hospitals. Currently, 38% of hospices are in rural areas, 24% in urban, and another 38% are considered to be operating in both urban and rural areas (NHPCO 2004). See Appendix B for a Profile of Hospice Operations as of 2003.

For-Profit Hospices Grow in a Traditionally Non-Profit Industry

Up until the institution of the Medicare Hospice Benefit in 1982, there was little incentive for for-profit hospices to enter the industry. The Medicare Hospice Benefit, along with the dramatic growth trends in patients seeking hospice care, has attracted for-profit players. If one measures by average daily census (ADC), nine of the top ten hospice providers in the US are for-profit.

Figure 5: The Nine Largest Hospice Operations in the US (2004)

	PROVIDER	STATUS	EST. ADC	REV. ($MM)	INDUSTRY SHARE
1	Vitas Healthcare Corporation	Public; For-Profit	8,500	$490	10.9%
2	Odyssey Healthcare Inc.	Public; For profit	7,700	$360	8.0%
3	VistaCare Inc.	Public; For profit	5,200	$192	4.3%
4	Manor Care, Inc	Public; For – profit	4,500	376*	8.4%
5	SouthernCare Hospice, Inc.	Private; For profit	3,500	180 **	4.0%
6	Beverly Enterprises, Inc	Public; For profit	2,000	$87	1.9%
7	Trinity Hospice, Inc	Private; For profit	1,400	$72	1.6%
8	Life Path	Private; Not For Profit	1,300	$67	1.5%
9	Wellspring Hospice Care	Private; For profit	750	$38	.9%

(Based on market of $4.5 B)

* =Hospice and Home Health Care

** = estimated by Shattuck Hammond Partners LLC

VISTACARE

Origins and Growth

VistaCare, Incorporated is the third largest provider of hospice services in the US. It was founded in 1995 by Barry Smith and Roseanne Berry in Phoenix, Arizona. Less than 10 years later, VistaCare had hospice operations in 45 facilities across 14 states, and served an overall average daily census of nearly 5,300 patients. Revenues have grown exponentially, approaching $200 million for 2003. In 2004, despite its expansion in hospice sites, revenues receded to just over $150 million.

VistaCare's Overall Business Strategies

VistaCare's business strategies revolved around the following imperatives:

1) Controlling operating costs,
2) Managing patient length of stay,
3) Establishing scale and geographic breadth, and
4) The development of referral partners

Controlling Operating Costs

In November, 2003, VistaCare successfully completed a long-planned transition to a new billing system designed to streamline processes and prevent errors in applications for Medicare reimbursement which tend to delay timely payment. This system, called CareNation, has a number of hospice-specific applications which enable them to track patient admission and certification, enroll patients in a nationwide network of pharmacies, monitor patient census and length of stay data, automate their bereavement communications, and process Medicare and private third-party payer reimbursement claims. Similarly, VistaCare also deployed a separate Pharmacy Cost Control System, which involves a flexible, proprietary disease and symptom-specific drug formulary that emphasizes the use of generic drugs (if as effective as the brand-name alternative). VistaCare maintains a commitment to reducing their patients' use of treatments that are needlessly expensive or clinically ineffective. Collectively, these internal systems help VistaCare control operating costs.

Managing Patient Length of Stay

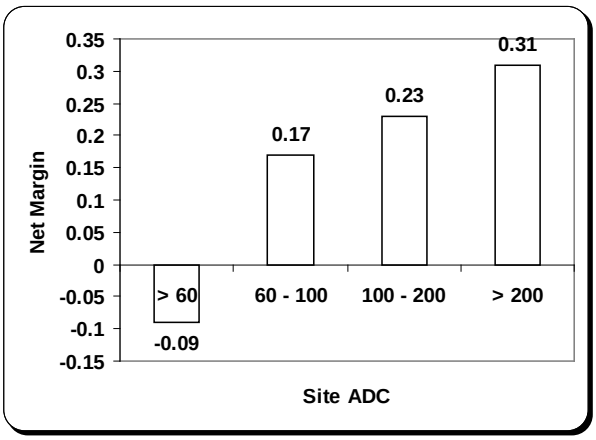
Patient length of stay appears to have the most impact on net patient revenue. Patient care expenses are usually higher during the initial and latter days of care. During the initial days of care, expenses tend to be higher due to initial purchases of pharmaceuticals, medical equipment, supplies, and 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.

Establishing 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 Figure 6 below.

Figure 6: The VistaCare Experience: Net Margins by ADC: 2004



(VistaCare Investor Day Presentation, May 17, 2005)

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. Management at VistaCare refers to their geographic strategy as "building out regional density" (VistaCare Investor Day Presentation, May 17, 2005). A recent example of this strategy can be found in the state of Georgia. VistaCare added 4 sites in Georgia in 2004 – 2005, essentially creating a cluster of sites around Atlanta covering 85% of the state population. VistaCare has similar clusters of operations throughout the Southeast, Southwest, Midwest and, to some degree, the East.

The Development of Referral Partnerships

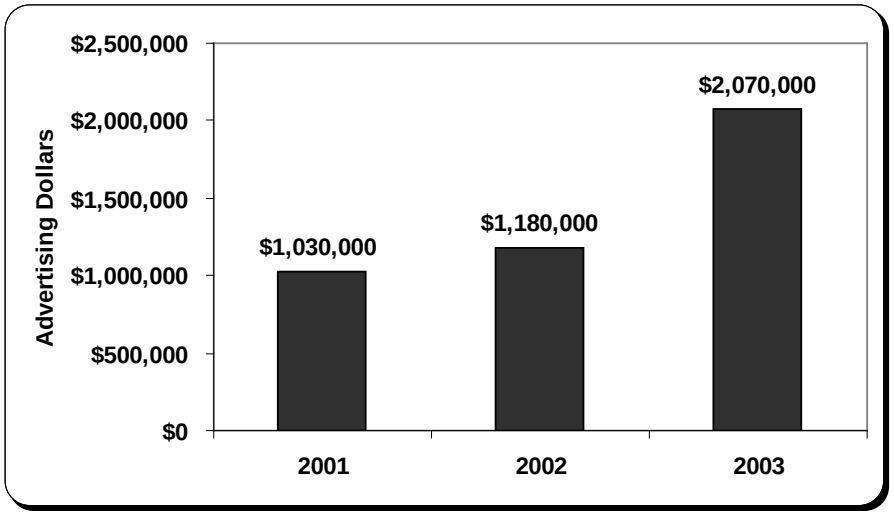
As previously mentioned, another trend toward aggressive marketing strategies in the hospice industry is to establish partnerships with hospitals and retirement communities. When these partnerships are established, the for-profit hospice relies on hospitals and retirement communities to generate referrals to their company. For example, when a person becomes terminally ill in a hospital or retirement community, a staff member from the organization will recommend that the patient seek hospice care with the partner hospice provider. These partnerships are a primary method used by for-profit hospices to increase admissions. For-profit hospices have created marketing departments specifically designed to promote referral growth. As of May, 2005, VistaCare had over 150 hospital contracts, as well as similar relationships with long-term care providers and managed care providers. (VistaCare Investor Day Presentation, May 17, 2005).

THE EVOLUTION OF MARKETING PRACTICES AT VISTACARE

Advertising and Promotions

Traditionally, the marketing strategies of nonprofit hospices have not utilized many resources of the firm. However, the for-profit firms are dedicating increasing amounts of their budgets to marketing activities – particularly the recruitment of referral partners. Figure 7 below shows the increasing trend of advertising expenditures at VistaCare from 2001 – 2003.

Figure 7: VistaCare Expenditures for Advertising (2001 – 2003)



(VistaCare Annual Reports 2002, 2003, 2004)

As a point of differentiation from its larger competitors, VistaCare promotes their "Open Access Philosophy", which means they will accept anyone who is eligible for hospice, regardless of the complexity of their medical needs. This "open access" policy is actually dictated by Medicare policy, but has not been stressed as explicitly by VistaCare's

leading competitors. The "Open Access Policy" has also been leveraged in the effort to convince patients and referrers to commit to hospice service in a more timely fashion (i.e., earlier in the progression of the terminal illness).

Personal Selling

As previously stated, VistaCare committed significant resources to establish personal selling teams to call on the various referring entities. Compensation plans were geared around numbers of referrals and types of patients obtained. In some cases, the teams specialize by type of client, such as nursing homes and oncology centers.

In June 2004, VistaCare created the new position of Vice President of Sales in their marketing department to further drive this critical aspect of their strategy. To date, they continue to aggressively recruit qualified candidates to aid in the pursuit of future growth. Other major for-profit hospices are pursuing similar strategies.

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, some 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. Vitas Healthcare, the leading for-profit hospice organization in the industry, distinguishes itself by specifically targeting 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 in the eyes of potential referral partners. Recently, VistaCare has seen the wisdom of offering inpatient facilities and has identified the establishment of IPUs (inpatient units) as a priority. In tandem with a regional density build-out strategy, VistaCare hopes to compete more effectively for referrals from large healthcare providers.

Distribution Strategy

The major for-profit competitors see rapid expansion and share growth as critical to their long-term success. All are using the following three methods of expansion to one degree or another: 1) organic census growth in existing operations, 2) acquisitions, and 3) the construction of new facilities. Capital costs to establish new facilities are relatively low. Thus, acquisition as a strategy for growth has been less attractive due to the relatively high cost of acquisition compared to the construction of new facilities.

VistaCare is focusing on both rural and the fringes of metropolitan areas to expand their business. Prior to 2005, their strategy focused primarily on rural areas, where competition was relatively benign, thereby improving the chances of ramping market share quickly.

Certification from Medicare is required to receive reimbursements from the government. Certification usually requires that a hospice be up and running for a period of several months, after which time Medicare will inspect he operation and certify the hospice. This, of course, means that a new hospice would have costs for several months with no income from Medicare, making the initial investment larger. To work around this issue, larger hospice operations make use of the stipulation that a hospice can operate within a 60 – mile radius of its certification. Thus, they use certified staff to establish hospices near the 60 – mile radius in order to operate under the other location's certification until the new operation can become certified. This insures consistent cash flow from Medicare. Once the new operation becomes certified, they can repeat the process to expand their operations into another 60-mile service area. Utilizing this process can cut the start-up costs for new hospices by up to 50%. VistaCare refers to this as their "leapfrog" strategy.

The Implications of a Fixed Pricing Environment

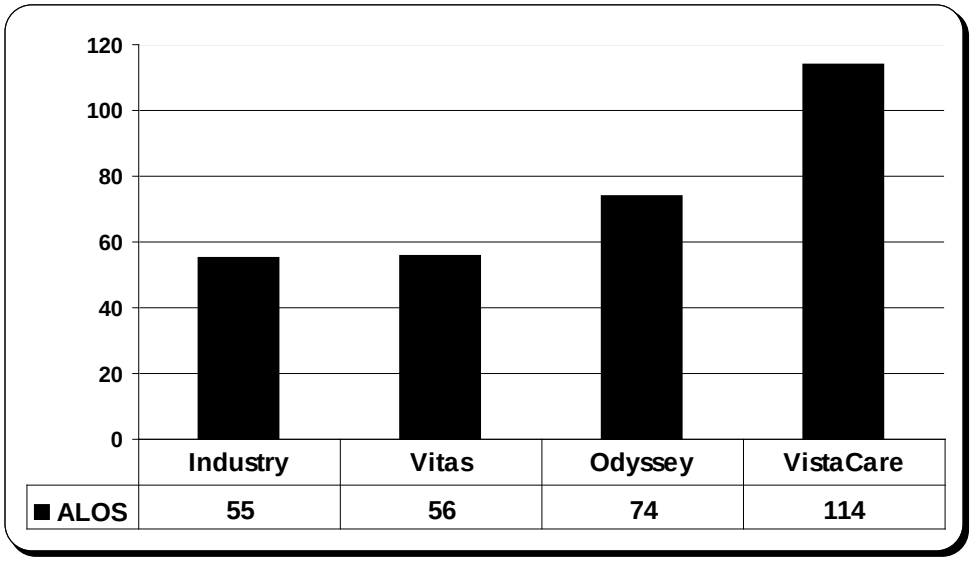
With over 90% of the revenues being obtained from Medicare and Medicaid, all hospice operators work under a fixed pricing system. Thus, the revenue function for a hospice operator is linear – a fixed per diem payment over time. The cost function, however, is not linear. The cost of a marginal day of 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). 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 primary implication of the linear revenue function and the U-shaped cost function is that 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.

Figure 8, below, shows the average length of stay for VistaCare as well as for the other two major for-profit operations and the industry overall. It is interesting to note that VistaCare, which touts an "Open Access Policy", has experienced considerably longer average lengths of stay.

Figure 8: Average Length of Patient Stay (2003)



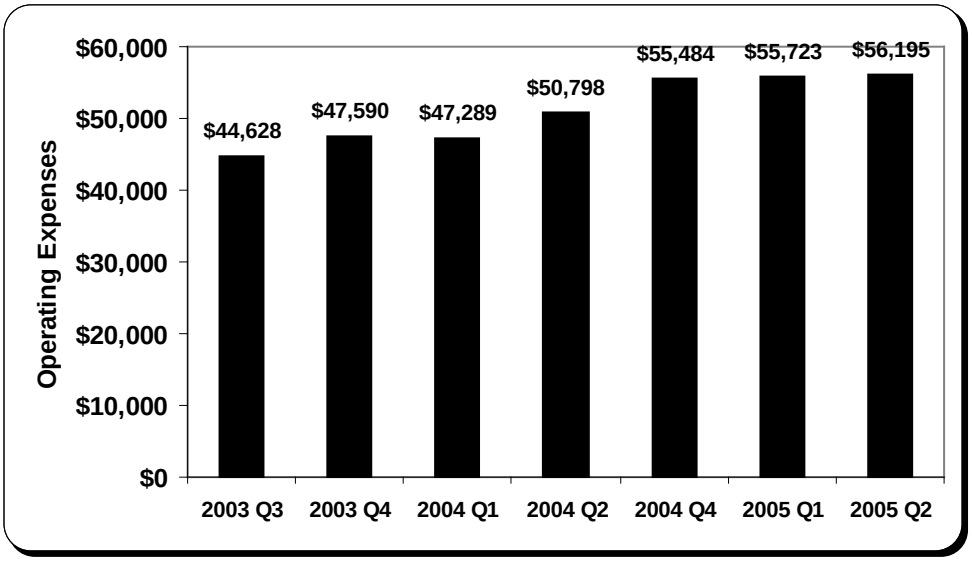
(NHPCO, Vitas, Odyssey, VistaCare Annual Reports 2004)

VistaCare must manage 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 Medicare Cap issue by attracting traditionally longer length of stay patients, and mitigating their impact by continuing to attract new patients with their inherently short tenures.

VISTACARE'S OPERATIONAL ISSUES

The year 2003 saw VistaCare seeking to expand its marketing activities with the expectation of increasing its admissions, particularly in some of the new sites it was launching. Among the key marketing initiatives was a hospital referral initiative: VistaCare was rapidly expanding its personal selling sales force (DPRs) and investing in training by retaining the services of an outside training agency. In addition, VistaCare revised its compensation structure for sales reps to provide incentives for enrollment at the program (local) level. This investment in personal selling continued into 2004. The number of DPRs expanded from 90 in 2003 to 141 in 2004, a 57% increase. Figure 9 shows the upward trend in operating expenses from 2003 to 2005.

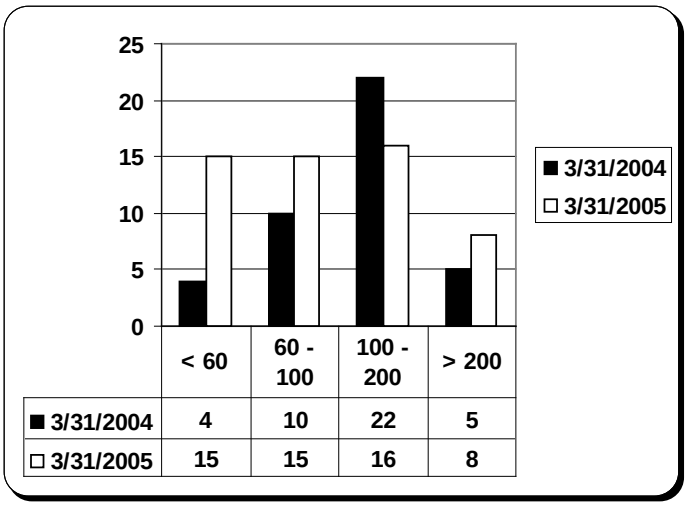
Figure 9: VistaCare Quarterly Operating Expenses (2003 - 2005)



(VistaCare 10Q Reports, 2003 - 2005)

2004 also saw a significant number of new sites becoming certified. As of March 31, 2004, VistaCare had 41 active sites. By March of 2005, there were 54 sites up and running. This amounts to an increase of 32%. Unfortunately, many of these new sites were operating at relatively low ADC levels, as Figure 10 below attests.

Figure 10: VistaCare Number of Sites by Site Size (2004 - 2005)

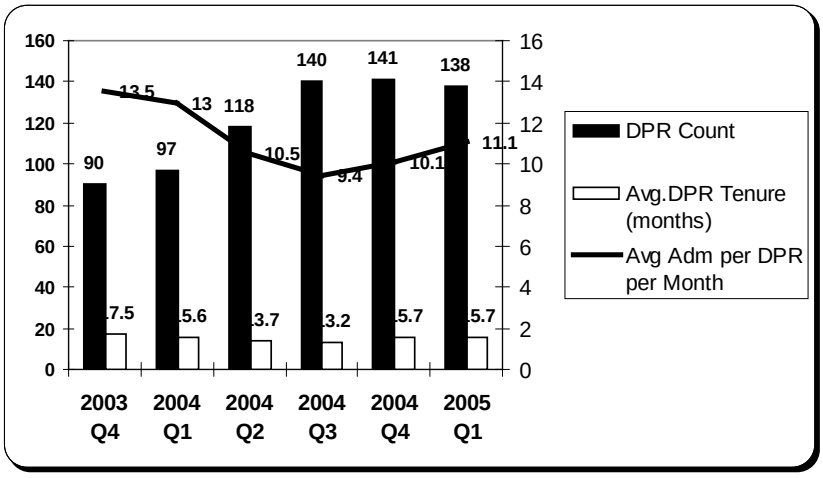


	< 60	60 - 100	100 - 200	> 200
3/31/2004	4	10	22	5
3/31/2005	15	15	16	8

(VistaCare Investor Day Presentation, May 17, 2005).

In addition, the new DPRs were not as productive in gaining referrals, due to the learning curve and the long sales cycle of relationship selling. Figure 11 shows the productivity of VistaCare's DPRs based upon tenure in the job.

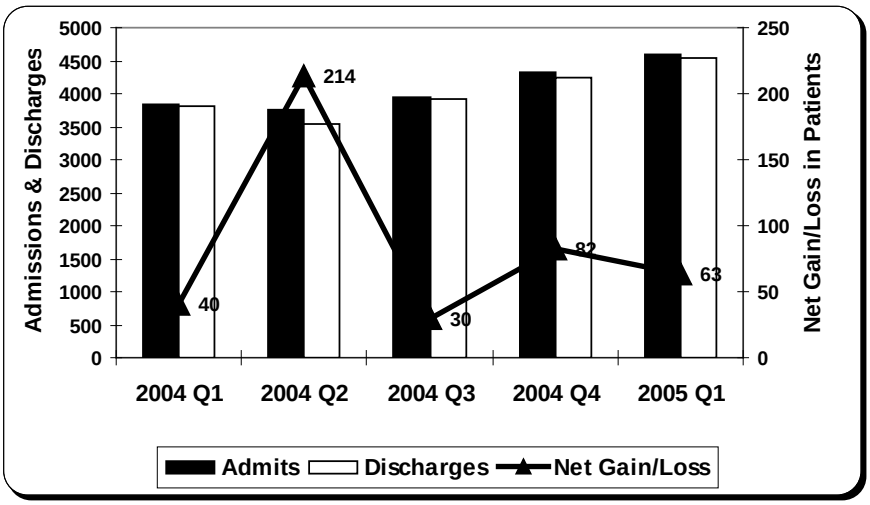
Figure 11: VistaCare Quarterly DPR Numbers, Tenure and Productivity (2005)



(VistaCare Investor Day Presentation, May 17, 2005).

The result of this lack of sales force productivity, perhaps exacerbated by the learning curve often involved in start-ups, resulted in a lack of net admissions growth in 2004, as is evidenced by Figure 12 below.

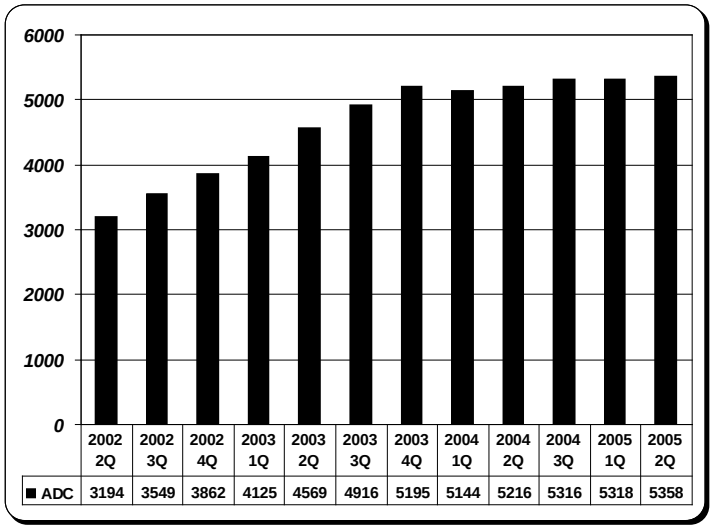
Figure 12: VistaCare Quarterly Admits, Discharges and Net Position (2004 - 2005)



(VistaCare Investor Day Presentation, May 17, 2005).

This dearth of net new admissions, in turn, led to a flattening of the Average Daily Census curve, as is shown by Figure 13.

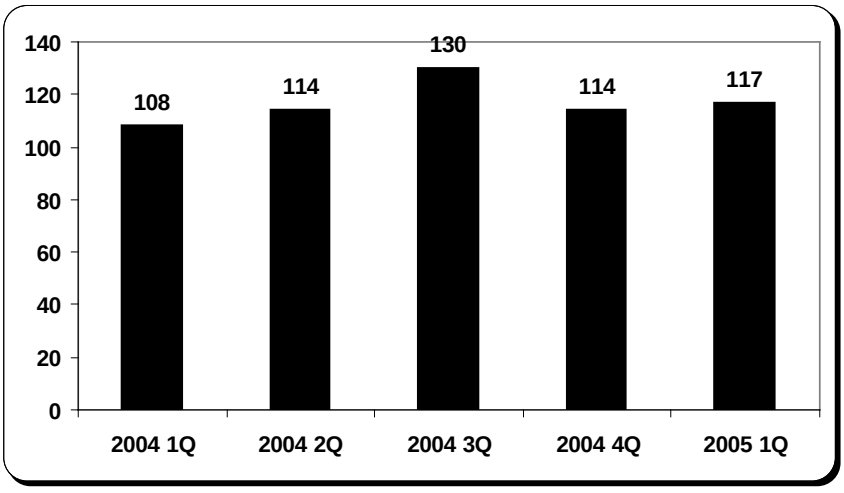
Figure 13: VistaCare Quarterly ADC (2002 - 2005)



(VistaCare Investor Day Presentation, May 17, 2005)

To further exacerbate the situation, VistaCare had issues in regard to their patient mix. Whereas the industry average for cancer-related hospice patients in the patient mix was 49%, VistaCare's mix of patients with cancer was running at 30%. Traditionally, VistaCare would specifically target non-cancer patients, as they would typically have longer average lengths of stay (ALOS), thereby boosting profitability. However, in the scenario of low ADC growth, the longer lengths of stay would prove to have an adverse impact upon the new sites, where lack of patient turnover would lead to issues with the Medicare Cap requirement. As Figure 14 depicts, during the first 3 quarters of 2004, average length of stay at VistaCare was surging to a high of 130 days -- over twice the industry average of 55 days.

Figure 14: VistaCare Average Length of Stay (2004 - 2005)

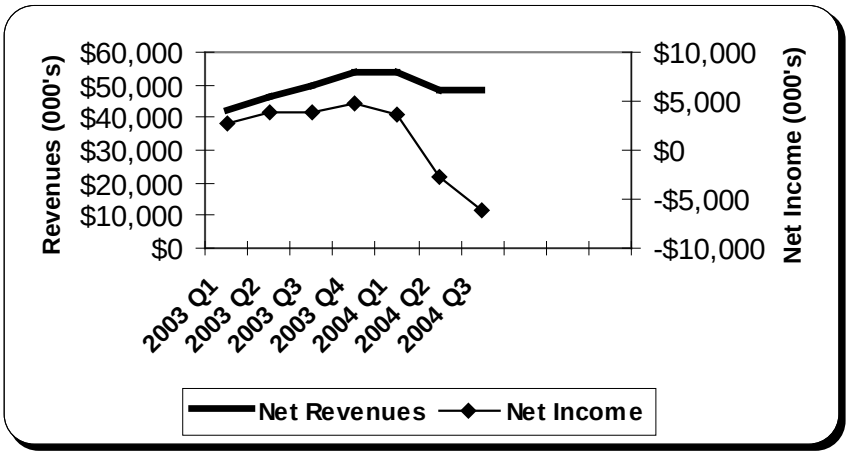


(VistaCare Investor Day Presentation, May 17, 2005).

VistaCare also faced a significant issue in the form of the Medicare Cap Accrual. Medicare caps reimbursements per patient per year at a fixed level (in 2004, that figure was $19,635.67). 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 an individual program during the period exceed the limit, the provider must repay the difference to Medicare. Since providers do not know if they have exceeded the limit until the end of the Medicare fiscal year (November 1), they must accrue accurately for this amount to avoid having an unexpected expense in the 4th quarter of the year. This can occur when hospices have patients with inordinately long lengths of stay. Assume the daily reimbursement rate for a typical hospice patient is about $125. A hospice with a patient who has accumulated more than 157 days in a given year would be "capped" at receiving the $19,635.67 per the guideline. Any days beyond 157 would not be paid for by Medicare, and essentially come right off the bottom line of the hospice. The Medicare Cap is compiled in an aggregate manner for each individual hospice site, by simply dividing the total Medicare dollars reimbursed by the number of new patients admitted in the fiscal year. This means that the hospice can mitigate their cap accruals by taking on patients with relatively short lengths of stay. They can then dedicate the "unused" portion of the $19, 635.67 of a short length of stay patient as a "credit" of sorts against the patients who are over the cap amount. Thus, proper cap management entails strict attention to patient mix.

VistaCare ran into serious Medicare Cap accrual problems in 2004, brought upon by an imbalance in patient mix and the resulting inordinately high length of stay in some of their programs. VistaCare had Medicare Cap issues in 9 of their 44 programs in fiscal year 2004, or 20%. In 2Q 2004, they would surprise their stakeholders with an accrual of $6.2 million, over 7 times the "normal" level of the previous quarter. The troubles continued: In 3Q 2004 they were forced to book an accrual of $7.8 million. These expenses are essentially taken out of top-line revenues, severely impacting the bottom line in those quarters, as Figure 15 attests. Refer to Appendix C for a more detailed profile of VistaCare's Income statement from 2000 – 2004.

Figure 15: VistaCare Quarterly Net Revenues & Net Income (2003 - 2004)



(VistaCare 10Q Reports, 2003 - 2004)

In December of 2004, CEO Rick Slager, CFO Mark Leibner and the rest of the VistaCare management team were likely sitting down to develop a plan to restore revenue growth and profitability to their operation. In addition, they were likely looking for the proper strategy to articulate to their potential customers, suppliers and investors that would renew their confidence in VistaCare's strategy going forward. In order to develop such a strategy, a number of issues were likely to be addressed:

1) What is the current situation in the industry? What is VistaCare's place in the industry? What imperatives, if any, exist for revenue growth and profitability in both the short term and the long term?

2) What factors, both internal and external, had led them to their current situation? Which were controllable, and which were not?

3) What elements of the marketing program were working effectively for them and which were not? Which should be retained or augmented? Which, if any, could be cut?

4) What is the best manner to move forward that will minimize the likelihood of a downside earnings surprise in the future?

It was clear that action must be taken immediately. The next few months might determine whether VistaCare returned to its high-growth, high-profitability glory days or languished in operational difficulty while competitors gobbled up share in the rapidly-growing hospice industry.

APPENDIX A: PROFILE OF HOSPICE PATIENTS (2004)

GENDER		
	Male	46%
	Female	54%
Ethnicity		
	Caucasian	77%
	African American	8%
	Hispanic	6%
	Asian/Hawaiian/Pacific Islander	2%
	Other	7%
Age		
	0 – 34	1%
	35 – 64	17%
	65 – 74	18%
	75 – 84	31%
	85 and older	33%
Diagnoses		
	Cancer	46%
	Heart-Disease	12%
	Dementia	9%
	Debility	8%
	Lung Disease	7%
	Kidney Disease	3%
	Other	15%

(NHPCO 2005)

APPENDIX B: PROFILE OF HOSPICE OPERATIONS (2003)

Ownership		
	Non-Profit	67%
	For-Profit	29%
	Government	4%
Affiliation		
	Free-standing entities	50%
	Affiliated with Hospitals	32%
	Affiliated with Home Health Agencies	13%
	Affiliated with Nursing Facilities	5%
Location		
	Urban	24%
	Rural	38%
	Both Urban and Rural	38%

(NHPCO 2004)

APPENDIX C: ANNUAL INCOME STATEMENTS FOR VISTACARE

VistaCare, Inc.
Annual Income Statements: 5 Year Trend
(Values in 000's)

	12/31/2004	12/31/2003	12/31/2002	12/31/2001	12/31/2000
Total Revenue	$207,051	$191,656	$132,947	$91,362	$81,595
Cost of Revenue	$135,204	$114,631	$79,752	$63,950	$55,256
Gross Profit	$71,847	$77,025	$53,195	$27,412	$26,339
Operating Expenses					
Sales, General and Admin.	$73,095	$55,784	$42,962	$30,716	$23,541
Other Operating Items	$4,060	$1,963	$1,349	$1,990	$1,797
Operating Income	$-4,402	$19,278	$8,884	($5,294)	$1,001
Add'l income/expense items	$967	$309	($112)	($111)	$194
Earnings Before Interest and Tax	$-5,369	$19,587	$8,772	($5,405)	$1,195
Interest Expense	0	$126	$935	$1,157	$1,497
Earnings Before Tax	-$5,369	$19,461	$7,837	($6,562)	($302)
Income Tax	($1,845)	$4,256	$281	$150	$81
Net Income-Cont. Operations	($3,524)	$15,205	$7,556	($6,712)	($383)
Net Income	($3,524)	$15,205	$7,556	($6,712)	($383)
Adjustments to Net Income	$0	$0	($4,052)	($3,839)	($3,482)
Net Income Applicable to Common Shareholders	($4,232)	$15,205	$3,504	($10,551)	($3,865)

(VistaCare Annual Report 2004)

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