Trends-in-Medicine

February 2004

By Lynne Peterson

SUMMARY

For-profit hospices generally expect length of stay to remain fairly constant over the next two years, but not-for-profit hospices are more hopeful they can extend it by reaching patients earlier. Half of hospice patients have cancer and less than 10% are admitted for dementia. Hospices would like to increase their dementia population because they are more profitable, but there is no concerted effort to market to specific types of patients. ♦ The perception of for-profit hospices varies widely, with Vitas considered a leader and Odyssey raising some eyebrows. Competition is heating up, with nursing home chains and others starting to get into the business. ♦ Currently, there is no increased level of regulatory scrutiny of the hospice industry. Cherry picking is not illegal, but not very common. Some hospices pay their sales reps a bonus for meeting patient quotas, but that also is not illegal. However, concerns have been raised about how some hospices pay their medical directors.

Trends-in-Medicine
Stephen Snyder, Publisher
1879 Avenida Dracaena
Jensen Beach, FL 34957
772-334-7409 Fax 772-334-0856
www.trends-in-medicine.com

TRENDS IN THE HOSPICE INDUSTRY

Hospice began as a small volunteer movement, but it is quickly becoming big business. The Hospice and Palliative Care Nurses Association (HPNA) and the American Academy of Hospice and Palliative Medicine (AAHPM) held a joint meeting in Phoenix AZ from January 22-25, 2004. Twenty-five hospice experts were interviewed, including medical directors, nurses, social workers, officials of for-profit hospice companies, and an official from the Centers for Medicare and Medicaid Services (CMS).

The Hospice Industry in 2002 *

Business model	%
Non-profit	78%
For-profit	17%
Government	5%
Type	
Free-standing	50%
Affiliated with hospitals	32%
Affiliated with home health agencies	19%
Affiliated with nursing facilities	1%
Demographics Served	
Urban communities	24%
Rural communities	38%
Both Urban and Rural	38%

*Source: National Hospice and Palliative Care Organization (NHPCO)

THE PATIENTS

The average length of stay at a hospice is 50 days. Among these sources, the average was 48 days. Increasing length of stay is important because patients who stay in hospice longer tend to get less expensive to manage. A source explained, "Our greatest effort is in the first few days a patient is in hospice as that's when we deal with pain, breathing, constipations, etc. Then it quiets down in a couple of days, and we can work on other issues…If new patients on expensive medications are gotten early enough, they get tired of the medication and stop it, so they get less expensive with time." A California medical director said, "It's in my contract to get the average length of stay up from 45 days to 50-60 days…We will always have a crisis population that goes up and down, but we can get people on hospice earlier."

Medical directors of most not-for-profit hospices said they want to increase their average length of stay, and they generally expect they will be able to drive it up by

several days over the next year or two. A Massachusetts medical director said, "We want to increase our length of stay. The key problem is the decision to do hospice. The hospital takes its time making a recommendation." Another medical director said, "Our goal is to increase length of stay, and we think that will happen with the hospice Medicare benefit." A third source said, "Right now, the specialty has a challenge to prove the cost savings of hospice." Another said, "The challenge to the hospice industry is to move our skills farther upstream to catch patients earlier."

In contrast, an official of a for-profit company doesn't expect his company's length of stay to change much in the near future. Rather, he expects it to hover around 56 days. He said, "I don't see a big change because physician attitudes change slowly."

On average, sources said 13% of their patients are in hospice care more than 180 days, and 23% less than seven days. However, they agreed there is no magic number of patients over 180 days that is likely to raise scrutiny from regulatory agencies. A source said, "There is not really a level. It's up to each fiscal intermediary." Another source said, "There is no magic number that triggers scrutiny."

Several of these sources have been audited or surveyed for potential Medicare fraud, but all said they had been vindicated. The medical director at a not-for-profit hospice in New England said, "We were audited, and we were in the clear…We had a 100 patients, and we dropped to 20, but now we are up to 30. We underwent a focused medical review, and the regulators looked at lots and lots of charts, but they agreed with all of ours. But it was a huge fear factor for us, and referrals went down for a while. And we wanted the numbers lower for a while for fear of more reviews." A California medical director said, "In San Diego, we had a focus review, and we had to refund $1 million to Medicare, but we appealed that, and we got it all back." A for-profit medical director said, "Five or six years ago the Office of the Inspector General (OIG) investigated fraud in Puerto Rico. They looked at us, but they didn't find anything, and then they left us alone." Another source added, "Operation Restore Trust by the OIG was focused on home health, but it drifted to hospice. Investigators only found one really bad apple – in Puerto Rico – which was billing for arthritis patients…Medicare wanted $1 million from Florida Suncoast, but never collected because of public outcry. However, Medicare established criteria that has been problematic for the hospice industry ever since."

Nationally, 50% of hospice patients reportedly are cancer patients, and that is exactly what, on average, these sources estimated. Dementia patients comprise 8% of hospice patients nationally, but an average of 10% among these sources. A not-for-profit medical director said, "We've seen an increase in non-cancer patients, especially dementia patients." A nurse said, "We have more dementia patients because they come from nursing homes."

Cancer patients are considered less profitable than dementia patients because (a) they are more expensive to care for in a hospice program than dementia patients and (b) they tend not to live as long. Cancer patients use more medications, perhaps some palliative radiation, etc. During one lecture at the meeting, half the audience indicated they provide chemotherapy to at least some patients at their hospice.

Dementia patients, on the other hand, require more time, but they are still less costly than resource-heavy cancer patients. A New England medical director said, "Cancer patients take more resources, but dementia patients' families need more support." Another source said, "Time is more important than the diagnosis. Hospices are on more solid financial ground with time…COPD, heart failure, and dementia patients are hardest to accurately forecast. They are hard to plan. Smaller organizations (<15 patients) need to focus on payor sources, diagnosis, and treatment that is being accepted or they won't be viable." A South Carolina not-for-profit medical director said, "Dementia patients are more profitable, so we would like to drive that part of our business." A for-profit medical director said, "The high cost patients are those with AIDS, those who need transfusions, and patients who demand procedures. Dementia patients are reasonably inexpensive; they are generally bed-bound, non-verbal, and require little care unless they are tube fed. Cancer patients are ambulatory." A for-profit official said, "There is a longer length-of-stay with dementia patients, but they use less medications. Dementia patients are more work, but they are more profitable…Our biggest cost is salaries." Another source said, "Cancer patients are easier to deal with, but you can't cherry pick." An Illinois for-profit medical director said, "Dementia patients are the easiest to care for, the least expensive, and have a longer length of stay."

Some hospice officials suggested that they provide unlimited cancer care, but sources were dubious that this can really be done without cutting services. It is a matter of economy of scale, sources insisted. The assistant medical director of a large not-for-profit hospice said, "With a larger mass, a hospice can be more inclusive. We can provide palliative radiation or transfusions because of our size." A California medical director said, "Nursing home patients are less expensive to take care of, and some hospices have a target of 50% of their patients in nursing homes. That gives them economies of scale and requires less travel. It isn't the diagnosis; it's where the patients are." A for-profit medical director said, "Probably not. The cost of treatment would exceed reimbursement."

On average, sources said 46% of their hospice patients are in nursing homes, which is considerably higher than the industry average of 22%. A for-profit official said, "About 10% of nursing home patients are eligible for hospice at any given time."

Sources offered mixed opinions about whether providing hospice in a nursing home is more profitable than at-home or in-house patients. A for-profit medical director said, "It is difficult to treat patients in a nursing home because of state oversight and state staffing regulations. The nursing home staff may not buy into our practices. And it is more problematic caring for patients in nursing homes...Suddenly nursing home aides don't have time to bathe patients, etc…Nursing homes are under fire from economics, regulations, lawsuits, and staffing." A Florida medical director said, "Nursing home hospice care isn't less profitable because of the patient concentration." A for-profit official said, "It's debatable. There is less travel time with patients in nursing homes, but they require the same care, so there is a give and take." An Illinois for-profit medical director said, "Nursing home patients are the ones that keep hospices going. They give you more control over how aggressive you need to be." Another source said, "Nursing home patients come to hospice too late and for too short a time, so we prefer non-nursing home patients." A nurse said, "We'd rather have home patients than nursing home patients, which have a high turnover and turf issues."

MARKETING

Much of hospice marketing is word-of-mouth referrals from patients, their families, and doctors. A medical director said, "The doctors know me, I talk at hospital medical meetings, and they see me on the (hospital) floor when I'm doing rounds." Another said, "Patients come from referrals, networking, and word-of-mouth. When you are present and visible, people ask. It is more like a grassroots effort." A California medical director said, "Churches, hospitals, and nursing homes all refer patients." An Illinois medical director said, "Our marketing is through education, doctors, and nursing homes."

Sources all insisted that their hospice – and all the hospices they know – accept a broad range of patients. Very few qualified hospice patients are turned away by hospice programs. The exception is a situation where a hospice doesn't have the staff or expertise to handle a particular type of patient. The medical director of a not-for-profit hospice in Massachusetts said, "Our goal is to keep solvent, but we make no effort to balance our mix." Another not-for-profit hospice medical director said, "Even if we wanted to target specific types of patients, the doctors would know, and they would get really upset and take their business elsewhere. Doctors like to advocate for patients." A California medical director said, "My advice is to take all the patients."

Generally, hospices do ***not*** reject patients, even difficult-to-treat patients. Rather, they usually target patients broadly and market broadly. Sources insisted that they are not seeing either for-profit or not-for-profit hospices target only specific, lower-care diagnoses (e.g., dementia) or even put an emphasis on those types of patients. An Arizona medical director said, "A hospice can specialize, but not if it is the only hospice in town."

Yet, hospices sometimes use approaches in their own markets that may funnel more of one type of patient or another to that hospice. A medical director said, "Every hospice has its own expertise and comfort level…In Chicago, you often see strategic alliances between a hospice and a hospital." The director of a hospice that merged with a local Visiting Nurse Association (VNA) said, "We've had a lot of success with palliative care. We get those patients much earlier, and there is reimbursement for that…We pick up patients earlier in VNA and that increases our hospital referrals…VNA plus hospice is a local phenomenon, but palliative care is growing nationally." Another source said, "What happens is that some hospices get known for what they do, like dementia. If they do that well, they get known for that expertise."

Hospices also may put marketing emphasis on a particular category of patient – oncology if they are near a major cancer hospital, nursing homes, etc. A not-for-profit medical director said, "For-profits send marketing people to nursing homes to solicit patients. They train the nursing home staff and lease beds, so there are trade-outs. For-profits do this more and better than most not-for-profits."

The marketing practices of the for-profit companies do not appear to differ significantly from the not-for-profit hospices, except that for-profits generally market more aggressively. A not-for-profit medical director said, "I've heard concerns from local hospices when a for-profit with large resources moves in…There are a lot of naïve people looking at home health care, assisted living, and hospice because of the reimbursement." A South Carolina not-for-profit medical director said "We market by going into the community and through doctor outreach. For-profit hospices give out free sandwiches and pens, but we don't offer any free lunches or free pens. We made a social worker the community liaison." A for-profit official said, "We market to the referral community – doctors, nursing homes, outreach programs, support groups, etc."

THE HOSPICE STAFF

Medical directors are very important to the operation of a hospice. Two doctors – the attending physician and the hospice medical director – must certify that a patient meets the criteria for entry into a hospice. A medical director ***alone*** can re-certify a patient to remain in the hospice. That is, the medical director can sign as both the attending and the hospice medical director for re-certification.

It is not uncommon for a hospice to have a full time medical director and several full or part-time assistant or associate medical directors. This practice generally does not appear to be a concern to hospice officials – provided the part-time medical directors actually work for their salary. One official

said, "I can't say there shouldn't be part-time medical directors." Another medical director said, "We had associate medical directors, all of whom had been in private practice, but they went full time hospice."

However, charges have been made that some hospices are hiring multiple associate medical directors as a way to provide referral streams. The allegation is that some of these associate medical directors don't actually perform hospice duties, that they simply are paid to send patients. A for-profit official said, "I heard some for-profits have seven to 10 medical directors to get referrals."

A CMS official said medical director duties and referrals could be a warning flag to regulators. He explained, "The medical director has to be part of the treatment team, and they have to work to be sure the patient is appropriate…If a hospice wants 10 medical directors, that is not a Medicare issue – unless there is impropriety in referring patients…It would be a yellow flag if the referrals were from an associate medical director."

Salaries of medical directors are a hot topic right now. There was even a course at the meeting to advise attendees on what salaries are proper and appropriate. A speaker suggested the following schedule is the industry average and warned hospices about varying substantially from this.

Status	Salary	Salary + Fee-for-Service
Full time administrative	$150,000-200,000	N/A
Full time patient care	$125,000-160,000	N/A
Part-time administrative	$40,000-60,000	N/A
Part-time patient care	$35,000-45,000	$20,000 - $30,000 + 80%-90% of Medicare allowable

Most hospices – not-for-profit and for-profit alike – have marketing or sales reps, though most call them by other names, such as customer service reps, community outreach people, or community education reps (CERs). A Texas nurse said, "Our Community Education Reps target different portions of the city. They see doctors the way drug reps do, and they market to the hospital, gerontologists, general practitioners, and oncologists. We take all comers…Long-term acute care hospitals are good referral sources…We also guarantee a three-hour response from the time the call comes in to when we have someone at the patient's bedside to talk with the family. That is important to doctors."

Sources all agreed that neither medical directors nor marketing reps get a "finder's fee" or bonus for signing up hospice patients. However, some for-profit hospices – but none of the not-for-profit hospices questioned – set goals or targets that marketing reps are expected to meet, and some give bonuses or rewards to the reps for meeting those goals. Medical directors – and some marketing reps – get bonuses based on the company's overall performance, but not the patient census. A Manor Care official said their customer service reps get a salary plus a bonus based on company performance. Another source said, "Vitas has a history of good sales. It is good at incentivizing sales, with a bonus for meeting goals." A for-profit medical director said, "Our sales reps are salaried, but they have quotas…and some are worried about meeting their goals." A for-profit official said, "Our medical directors can earn a bonus based on the overall performance of the company, but it is not based on the patient census, admissions, or referrals. We are careful not to create an inducement." A nurse said, "Our marketing reps get a bonus for meeting a quota." A CMS official said, "If a hospice rewards staff for making goals, it is not a Medicare issue."

Sources were asked who is liable if an enrolled hospice patient is found ineligible – the medical director or the referring (attending) doctor. Most sources tried to avoid answering this question directly. They did not want to put the blame or responsibility on any one individual. One source said, "Both the medical director and the referring doctor would be responsible. Throw a lot of mud, and everyone is named."

THE DARK SIDE OF HOSPICE

Some hospices have policies that are raising eyebrows, including:

- **Avoiding private pay patients.** The medical director of a not-for-profit hospice said, "There are organizations that look at the payor source to see if there is a Medicare benefit, and if the patient doesn't have Medicare, they won't take the patient." An Illinois for-profit medical director said, "We have less than 5% private pay patients…We shy away from them."

- **Churning.** A source said, "There are reports of unethical practices that churn patients in and out of hospice." However, this source did not identify any specific hospice doing this.

- **Cherry picking.** This is not a violation of Medicare rules, but most hospice directors frown on it, and none admitted to doing it. However, one medical director said, "There is cherry picking more out of ignorance than anything. It happens especially with ESRD patients, which are very concerning for smaller organizations." Another medical director said, "Some for-profits will deny a patient, but we wouldn't. They also refuse chemotherapy or transfusion patients, and we don't refuse them." A for-profit medical director said, "Some do cherry pick, but it is getting harder to do that because of increased competition." A CMS official said Medicare regulations do not prohibit cherry picking patients.

Most hospices accept private pay patients as well as Medicare patients, but not-for-profit hospices have a higher rate of private pay patients nationally (40%). A Vitas medical director said private pay patients account for <10% of its

clients, but he insisted the company does not avoid those patients, "We take all comers. We don't turn away private pay patients." A for-profit medical director speculated, "It could be the catchment area and a lack of economy of scale." Another for-profit official said, "Some non-profits focus on private pay patients to avoid certification by Medicare."

REGULATORY ISSUES

Sources generally described the Medicare reimbursement for hospice as "fair to good." There were few complaints about reimbursement. Medicare requires that patients have the right to choose their hospice provider. A CMS official said, "We emphasize that providers have an obligation to list a variety of people who can provide the services."

Several years ago, there was federal scrutiny of the hospice industry, and several sources said their hospices were investigated, but sources did not know of any current investigations that are ongoing.

180-Day Rule

Under Medicare rules, hospices are only supposed to admit patients to their program who are not expected to live more than 180 days. However, predicting when someone will die is more of an art than a science. Thus, there is a small percentage of patients who remain in the program more than 180 days. On average, 7% of hospice patients go over 180 days, but sources said the number is actually much higher. Sources insisted there is no magic number at which the percent of patients in a hospice longer than 180 days would raise scrutiny from regulatory agencies.

Medicare Cap Rates

CMS officials did not see this as a problem, but it is not uncommon for a hospice to occasionally exceed the Medicare cap rate. An assistant medical director at a large not-for-profit hospice said, "The cap rate is a moving target, and sometimes organizations, as they grow, haven't paid attention to this, so they periodically exceed the cap rate." A for-profit official said, "If you exceed the cap, you can serve patients, but you don't get paid for them…Cap problems occur in rural, remote areas where the population is under-served by hospice. They come in early and stay longer."

Cherry Picking Patients

As explained above, cherry picking does not appear to be a significant problem in hospice – at this time. Furthermore, even if it were occurring, it probably is not illegal. A CMS official said he does not believe cherry picking is a violation of Medicare rules and regulations. This official also said he is not aware of any ongoing regulatory scrutiny of cherry picking, at least in his region (California, Arizona, Nevada, and Hawaii). He said, "Sometimes a hospice can't accommodate a patient because of the patient's other medical complications. Then, it can say, 'We can't provide the services you need, but another hospice can.' I'm not sure if it can turn down a cancer patient in favor of a dementia patient, but I don't think most do that…Focused marketing is okay, but I haven't seen it, and I haven't heard any complaints about that."

Regulatory Oversight

A CMS official said he didn't know of any serious investigations ongoing about hospice or hospice practices. He commented, "We (at CMS) are cracking down, even on hospice, but we go where the money is – and there isn't much money in hospice. We also have less money to investigate under President Bush…But I'm not aware of any fraud in hospice in our region." A for-profit official said, "The level of regulatory scrutiny right now is just average."

The official said that if an infraction were reported, it would be referred to the state licensing agency which "must investigate and make a recommendation to the regional CMS office, which has the authority to revoke the hospice's provider number." Even if the infraction is reported directly to CMS, CMS will refer it to the state to investigate first.

Few sources – including CMS officials – were aware of any increasing regulatory scrutiny on the for-profit hospice companies or the hospice industry in general. There have been a few fraud investigations in the past, but nothing serious appears to be pending. However, one source said, "Regulators are particularly interested in the criteria for why a patient changes status. Is the change in services justifying the change in status? A company that generates unusual profits will bring additional scrutiny on all of us."

Regulatory Changes

Sources were dubious that CMS will impose a DRG-type system for hospice any time in the near future – if ever. A California medical director said, "The government was looking at cutting reimbursement to hospice patients in nursing homes, but they dropped that idea after not-for-profit lobbying." A for-profit official said, "There's been talk of that, but I don't know what will happen." Another for-profit official predicted hospice would never move to a DRG. A third source said, "I'm not sure it is feasible to move to a DRG for hospice because how can you predict spiritual needs, etc.?" A Colorado medical director said, "I heard CMS was going to change the per diem, basing it on where the patient is in the admission process – a higher payment for the first few days and then reducing that." Another expert said, "I can't see why the government would do that…Medicare has already limited hospice with the prospective payment system…I recommend a change in the time from admission payment, but I'm not hearing anything about that happening."

CMS officials suggested the trend is toward PPS. One said, "I think the PPS trend will continue until all providers are in PPS Part A, and on a fee schedule on Part B. But that won't happen soon. We have other providers before hospice. We are working on specialty hospitals now…Currently the level of services and the status of the patient determines payment, with four levels. PPS is likely to be based on frequency and intensity of services, and that probably means added payment categories (>4)."

Nursing Home Pass-Through Payments

When a Medicaid patient in a nursing home opts for hospice care, the patient can still remain in the nursing home, but the care shifts to the hospice organization. Medicaid starts paying the hospice (at 95%) for both the hospice care and the room and board, and the hospice is responsible for paying the nursing home for the room and board it provides. This is referred to as the nursing home pass-through. Thus, if Medicaid had been paying the nursing home $100 for Mrs. Jones' room and board and care prior to her entering a hospice program, it would switch to paying the hospice instead, but the hospice would only get 95% or $95. The hospice then would have to reimburse the nursing home for the room and board it provided; this is called the pass-through payment.

How hospices handle the pass-through varies considerably.

- **<100%.** Some hospices pay nursing homes exactly what they receive from Medicaid (e.g., the $95).

- **100%.** Others make the nursing home "whole" and pay the original amount (e.g., $100), making up the extra $5 out of their own pockets. A Texas medical director said, "We pay the nursing home 100%. It is not illegal. The nursing home gets the same money, so it has no dis-incentive to refer patients, and no incentive to refer patients." Another source said, "We pay nursing homes 100% or less…We never pay more than 100%…How much we pay depends on the contract…You have to have nursing home contracts on services…If we paid over 100%, it would be an inducement unless it was for supplies (DME, drugs, etc.) at fair market value." A Colorado medical director said, "We pay 100%, which our lawyers say is okay. More than 100% would be an inducement, unless we were paying for defined functions."

- **>100%.** A few pay more than 100%, generally by negotiating a formal contract with the nursing home under which the nursing home agrees to be responsible for certain duties or services in return for the higher payment. A CMS official said, "Hospices can pay nursing homes 100% of the pass-through. I'm not sure that more than 100% would be an inducement; that is between the hospice and the nursing home. Unless there is undue influence (on patients) from the nursing staff, I don't see a conflict with Medicare rules."

CMS officials said all of these practices appear to be legal – provided the nursing home is providing real services for any extra money. Then, the additional money would not be construed as an "inducement" to refer patients to hospice.

Sources do not expect – and do not want – the pass-through system to be eliminated in the future. A for-profit medical director said, "I hope not. We keep patients out of the hospital, which saves money…If the pass-through were eliminated, it would decrease care in nursing homes." Another for-profit official said, "My state and one other doesn't have pass-through now, but we still see patients in nursing homes." A third for-profit official said, "Eliminating the pass-through would eliminate the incentive for nursing home companies to outsource hospice."

FOR-PROFIT HOSPICE COMPANIES

While the industry is still dominated by not-for-profit hospices, there are a growing number of for-profit companies. The image of for-profit hospices is very company-dependent. A medical director said, "A hospice is not a hospice is not a hospice…Branding is one way to market, and this is a big advantage for for-profits." Another source said, "There are some bad apples, especially in some markets, where hospices are looked at as potential acquisitions. These tend to be more liberal in the definition and diagnosis, with a good increase in their patient numbers in hope of selling to a for-profit…The for-profit are a concern for the future." Another medical director said, "Some for-profits have higher standards than a lot of small hospices." The medical director of a for-profit hospice said, "We don't charge co-pays or for diapers, etc., and many for-profits do that…We also pay taxes, but they don't – and they don't provide more services." A source said, "In my town, we had a not-for-profit hospice and a for-profit hospice. The for-profit was more motivated to take care of indigent patients. They worked hard to show they weren't cherry picking." Another source said, "I'm not aware of any for-profit hospice gaming the system, but they have a more corporate mind-set. They are well-informed on Medicare rules and very legalistic."

The most common criticisms of for-profit hospices were:

- **Foundations**. Often, for-profits set up subsidiary foundations that allow them to accept donations. Some not-for-profit medical directors worry that for-profit hospices are using the foundation money to lower their costs, which would be illegal, but for-profit sources insisted the funds are used only for education and scholarships, not for patient care. An Illinois for-profit medical director said, "We have a foundation, and we use the money to help families."

- **Cutting services, including volunteers**. A not-for-profit medical director said, "We are mandated to have 5% of our hours from volunteers, and some for-profit hospices don't do that. For-profits are worse at attracting volunteers."

- **Focus on margins.**
- **Cherry picking**. A few not-for-profit competitors complained that for-profits pick and choose only the most profitable patients, but most sources do not believe much of this occurs. A Florida medical director said, "I don't think hospices would do that, but there are no regulations to stop cherry picking…Some hospices do refuse patients without a DNR (do not resuscitate) order…and a phone survey found that a number of hospices won't admit patients with costly interventions." A Colorado medical director said, "It is legal to cherry pick. It's done all the time if you have criteria. You can bar TPN patients if you say you don't have staff qualified to care for them."

Many not-for-profit hospices have never faced any competition from another not-for-profit hospice much less a for-profit one. In some cases, that is because they are in a Certificate of Need (CON) state, which limits competition. Or, the hospice may be in a rural area or a state where the regulatory burden to opening a hospice is high. Most for-profit hospice companies have, understandably, chosen to concentrate first on states with lower regulatory hurdles. The medical director of a not-for-profit hospice in New England said, "I would be concerned if a for-profit hospice came into my area. If it did, I would redouble my communication with doctors."

Sources offered a variety of reasons – none definitive – on why some of the for-profit companies have been able to generate much higher profit margins (15%-20%) vs. not-for-profit hospices. A medical director said, "They discharge patients who are on a lot of active therapy." Another medical director said, "They control pharmacy costs. They may use a lot of methadone instead of OxyContin (Purdue Pharma, oxycodone)…Maybe they are running it like a business." A for-profit official said, "They manage salaries better, and salaries are more than 50% of revenue, maybe even 75%. If you do business where labor costs are lower, you do better even if the reimbursement is lower." Another for-profit official said, "For-profits can buy in bigger volume." A medical director whose hospice was recently purchased by Odyssey said, "Odyssey's profits are higher, but I don't know how. I hope it is economy of scale, centralized payroll and purchasing. I haven't seen any evidence of them short-changing patients." Another expert said, "A fat profit margin is a flag, but I'm not sure how they are doing it, but it would have to be clearly wrong – not just something marginal – for regulators to attack a hospice company."

For Profit Hospice Companies

For-Profit Hospice Companies	Average daily census	Number of sites	Locations
RotoRooter's Vitas	8,100	25	8 states: California, Florida, Illinois, New Jersey, Ohio, Pennsylvania, Texas, Wisconsin
Odyssey	6,500	66	29 states
VistaCare	5,000	40	N/A
HCR Manor Care	4,203	80	N/A
Southern Care	3,400	51	12 states: Alabama, Georgia, Indiana, Kansas, Louisiana, Michigan, Mississippi, Missouri, Ohio, Pennsylvania, South Carolina, Texas
Hospice South	N/A	22	3 states: Alabama, Mississippi, Tennessee

Some for-profits have excellent reputations, and some do not. Following is a discussion of the major for-profit companies.

VITAS

This company has an exceptionally good reputation among these sources. They praised the company for its ethics, services and commitment to the field. Not surprisingly, there were quite a few laughs and jokes about Vitas' purchase by RotoRooter. A Vitas medical director said, "I'm concerned about RotoRooter because I'm the highest paid doctor in my branch. Why would they buy Vitas when they aren't in healthcare? I wonder who they will turn around and sell us to." Another source said, "The fear is that RotoRooter will gut Vitas, milk it." A nurse said, "I'm impressed with Vitas, especially the Duke University project on spirituality which it funded. Vitas works with the community at large, not just the hospice community. And it does a lot of education, which is my goal for Odyssey."

ODYSSEY

Odyssey appears to have a less than stellar reputation, at least among these sources. Few sources offered any positive comments about Odyssey, and several hinted that the company's practices were questionable. A medical director said, "Odyssey is under scrutiny. It was reported in the spring of 2003 for paying associate medical directors who did nothing. Odyssey has had incredibly high turnover, and a whistleblower wouldn't surprise me." Another medical director said, "Odyssey is pure business. It doesn't come across as a warm and fuzzy hospice." A Colorado medical director said, "The Odyssey model is very different from our model. We are very doctor-oriented, but Odyssey relies more on non-physician team members, and Odyssey patients see doctors a lot less…But Odyssey has a good reputation, and I would go to work for Odyssey." Another source said, "Odyssey's growth-by-acquisition strategy is an issue."

Sources said one way that Odyssey has been able to keep costs down is by skimping on IT spending. An expert said, "Anyone who says IT is not important is missing the boat." Another source said, "Odyssey is not investing in IT, and that does raise eyebrows. It is a big company and profit-focused, but IT will bite them in the future. The lack of spending on IT saves money, and it means you can hide things that are more apparent with good IT."

A nurse explained why she decided to work for Odyssey: "I joined Odyssey three years ago because with its large size, it can do more things, and because I could climb the corporate ladder if I wanted…Odyssey gave me the ability to carve out a niche – to expand education and research. I have more career here than I did at (a university) hospice…Odyssey is very supportive, and they are letting me do education."

Odyssey employees had positive things to say about the company and the treatment teams. One commented, " We have a medical director on top and three associate medical directors – a hospitalist, a primary care doctor, and a home health care doctor. They rotate call weekly, all are at our disposal (we can call them), and each sits with a team weekly…The associate medical directors all have other practices, but we get fewer referrals from them than we expected. However, a lot of referrals come from their colleagues."

A source offered these criticisms of Odyssey: "The pressure is on the numbers, though that is good to grow the company. IT is weak. It is expensive to do, but it would be more efficient to chart electronically…I would also like to see more over-staffing, not under-staffing, but staffing is hard to find…Plus the company offers very low maintenance, so it makes good money on nursing home patients."

Asked to compare Odyssey to a competing not-for-profit hospice, a source made these points:

- "Odyssey is faster in responding to a referral. That is the No. 1 advantage to Odyssey with our referral sources."
- "Our nurses work harder. They call patients every day, even Christmas Day."
- "We use less IT."
- "We market more, and we do community education."
- "We do less in-patient care. We prefer in-home care (continuous care)."

VistaCare

VistaCare had a large booth at the meeting, and sources generally offered positive comments when questioned about this company, but they rarely volunteered comments. An official said the company specializes in small markets, "We are starting three new hospices in the next month, and all are in smaller cities without a for-profit hospice…People may choose a hospice sooner if they have to travel far to a doctor or hospital."

HCR Manor Care

This company also had a booth at the meeting, and it is seeking to expand.

Southern Care

A source said, "Southern Care is very good at start-ups."

Other Providers

Nursing home chains are starting to get into hospice care, and Beverly Enterprises appears to be the potential big gorilla. A source said, "Beverly, for instance, has been trying to do this for a long time, but it will be very hard." Another source said, "Beverly is getting into this big time." A not-for-profit medical director questioned whether nursing homes would get into Stark issues by getting into hospice, but a CMS official said, "Beverly can do it if it is careful." A for-profit medical director said, "Beverly will be a major threat." A for-profit official said, "Beverly is really getting into it." A Midwest for-profit medical director said, "Nursing homes are not a threat. Patients, their families, and the doctors still have a choice."

Some **health plans** also are looking at the hospice space. United Health Group opened its first hospice recently in Phoenix, Arizona. It is licensed as Ovations, but the brand (street) name has not yet been determined. The United/Ovations hospice had a booth at the meeting, and an official said the company plans to open more hospices if this one does well. She commented, "Our Evercare is not in palliative care, so we are a hand-off for them. They can refer to us." A for-profit official said, "We are seeing HMOs getting into hospice, and I worry about an HMO buying us…I can't imagine managed care getting into hospice will help."

Home nursing agencies, like Visiting Nurse Association, also are starting to do hospice. A source said, "Some are trying to do it really right."

Acquisitions

Most of the medical directors questioned have no interest in having their hospice acquired by a larger hospice, but most knew of other, generally small, hospices that were trying to position themselves as an acquisition target. A South Carolina medical director said flatly, "I don't want to get bought." A for-profit medical director laughed at the idea, saying, "We are not interested at all in being acquired…We are a threat to Vitas in our area. A lot of patients don't like a national chain. We are in acquisition mode." A for-profit official said he expects to see more consolidation of both not-for-profit and for-profit hospices over the next couple of years.

Barriers to Entry

Sources generally agreed that getting into the hospice business can be quite difficult. State regulatory hurdles can be particularly complex, they said. One source explained, "It is a complex business, and you need to build a referral base." Another source said, "In some states you need a Certificate of Need, plus you need a trained staff – and most doctors are not adequately trained. You also need pharmacy people familiar with our doses and medications – some Walgreens' pharmacists are not comfortable with it." A third source said, "There are a lot of costs to set up a hospice, plus regulations

and staffing issues." A for-profit official said, "It can be hard to get Medicare licensure for each office." Another for-profit medical director said, "Starting a hospice is complex, and there are numerous regulations and HIPAA rules." A Nevada source said, "Staffing (RNs) is a barrier, and so are state licensing and regulations. Those are very difficult."

MISCELLANEOUS

PROGENIX had a booth at the meeting and was educating doctors about its investigational subcutaneous treatment – methylnaltrexone – for opioid-induced constipation. Phase III data on methylnaltrexone will be presented at ASCO 2005. The company also is working on an oral version of methylnaltrexone, which also is in Phase II for postoperative ileus. Several medical directors pointed to methylnaltrexone as the most exciting thing at the meeting.

♦