Teaching Case

Journal of Applied Case Research
Sponsored by the Southwest Case Research Association

Odyssey Healthcare

John J. Newbold

Sam Houston State University

Accepted: December 2006

INTRODUCTION

Richard Burnham thought he was easing out of the day-to-day management of Odyssey Healthcare, the hospice concern he co-founded. He had stepped down as CEO in January 2004 and turned the reins over to his cofounder, David Gasmire. Now, less than six months later, company performance issues and negative publicity were compelling him to weigh in on a turnaround plan.

Founded in 1995, Odyssey Healthcare had enjoyed tremendous growth for nearly 10 years. Odyssey had grown its base of business through "same store" growth, acquisitions and newly constructed operations to become one of the largest for-profit hospice organizations in the United States. The number of Odyssey hospices had more than doubled from 2001 – 2003, from 30 to 74.

However, as Burnham and Gasmire navigated into 2004, Odyssey began to experience some operations-related problems. In February 2004, Odyssey released its earnings for the fourth quarter of 2003. While the numbers for 2003 came in on target, Odyssey management advised investors that their earnings estimates for fiscal year 2004 were being lowered due to operational issues. Based upon this news, the stock price dropped 26% in a single day (Yu 2004). In April, 2004, Barron's, a widely-read financial newspaper, wrote an unflattering article about Odyssey which strongly hinted at Odyssey engaging in less than ethical practices related to patient admissions, patient care and patient discharges (Ward 2004).

Immediate action was required. As Burnham prepared to meet with his friend and cofounder, CEO David Gasmire, he wrestled with a number of issues: What could be done to improve the operations of the firm and restore investor confidence? How could the organization ensure that individual hospice programs kept their eye on organizational goals while still behaving ethically?

THE HOSPICE INDUSTRY

Hospice Care

Hospice care has been 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)

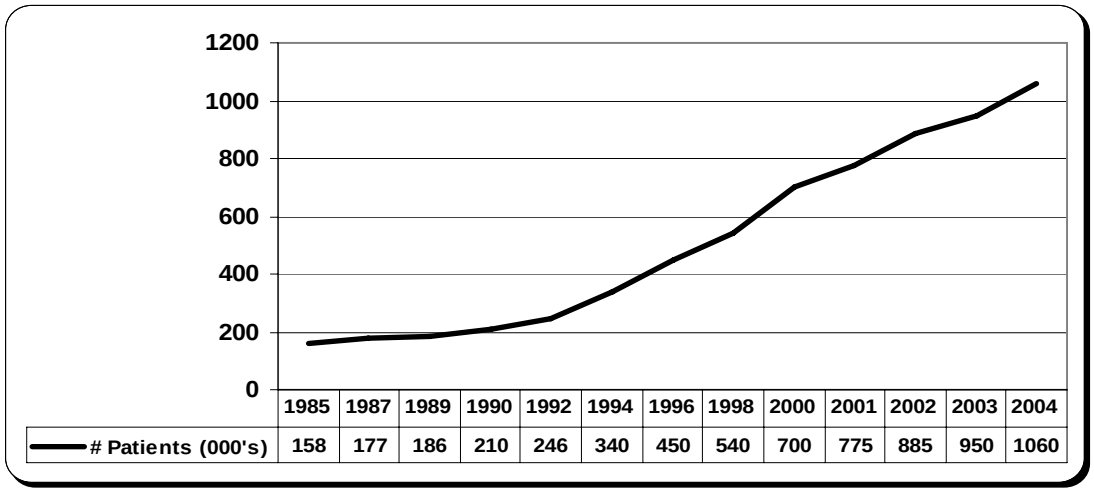
The palliative (pain reducing) care provided by hospices differed from curative care which was traditionally provided by hospitals in the sense that the primary focus was not on curing the patient. Rather, a holistic program was designed which was directed at all aspects of care which made the patient more comfortable and improved the quality of life. A broad range of services, from traditional nursing care to respite care for family caregivers to bereavement services for family members was traditionally offered.

The Institution of the Medicare Hospice Benefit Spurs Industry Growth

In 2003, the hospice industry in the US was a relatively small and fragmented component of the overall healthcare industry, generating aggregate annual revenues of about $4.5 billion. Spending on hospice services amounted to less than one half of one percent of the $1.4 trillion in annual US healthcare spending. Further, hospice spending accounted for only 1.5% of annual Medicare spending (Shattuck Hammond Partners 2004).

In 1982, Congress enacted the Medicare Hospice Benefit on a provisional basis. In 1986, the provisional law was made permanent. Each state was given the option of including hospice care in their Medicaid program. In addition, hospice care was made available to terminally ill patients in nursing homes. A significant jump in usage of hospices occurred after 1990.

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

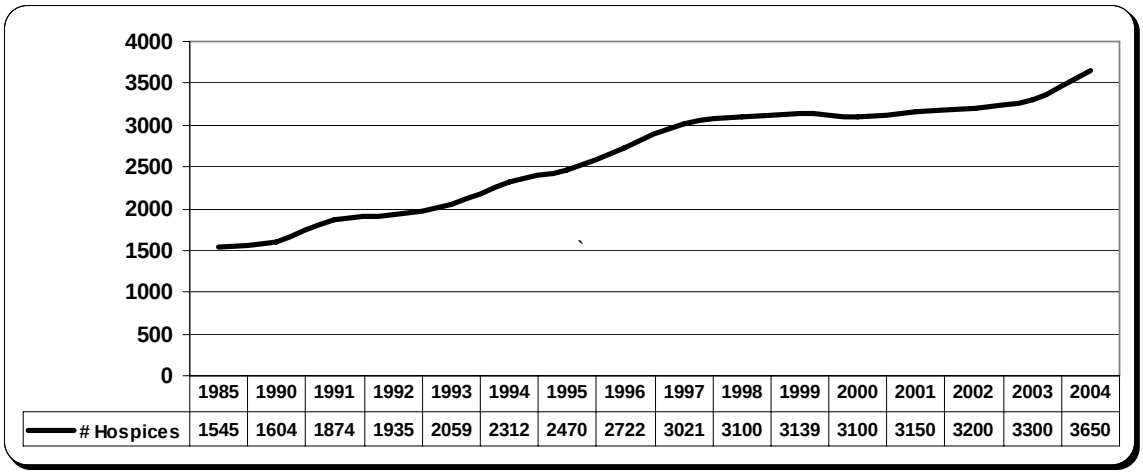


	1985	1987	1989	1990	1992	1994	1996	1998	2000	2001	2002	2003	2004
# Patients (000's)	158	177	186	210	246	340	450	540	700	775	885	950	1060

(National Hospice and Palliative Care Organization (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, dampening the growth rate of hospice sites, as evidenced in Figure 2.

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 Increasing Acceptance of Hospice Care Services in the US

In 2004, there were several factors driving growth in the hospice industry. Foremost was the overall aging trend in the US and the increasing size of the over-65 population. In addition, there was an increasing role of advocacy groups in promoting hospice care over other end-of-life alternatives. Finally, The Center for Medicare and Medicaid Services appeared to be promoting hospice care through its liberal policies for reimbursement (CMS 2004, 2005). The CMS's favorable treatment of hospice care in their reimbursement policies was thought to be at least in part because hospice is viewed as a lower cost alternative to traditional, hospital-based end-of-life care.

Hospice Patient Trends

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

In the 10 years preceding 2004, the greatest increase occurred in the number of beneficiaries with non-cancer diagnoses and those living in nursing homes and rural areas. Though cancer patients accounted for 49% of hospice admissions in 2003, this was down from 76% in 1992. Other ailments such as heart disease, dementia, lung disease, kidney disease, and liver disease were becoming more common among patients admitted to hospice care (NHPCO 2005).

The Growth of For-Profit Medicare-Certified Hospice Operations

Traditionally, the hospice industry had been comprised of non-profit operations with an average of less than 50 patients at any given site at any given time. In 2004, 63 % of all hospices were non-profit, with for-profit operations comprising 31%. Most of the growth in the industry was driven by the for-profit sector (NHPCO 2005).

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

The Medicare Hospice Benefit

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

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

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

Medicare reimbursements were made along the following guidelines:

1) Medicare beneficiaries were required to 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 could not exceed the Medicare hospital deductible.

3) Medicare capped (i.e., limited) reimbursements to hospice programs in three ways:

   a. Inpatient care days could not exceed 20% of all patient care days per provider. If the cap was reached, reimbursement continued, but at a reduced rate. This wais referred to as "The 20/80 Rule".

   b. Annual reimbursements per beneficiary were capped at $19,635.67 for FY 2004. This rate, which was updated every year, wais 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 exceeded the total, the provider was required to repay the difference to Medicare. This aggregate reimbursement cap effectively served as a corrective mechanism to programs with patients with inordinately long lengths of stay. This version of the cap was applicable on a per site basis, not for a firm's 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 four 6-month benefit periods, or roughly 720 days. By 2004, rules for maximum reimbursement had been further slackened: There were no limits to the number of days of care for which Medicare would pay. However, in order to continue to receive reimbursements, a patient's prognosis had to be reaffirmed at 90 days, at 180 days, and every 60 days thereafter.

In particular, the Medicare cap accruals posed a significant operational challenge for Odyssey. Medicare capped reimbursements per patient per year at a fixed level (in 2004, that figure was $19,635.67). This rate, which was updated every year, was multiplied by the number of new beneficiaries enrolled by each individual site during the fiscal year. If actual Medicare reimbursements to an individual site during the period exceeded the limit, the provider was required to repay the difference to Medicare.

Since providers did not know if they had exceeded the limit until the end of the Medicare fiscal year (November 1), they struggled to accrue accurately for this amount. Thus, they often faced an unexpected Medicare cap expense in the 4th quarter of the year. This could occur when hospices had 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 could mitigate their cap accruals by taking on patients with relatively short lengths of stay. They could 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 were over the cap amount. Thus, proper cap management entailed strict attention to patient mix.

ODYSSEY HEALTHCARE

Odyssey was founded by Richard Burnham and David Gasmire, both former employees of another large, publicly held hospice organization – Vitas Healthcare. Burnham was a former regional manager for Vitas and Gasmire a former hospice site manager.

With headquarters in Dallas, Texas, Odyssey Healthcare, Incorporated operated 74 hospice care facilities in 30 states and employed over 4,000 healthcare workers in 2004. However, roughly half of those operations were located in California, Texas and Arizona. With an average daily census of 7700, they were the second largest hospice organization in the United States.

ODYSSEY'S BUSINESS STRATEGIES

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

Rapid Expansion into New Geographies

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

Increasing Scale and Geographic Breadth

The hospice business model was also highly sensitive to scale. Once the average daily census (ADC) breakeven point was reached (between 30 – 40 patients per month), operating margins in the 10% range were achievable and increased as the census rose. Odyssey's specific experience with scale effects are summarized in the Figure 3.

Figure 3: Odyssey Average Daily Census and Net Margins: Q3 2004

AVERAGE DAILY CENSUS	NET MARGINS
51 - 100	14.7%
100 - 200	27.3%
Over 200	31.9%
Overall	25.2%

(Odyssey Earnings Conference Call Transcript, Q3 2004)

Hospice providers who achieved significant scale were able to negotiate volume discounts on the purchase of pharmaceuticals, durable medical equipment and medical supplies. In addition, they were in a better position to enter into favorable contracts with private insurers HMOs and pharmacy benefit managers. Finally, large hospice operations were able to spread certain fixed costs (corporate overhead, IT infrastructure, and marketing spending) over a larger patient population.

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

Controlling Operating Costs

In 2003-2004, Odyssey struggled to adequately control their pharmaceutical costs. In many locations, they were paying local rates. In 2004, Odyssey completed an extensive project whereby a national formulary plan and an electronic drug adjudication system was implemented. This system provided better visibility and control over the drug side of the business. Odyssey also completed a switch-over to a new internal management IT infrastructure. The new software and hardware system was intended to improve the clinical and billing systems. It provided management at Odyssey with better real-time visibility into the day-to-day operations of the firm, such as the drug usage rate, patient length of stay and Medicare Cap accrual status reports

ODYSSEY'S MARKETING STRATEGIES

Products/Services Strategy

In order to be certified by Medicare, marketers of hospice services were required to offer specific core and non-core services. However, marketers at certain for-profit hospices recognized the value of differentiating their services to appeal to certain types of referrers. For example, certain national or regional health care providers appreciated the ability to work with a larger partner who could offer a consistent level of care and administration over a larger geographical footprint. Further, hospices were beginning to

differentiate themselves by specializing in services for patients with specific diagnoses by investing in the durable medical equipment necessary to care for cancer patients with acute symptoms and a need for continuous care. Vitas, an Odyssey competitor, diverged in strategy by specifically pursuing patients that required general inpatient care and continuous home care. This allowed Vitas to attract relatively short length of stay patients (as these patients tend to be cancer-related), achieve higher revenues (due to the relatively higher compensation levels called for by these services), and differentiate their offerings from those of Odyssey and other competitors. This change in strategy wais reflected in Vitas' mix of business as shown in Figure 4.

Figure 4: Patient Mix by Level of Care (2003)

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

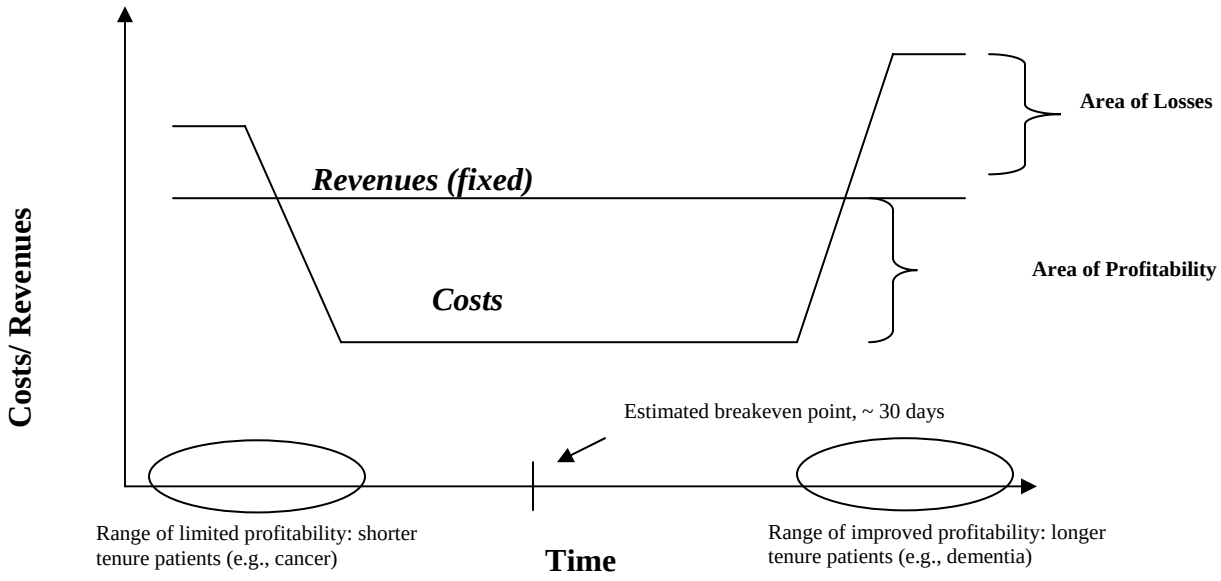
(NHPCO, Vitas, Odyssey, VistaCare Annual Reports 2004)

The Impact of Fixed Pricing on Odyssey's Target Market Strategy

With over 90% of their revenues obtained from Medicare and Medicaid, all hospice operators worked under a fixed pricing system. Thus, the revenue function for a hospice operator was linear – a fixed per diem payment over time. The cost function, however, was not linear. The cost of a marginal day of care was relatively high at the onset of care, when there were initial costs of learning about the patient's background, and when the hospice developed a plan for facilitating the move to a hospice environment. Similarly, costs were 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 were lower (Huskamp, et al 2001). This pattern of cost was the same regardless of diagnosis. The important implication of the linear revenue function and the U-shaped cost function was that longer lengths of stay would yield higher profits.

Further, a patient's diagnosis served as a predictor of length of stay: Cancer patients tended to be referred late and have relatively short stays. In contrast, non-cancer patients tended to have longer lengths of stay. For these reasons, there had been a natural tendency of for-profit hospices to target *non-cancer* patients for admissions. Figure 5 illustrates the impact of the "U -shaped" cost function and the fixed pricing environment on hospice profitability.

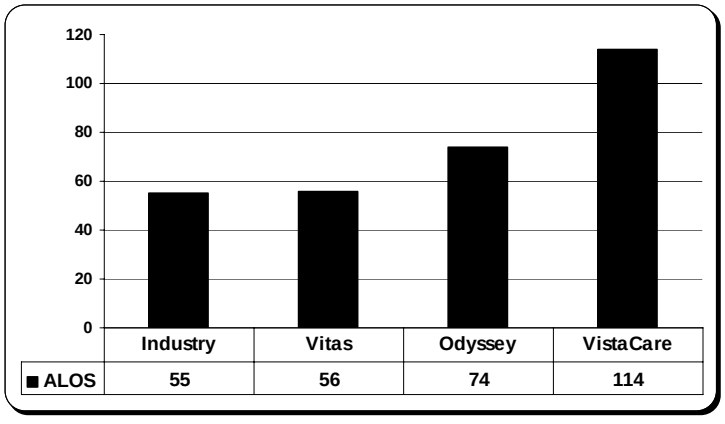
Figure 5: Schematic of Fixed Revenue and U-Shaped Cost Function in Hospice Care



Managing Patient Length of Stay

Patient length of stay appeared to have the most impact on net patient revenue. For each patient, if length of stay was only a few days, the high costs were spread over fewer days of care, which increased patient care expenses as a percentage of net patient revenue. Consequently, profitability was negatively impacted. Clearly, the ideal scenario for a for-profit hospice was to have each patient stay as long as possible so that the patient care expenses were spread over more days, positively impacting profitability. As a result, Odyssey had a relatively high length of stay compared to the industry, as Figure 6 attests.

Figure 6: Average Length of Stay (2003)



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

Thus, Odyssey was faced with a challenge of managing the type and number of their patients in an environment where they were expected to take on all types of cases.

This objective was approached in the following two ways. First, marketing appeals were directed at the type of patients needed at the time to keep the mix of patients by diagnoses in an acceptable range. Second, rapid census growth was 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 potential negative impact on their business model (via larger than anticipated Medicare Cap accruals) by continuing to attract new patients with inherently short tenures. Thus, on a per site basis, the average length of stay used for the Medicare cap accrual calculation could be managed.

Driving Admissions Growth through Personal Selling

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

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

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

In 2003, Odyssey expanded their training and support staff to include two professionals whose sole responsibility was to educate their field sales representatives who called on their referral sources. This corporate function was referred to as The Support Center. The primary recipients of the training were the CERs, the local patient care managers, and the general managers of each individual hospice facility. In 2004, faced with a slowing admissions trend, Odyssey accelerated their training schedule for these individuals.

Compliance and Oversight

Odyssey's Annual Report for 2004 delineated their compliance program as follows:

1) The appointment of a compliance officer and committee,

2) The adoption of a corporate code of business conduct and ethics,

3) Employee education and training,

4) The implementation of an internal system for reporting concerns on a confidential, anonymous basis,

5) Ongoing internal auditing and monitoring programs, and

6) A means for enforcing the compliance program policies.

(Odyssey Annual Report 2004)

Odyssey placed heavy emphasis on compliance with Medicare rules and regulations. Kathy Ventre, Senior Vice President of Clinical and Regulatory Affairs reported directly to the CEO and regularly reported to the Board of Directors. She headed up a team of twelve clinicians whose primary objective was to ensure that all of Odyssey's hospices remained Medicare compliant. Of the twelve clinicians, one clinician was assigned to each of the eight sales regions. The remaining four clinicians monitored activities at all start-ups and new acquisitions. In addition to this central staff, each of the individual hospices also employed one full-time clinician.

Medicare regularly sampled paperwork submitted by its certified sites for compliance to its rules and standards. In the first quarter of 2004, 17 of Odyssey's 70+ sites had been scrutinized by Medicare: All had passed.

A summary of key excerpts from Odyssey's Corporate Code of Business Conduct and Ethics can be found in the Appendix to this case.

ODYSSEY'S EARNINGS MISS

In February of 2004, Odyssey management advised investors that their earnings estimates for the fiscal year 2004 were being lowered. The primary drivers of Odyssey's reduced profit outlook included:1) higher than anticipated costs in the form of newly acquired hospices, 2) greater pharmacy and salary expenses, and 3) greater than anticipated costs in the form of Medicare cap accruals.

On the operations front, admissions growth was slowing, apparently due to a potential lack of productivity of a relatively new sales force. This slow-down in admissions was exacerbated by new challenges from competition. Net income was squeezed by

increasing marketing expenses and issues with Medicare Cap accruals at selected sites. In 2003, the total reduction to net revenues based upon Medicare Cap accruals was $1.3 million. In 2004, this figure was expected to more than double, which was largely responsible for the reduced earnings outlook. The exponentially growing Medicare Cap accruals were caused by extremely long average length of stays in combination with a dearth of new admissions at selected sites. Whereas the industry average for cancer-related hospice patients in the patient mix was 49%, Odyssey's overall mix of patients with cancer was running at 35%. Traditionally, Odyssey would specifically target non-cancer patients, as they would typically have longer average lengths of stay, thereby boosting profitability. However, in the scenario of low census growth, the longer lengths of stay proved to have an adverse impact upon some of the newer sites, where lack of patient turnover had led to issues with the Medicare cap requirement.

ADVERSE PUBLICITY

The last thing Odyssey needed on the heels of their February 2004 earnings announcement was to have an unfavorable article come out in a prominent business periodical. Yet on April 12, 2004, Barron's featured an article by reporter Sandra Ward entitled: "Troubling Odyssey, Questions Arise About Hospice Company's Patient Care, Level of Medicare Payments". On the surface, the article appeared to be about operational problems associated with Odyssey's aggressive growth. However, the article intimated that Odyssey may have been engaging in less-than-ethical marketing practices. Consider the following excerpt:

> "There are also suggestions that some of Odyssey's strong growth is the result of providing a level of care and services below the standards set forth under government guidelines, including providing adequate bereavement services for patients' families. A son tells *Barron's* of Odyssey's ignoring calls from a nursing home as the staff sought the assistance of the hospice firm with which he'd contracted. Some former nurses and marketing representatives tell *Barron's* of patients being kicked out of Odyssey programs after 90 days upon being 'reevaluated' or because they required hospital care. Former staffers complain about lack of access to supplies, and caseloads that are heavier than industry norms. The company's CEO, David Gasmire, says Odyssey follows all federal guidelines."

The article went on to imply that Odyssey may have been skirting Medicare requirements for admission into hospice care:

> "In a business almost entirely dependent upon Medicare for reimbursement for revenues, adherence to guidelines is crucial. People familiar with the Medicare system say that exceeding the reimbursement cap is very unusual and is considered a serious breach of accepted practice by the Centers for Medicare and Medicaid Services, as well as by the insurance intermediaries who handle Medicare claims. Such breaches

> raise red flags about admittance procedures and the possibility that ineligible patients are being accepted into hospice programs, which are supposed to admit only those whom doctors believe have no more than six months to live."

Toward the end of the article, the author highlighted the tension caused by the incursion of for-profit firms in a traditionally non-profit industry:

> "In a business expanding as fast as the hospice industry and at a company expanding as quickly as Odyssey, growing pains are to be expected. Nonetheless, there is mounting concern within the industry that the quest to show profit growth and stock price gains can sometimes conflict sharply with the needs of dying patients and their families. Nonprofit hospices increasingly complain that they are shouldering a heavier burden than the for-profits – caring for a higher proportion of expensive-to-care-for patients and providing services that should be available at all hospices.
>
> Says Dorothy Deremo, president and chief executive of Detroit-based Hospice of Michigan: 'For-profit organizations in health care have a different social contract: to deliver a return on investment and improve the equity of their stockholders. The social contract for the not-for-profit is….to return value to our shareholders who are the patients, the families, and the community-at-large'".

Despite the intimations of the Barron's article, at the time of its publication, Odyssey was not under investigation by the U.S. Department of Health and Human Services' Inspector General's Office, the watchdog agency for the Centers for Medicare and Medicaid Services.

ODYSSEY MANAGEMENT MULLS NEXT STEPS

In May of 2004, Odyssey Chairman Richard Burnham and CEO David Gasmire were struggling with significant operational issues as well as the challenge of fending off a high-profile article intimating there were ethical issues with their operations. Key issues for them to consider included:

1) What, if anything, could Odyssey do to promote a corporate culture where the ethical issues were better balanced with its business objectives? Was a change in leadership needed to signal a new direction in terms of ethical conduct?

2) What was the relationship between effectively managing the business to turn a profit and the adherence to ethical concerns? Did meeting the needs of one preclude meeting the needs of the other?

3) Where was the line drawn between ethical and unethical practice in the delivery of hospice services? Did adherence to Medicare guidelines constitute

ethical behavior? Or were firms such as Odyssey somehow held to a broader standard?

REFERENCES

Centers for Medicare and Medicaid Services (CMS); "Medicare Hospice Benefits"; November, 2004, November 2005

Hospice Association of America; website, March 2005

Huskamp HA, Buntin MB, Wang V, Newhouse JP: "Providing Care at the End of Life: Do Medicare Rules Impede Good Care?" Health Affairs; 2001:20:204-211

National Hospice and Palliative Care Organization (NHPCO) report, "Hospice Facts and Figures"; 2004 & 2005

Odyssey Healthcare, Inc.; Annual Report: 2004

Odyssey Healthcare Quarterly Earnings Conference Call Transcript, Q3 2004

Shattuck Hammond Partners; "The US Healthcare Industry: Focus on the Hospice and Palliative Care Industry", Summer 2004

VistaCare Healthcare, Inc.; Annual Report 2004

Vitas Healthcare Inc.; Annual Report 2004

Ward, Sandra; "Troubling Odyssey" Barron's; v. 84 no. 15 (April 12, 2004) p. 20 – 22.

Yu, Roger; "Inquiry Targets Hospice Operator Odyssey Healthcare, Inc"; The Dallas Morning News; October 19, 2004

APPENDIX

SELECTED EXCERPTS: ODYSSEY HEALTHCARE
CORPORATE CODE OF BUSINESS CONDUCT AND ETHICS
(April 29, 2004)

The following are excerpts from Odyssey's Corporate Code of Business conduct and Ethics, as adopted April 29, 2004. For a complete version of this document please refer to the following hyperlink:

http://media.corporate-ir.net/media_files/NSD/ODSY/cgov/Business_Conductupdated.pdf

Under "General Policy"

Along with legal compliance, all Associates should observe high standards of business and personal ethics when performing assigned duties. This requires using honesty and integrity when dealing with other Company Associates, the public, the business community, stockholders, patients and their families, suppliers and governmental and regulatory authorities.

***Fraud and Abuse* Laws.** All Associates shall refrain from conduct that may violate fraud and abuse laws. These laws prohibit:

- direct, indirect or disguised payments in exchange for the referral of business or patients;
- the submission of false, fraudulent or misleading claims, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements; and
- making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service.

Quality of Services

Each Employee must provide high quality services in the performance of their responsibilities for the Company. Patients and other individuals in the Company's care have a fundamental right to considerate care in a manner that safeguards their personal dignity and respects their cultural values. It is the right of such individuals to receive accurate and timely information regarding their health, diagnosis, prognosis and information necessary to make informed decisions and choices regarding treatment.