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Selling Hospice

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The Buying and Selling of Health Care

Guest Edited by Joshua E. Perry and Larry R. Churchill

Symposium Article

Sam Halabi ^{a1}

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SELLING HOSPICE

I. Introduction

Hospice care in the United States has undergone a remarkable transformation since it assumed its modern form in the late 1960s. It began as a movement driven by small organizations staffed with many volunteer providers focusing on comprehensive spiritual, palliative, and mental health services for a relatively small number of terminally ill patients, typically suffering from cancer. The idea behind hospice during its early days was that a terminally patient and his or her family made a decision to focus on easing a patient's pain and anxiety, making him or her more comfortable, rather than pursuing additional curative treatment.¹ Because these objectives required a wide range of professional and non-professional skills, hospice care involved not only physicians and nurses, but clergy, social workers, volunteer caretakers, homemakers, and, of course, family members.² The process of decision-making by the patient and his or her family was never uniform and never systematically studied. Early experiments in hospice coverage noted the complex considerations at work during the hospice election process, including a patient's informed consent when he or she was in pain or heavily sedated, and the need to incorporate opinions from an attending physician, nurse, clergymember, social worker, and family member, among other constellations of participants.³ As a result, hospice care in the United States before 1983 was characterized by small providers who worked within the limits of prevailing institutional norms, tight budgets and diverse approaches to the care of terminally ill patients. Matching terminally ill patients and their families with available and appropriate hospice providers was accomplished through the loose and inchoate network of participating physicians, nurses, clergy, social workers, and volunteers who, early on, saw value in the alternative hospice care provided.⁴

Now, hospice is one of the fastest growing costs of Medicare, which began covering hospice in 1983.⁵ According to the National Hospice and Palliative Care Organization, the number of people using hospice increased from 495,000 in 1997 to 1.3 million in 2006--an increase of 162% during 10 years. While cancer remains the top diagnosis among hospice enrollments, its percentage is decreasing as more patients are referred to hospice with diagnoses like Alzheimer's, dementia, and failure to thrive.⁶ Between 2002 *443 and 2008, four in ten Medicare patients died while under the care of a hospice provider.⁷ For its proponents, this trend makes sense; hospice is a compassionate, humane alternative to the toxic, painful, dehumanizing aspects of curative medicine especially as it is applied to patients suffering from particularly painful terminal illnesses.⁸

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Yet parallel to this trend of greater acceptance (and therefore utilization) of hospice care, the economic and commercial structure of hospice provision has also radically changed. A health care sector that originated with small, non-profit providers is now divided between non-profit and for-profit firms, the latter of which are increasingly answerable to shareholders as well as patients. In 1992, 13% of Medicare certified hospices were for-profit; in 1999 that number swelled to 27%.⁹ By 2002, that number had grown to 47%.¹⁰ As of 2010, the Medicare Payment Advisory Commission estimated that there were 3,555 Medicare-certified hospices in the United States, over half of which were for-profit providers.¹¹ For-profit providers accounted “almost entirely” for the increase in providers after 2002.¹² The expanding networks of physicians, nurses, social workers, clergy, and volunteers who originally played a facilitating role for patients and families who needed them now represent a key nexus of influence for the hospice providers who compete for their referrals and recommendations.

These trends--not mutually exclusive yet incongruous in their outlook--beg the question: have Americans really undergone a paradigm shift with respect to end-of-life decision-making for the terminally ill, or are changed attitudes toward, and use of, hospice shaped and influenced by firms seeking to enroll as many of the right type of patient as possible to maximize revenues? The scholarly effort to answer this question has been underway for some time but has generated only indirect evidence in support of tenuous conclusions. As the brief literature review provided above suggests, the distinction between for-profit and non-profit hospice providers has served as a major fault line in the literature. Several studies have found that for-profit hospices tend to care for patients with diagnoses other than cancer who also tend to have longer stays.¹³ Between 2001 and 2002, the average length of stay for a hospice patient increased from 50 to 55 days, but the median stay remained constant, suggesting that long stays were getting longer.¹⁴ This trend continued through 2011. According to the NHCPO, the median stay is now 19.1 days and the average stay is 69.1 days.¹⁵ For profit hospices have “proportionally fewer registered nurses per nursing FTEs, proportionally fewer medical social workers per psychosocial FTE, and proportionally fewer clinicians per total FTEs.”¹⁶ In their study of publicly traded hospice firms, or hospice providing subsidiaries of publicly traded firms, Michael McCue and J. M. Thompson found that “[l]arge hospices owned by publicly traded companies generated a profit margin that was nine times higher than large, nonprofit hospices and three times higher than large, for-profit hospices.”¹⁷ Richard Lindrooth and Burton Weisbrod concluded that for-profit hospices “achieve [longer stays by hospice patients] by selectively admitting patients with observable characteristics that are associated with longer expected lengths of stay.”¹⁸

No study in the current literature has found that patients in for-profit hospices receive lower quality care nor is there any systematic study of for-profit hospice admission practices nor, to the extent they may be clearly identified, whether they introduce inappropriate or ethically questionable practices that affect patient and family decision-making. This may very well be attributable to the difficulty researchers experience in assessing how and why patients and their families choose hospice and, for that matter, establishing clear quality measures.¹⁹ As David Casarett and his colleagues noted;

[I]t is not known whether patients and families receive information about hospice from their physicians or other sources before referral. Nor is it known what kinds of information patients and families want to make a decision. Finally, it is not known how the enrollment decision is shared between patients and their families and whether hospice information should be provided to the patient, family, or both.²⁰

Despite a growing body of research identifying political, cultural, familial, medical, and legal factors affecting the enrollment decision, “how people and their families think about the transition to hospice care is largely unknown.”²¹ Both federal law and professional licensing requirements imposed by state law nevertheless impose clear constraints on who may influence a patient's hospice election as well as how they might do so. Federal law requires that patients

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and families be informed of their rights during the initial assessment, prior to the hospice providing care. While specific conditions of participation for federally reimbursed hospice providers are simply worded, their supporting commentary specifically prohibits hospice providers from (1) exercising “undue influence” on the patient's selection of physician and (2) allowing any member or consultant of a patient's interdisciplinary group to base “patient care decisions ... on financial or business incentives.”²² This article explores the substantial *444 pressure commercialization of hospice has brought to bear upon these legal and professional constraints.

This article makes two principal contributions to the current debate. First, it takes an approach which combines aspects of longitudinal and case study methods in a field dominated by cross-sectional research. Specifically, it analyzes the corporate, investment and regulatory architecture of the nation's largest hospice service provider, Vitas Innovative Hospice Care (Vitas). Vitas is a trade name that masks 20 or more business entities whose origin may be traced to the early days of the hospice movement and its growth through acquisition and establishment of new hospices. Vitas's growth reflects the trajectory of the hospice service sector generally. Between 1998 and 2012, its revenues increased 300%, with 90-95% of those revenues received through Medicare reimbursements.²³ Between 2009 and 2012, its growth was largely attributable to increases in the enrollment of hospice patients and stretching the stays of those who enrolled. These factors determine what it is known generally as “average daily census,” that is, the number of patients admitted, discharged, and the average patient length of stay. Since 2009, Vitas has annually reported growth in its census of between 5.5 and 6.1%. In addition to growth in the number of patients and the length of their stays, Vitas has also reported growth in Medicare reimbursements for “continuous care” of hospice patients, the classification of care which receives the highest reimbursement. The cumulative effect of Vitas's growth is evident: in 2012, it reported over 1 billion dollars in revenue.²⁴ Through its establishment, growth and expansion, Vitas persistently shaped its competitive environment not only through encouraging state and federal law-makers to increase direct support for hospice, but to create exemptions, carve-outs, and qualifications that advantaged certain hospice providers over others. Vitas accompanied its legislative and regulatory initiatives with innovative forms of marketing that effectively sold hospice to families (as much as patients) as a form of subsidized long-term care.²⁵ The network surrounding patients potentially eligible for hospice has become a key focus of business and financial incentives.

Second, relatedly, this article argues that the current orientation of hospice scholars toward the division between for-profit and non-profit hospice providers may conceal as much as it reveals about patient autonomy, patient care, and the integrity of the Medicare and Medicaid programs which largely fund hospice. Non-profit providers have been shown to engage in the same fraudulent practices as for-profits, and, indeed, certain broad features of non-profit hospices may make it easier to do so. The entry of a for-profit hospice provider into a market necessarily pressures non-profit hospices since they must “compete” for patients. For-profit providers also regularly acquire non-profit providers and non-profit providers may therefore “behave” like for-profit providers if they are interested in acquisition. In their study of changes in the hospice sector, Jennifer Thompson, Melissa Carlson, and Elizabeth Bradley found that while for-profit hospices represented most of the growth of the industry generally from 1999, many for-profit hospices closed while many non-profit hospices transitioned to for-profit entities.²⁶ This article argues, therefore, that it is not a hospice provider's status as for-profit that explains its behavior as much as it is its corporate, investment, and regulatory environment. This argument in turn highlights the difficulty in answering the original question-- whether culture or commercialization explains increasing hospice utilization. This study suggests that commercialization exercises an extraordinary influence on individuals, their families, and, therefore, the broader social and cultural milieu.

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This article takes as its principal sources Vitas's filings with state secretaries of state offices with whom its limited liability business organization *445 elections must be filed, a Form S-1 securities registration prospectus filed by Vitas in preparation for a 1997 public offering of securities, investor communications and securities filings by Chemed Corporation since 2004 when it obtained full control of Vitas (it made its initial investment in 1991), as well as analyses undertaken by business organization and public health scholars, newspaper articles, and whistleblower and government pleadings in a False Claims Act (FCA) lawsuit against Vitas filed on May 2, 2013.

The FCA is the United States' primary tool for fighting fraud directed against the public coffers. Under the False Claims Act regime, private citizens (“whistleblowers” or “relators”) work closely with the U.S. Department of Justice (DOJ) to identify inappropriate claims submitted to the government for payment. In 1986, Congress strengthened its provisions to allow whistleblowers to file suit under seal and share up to 30 percent of the United States' ultimate recovery. While the complaint is under seal, and before it is served on the hospice provider, the DOJ investigates to decide whether to intervene and take over the prosecution of the action or decline to intervene and allow the whistleblower to proceed alone. The FCA establishes liability for any person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.

While pleadings differ from other forms of evidence in that they are shaped to convince a trier of fact that they are more true than not true, assertions made by the U.S. government deserve special weight given the hurdles that must be overcome for the government to appear as a party against a hospice provider. First, while whistleblowers typically file the initial complaint and the government investigates, the government might not intervene in the dispute for a number of reasons including resource scarcity (an overwhelming level of fraud perpetrated against the federal government necessitates prioritization), the strength of the whistleblower's claims, the clarity of the law under which the claim is being brought, or even the preference of the federal agency that the DOJ represents. When the government intervenes, therefore, it is a strong signal both that the case enjoys substantial evidentiary support and that it is sufficiently important to commit scarce resources toward prosecuting. Second, the government enjoys wider investigative powers than other civil litigants including civil investigative demands, investigative personnel and resources from federal agencies, and access to information disclosed through criminal investigations that often but not always accompany FCA civil suits.

II. Corporate and Regulatory Influences on Vitas's Growth 1978-1993

Vitas materialized over a five-year period as a result of the grassroots hospice movement, entrepreneurial expectations that a new type of governmental benefit may generate returns for investors, and the appeal of hospice as a lower cost alternative to aggressive treatment at the end of life. At Miami-Dade Community College, Hugh A. Westbrook, who spent much of his pre-Vitas career as a hospital chaplain specializing in the care of terminally ill patients and their families, and Esther Colliflower, a registered nurse and fellow Miami-Dade administrator, developed a program on caring for the terminally ill.²⁷ In 1978, they formed the non-profit Hospice Inc., an all-volunteer hospice.²⁸ Several years later, they formed the for-profit Hospice Care Inc. with future Florida legislator Don Gaetz, who ran a Jacksonville hospital at the time he met West-brook.²⁹ Westbrook and Gaetz together shepherded the nation's first hospice licensing law through the Florida legislature and led a parallel effort to convince Congress to cover hospice services under Medicare.³⁰

There has never been agreement as to whether Gaetz, Westbrook and Colliflower were fundamentally driven by the hope of profiting off of a new medical entitlement or saw the establishment of federal coverage of hospice as the natural outcome of a movement that sought to educate Americans (both the terminally ill and the medical professionals who served them) about the relative benefits in terms of cost and dignity of palliative alternatives to curative treatment. Indeed, the commercialization process itself tunneled capital to the Vitas founders personally in a way that was closely tied to the objective of expanding access. Long after they accumulated substantial wealth, Westbrook and Colliflower

claimed that their personal financial success occurred as a byproduct of their commitment to spreading their vision.³¹ Gaetz claimed that Vitas began as an \$1,800 “investment.”³² They formed Vitas Healthcare Corporation in 1983 (it entered into most of its publicly available contracts under the name Hospice Care Inc. until 1992 when Vitas became its principal trade name) as a Delaware corporation soon after Medicare began paying for hospice. As Professor Joy Buck phrased it, “[Westbrook's and Gaetz's] mission was to both create and corner the market for hospice at the national level and standardization of hospice was a critical element of their potential success.”³³ Creating and cornering the commercial market for hospice care required careful navigation of federal and state law to avoid ensnarement within other highly regulated providers at the time (and since) especially home health services, nursing homes, and hospitals.³⁴

*446 Indeed, aimed at relieving pain, symptoms, stress, emotional and spiritual preparation for the end of life associated with terminal illness, hospice as a federally reimbursable benefit is defined by (1) its patients' diagnoses and (2) its interdisciplinary approach to holistic care. Medicare patients must be certified as being terminally ill, which under federal law means a medical prognosis of a life expectancy of six months or less if the disease runs its normal course.³⁵ For initial admission to hospice, the patient's status must be certified by his or her attending physician and a physician member of the hospice provider's interdisciplinary group; subsequent hospice periods need only to be certified by either the attending physician or a hospice physician, not both.³⁶ In addition to being certified as terminally ill, when a Medicare patient elects to enroll in hospice, he or she has traditionally been required to agree to forego curative care and receive only palliative care for terminal illness.³⁷ A Medicare recipient may initially enroll for two 90-day periods, followed by an unlimited number of 60-day periods. The patient must be recertified as terminally ill at the beginning of each period of care after the first. After eligibility is established, the federal hospice benefit generally provides four types of care: (1) inpatient respite care, (2) general inpatient care, (3) routine home care, and (4) continuous home care. Inpatient respite care allows for short-term inpatient hospice services to provide relief to the patient's primary caregiver. General inpatient care is provided when the patient's pain and other symptoms cannot be adequately managed in any other setting. Routine home care is intended to be the primary type of care that hospice services provide. These are the general services provided to hospice patients; this care is usually given either at home or in a nursing facility. Much of the care is provided by nurses' aides and other non-skilled medical staff, and the patients are visited approximately three times a week by a registered nurse or other skilled medical professional. Routine home care provides the lowest daily reimbursement rate to the hospice provider.

Continuous home care is also rendered at the patient's home or a nursing facility; however, it is only furnished when medically necessary during a period of “crisis.”³⁸ In this situation, the patient's acute symptoms require more intensive care than usual to maintain the patient's comfort level. Continuous home care must be provided for a minimum of eight hours of care each day and is expected to be predominantly provided by skilled medical staff such as registered nurses, licensed vocational nurses, or licensed nurse practitioners, rather than non-skilled care providers such as nurses' aides or family members. Continuous care is intended to be short term and patients should not generally be able to perform routine tasks or leave their place of care unnecessarily. Continuous or “crisis” care provides the highest level of daily reimbursement to the hospice provider. The Medicare reimbursement structure--routine care, general inpatient, continuous care, and general respite care--as well as federal eligibility criteria for patients and providers allowed hospice providers to establish regulatory distinctions while retaining the ability to access existing health care infrastructure to not only increase enrollment in hospice care, but also, when possible, to steer patients into higher reimbursement care categories.

After Vitas became a for-profit entity, Westbrook led the organization as Chairman of the Board and CEO and Gaetz served as vice-chair.³⁹ Gaetz and Westbrook took a 15% stake in the corporation, obtained substantial investments

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from Alex Brown and Sons (now a unit of Deutschebank), Kleiner, Perkins, Caulfield *447 and Byers (a top Silicon Valley venture capital firm), and Home Health Care of America (now CVS Caremark), and retained about half the corporation's shares for employee and management incentives.⁴⁰ Between 1984 and 1986, Vitas struggled to retain investors and scrapped plans to expand to Atlanta and New Orleans.

Attributing its stalled growth to a slow and bureaucratic reimbursement system which only paid for services after they were rendered, Westbrook and Gaetz collaborated again in 1986 to lobby Congress not only to make the hospice benefit permanent, but to reimburse hospices based on the projected number of patients a hospice would serve.⁴¹ While Gaetz and Westbrook worked as part of a broader movement of hospice organizations, their leadership is credited with prevailing upon Congress to both make the hospice benefit permanent and implement the advance payment system.⁴² Together with the establishment of the permanent Medicare hospice benefit and the expansion of the hospice benefit to Medicaid, federal and state law created incentives to both increase enrollment in hospice and to find ways to use higher-reimbursement services like general inpatient care and continuous care. This incentive arguably created a positive feedback loop: anxious to please investors or to spread fixed costs, hospices overstated estimated patient census; in order to avoid returning reimbursements to the government, hospices using the advance payment system found ways to fulfill its promised census, even if it meant enrolling patients for whom hospice was inappropriate or whose consent was not fully voluntary and informed.⁴³

Vitas achieved growth both through persistent pressure to add the hospice benefit to federal programs and to shape hospices' legal environment. For example, Vitas contributed substantial amounts of money to law makers who sought to add hospice to veterans' benefits and obtained hospice coverage under President Clinton's failed 1993 effort to piece together a national health care plan.⁴⁴ Vitas also influenced or shaped structural aspects of the hospice market. In 1989, the Florida state legislature revised its 1979 hospice licensing law--which required hospices to be run as non-profits--to allow hospice programs incorporated on or before July 1, 1978 to change their corporate status to a for-profit or not-for-profit entity and transfer licensure to that entity.⁴⁵ The 1989 loophole allowed Vitas to serve as Florida's only for-profit hospice provider until 2006, when it ran 7 of 55 authorized programs and erected a substantial barrier to entry for southern Florida's lucrative hospice market.⁴⁶ When HHS rolled out guidelines for hospice compliance in 1999, Vitas general counsel Robert Clark conceded that the guidelines would disproportionately burden smaller providers and cause few problems for hospices with expensive compliance programs, like Vitas.⁴⁷ Vitas boasts that it is the "only major hospice provider employing full-time state and federal public affairs professionals to work with legislators, regulators and public policy experts to improve and expand end-of-life care."⁴⁸

Between 1986 and 1990, Vitas expanded through the establishment of new hospice centers in more states, acquisition of existing hospices, and expansion of patient census in then-served hospices. From its inception, Vitas used the expansion of its patient population as a key to drawing investors.⁴⁹ Through September 17, 1984, Vitas managed two hospices in southern Florida and opened a third in Dallas.⁵⁰ By 1989, it had acquired, opened or managed hospices in Boston, Chicago, Fort Worth and Houston. By 1997, it had expanded to California, Ohio, Pennsylvania and Wisconsin. Its growth was also fueled by innovations in patient recruitment and careful attention to the relationship between referral sources and hospice reimbursement rates. Internal memoranda and nursing home contracts from as early as 1990 showed that Vitas paid nurses cash bonuses for patient referrals, encouraged enrollment of patients in services that received higher Medicare reimbursements, and required that sales personnel be given access to nursing home customer files for possible hospice referral.⁵¹ Vitas tied employee compensation to growth in census.

“Everything was based on census,” says one former [Vitas] executive who asked not to be identified. “This is a for-profit company. Salaries are based on your success with census. Commissions, bonuses, pay for performance was all based on census. It was the organization’s goal to be the largest hospice in the country and to dominate the [geographic] area that you are in.” Until [1993] a special bonus program rewarded admission counselors for the number of patients they recruited. With 300 patients a counselor received a bronze medal and a \$1000 bonus. For 500 patients the counselor was given a silver medal and a \$2000 bonus. At 750 patients the admission counselor was awarded the company’s gold medal and a \$4000 bonus. And after recruiting 1000 patients into the program, the counselor would earn what was called the Founder’s Medal and a bonus of \$10,000. “I invented that,” says [Vitas] founding partner Don Gaetz, referring to the bonus system. “I’m a great believer in pay for performance.”⁵²

*448 III. The Chemed Investment, Influence and Takeover of Vitas, 1991-2004

In 1991, Vitas entered into an investment agreement with a subsidiary of Chemed Corporation, then as now known primarily for its ownership of Roto-Rooter, a franchise deliverer of plumbing and drain cleaning services. In return for a \$27 million investment, the agreement provided that Vitas would issue Chemed 270,000 shares of 9% preferred stock as well as warrants for Chemed to grow its interest in Vitas to as large as 28.3% of the corporation’s fully diluted shares.⁵³ While the investment was, strictly speaking, Chemed’s, it was negotiated by Edward L. Hutton (and signed by his son Thomas), who chaired Omnicare, Inc.--a large pharmaceutical provider for nursing homes spun off from Chemed in 1981--and who had extensive experience in the U.S. healthcare market.⁵⁴ Indeed, Vitas and Omnicare have maintained close commercial and corporate governance relations especially after Chemed assumed total control of Vitas in 2003.⁵⁵ In 1994, Chemed also acquired Patient Care, Inc., a large provider of home health aides.

The investment accompanied two important inflection points in Vitas’s history. First, it allowed Westbrook and Colliflower (who had personally purchased their non-profit Florida hospice for \$4.5 million in 1989) to sell their new Florida for-profit hospice to Vitas for \$10 million.⁵⁶ Second, it accompanied a shift in Vitas’s business strategy from hospice specialization into a more diverse portfolio of health care services. The Chemed investment resulted in a place on Vitas’s board of directors occupied by Timothy O’Toole who, at the time of the election was a director of Chemed and Omnicare and later of Patient Care.⁵⁷ Westbrook assumed a director position on Chemed’s board in 1992. The investor directors at Vitas--O’Toole and one designee each from Warburg Pincus and Galen Partners--comprised Vitas’s compensation committee which controlled recommendations for salaries, incentive compensation and benefits for executive officers and other employees and consultants. As of September 23, 1997, Westbrook, Colliflower, and their spouses and family foundations owned approximately 40% of Vitas’s outstanding shares. Additionally, Westbrook was the sole trustee of the employee stock ownership plan which controlled an additional 4.7% of Vitas shares. Chemed, which held only 1.4% of outstanding shares in September 1997, held warrants that enabled it to significantly grow its stake. More importantly, O’Toole, at least structurally, served as an important nexus of information and influence between Omnicare, Patient Care, Vitas and compensation arrangements for Vitas managers.⁵⁸

Vitas’s experiment with health care diversification crested with a failed 1996 merger with Apria Healthcare Group.⁵⁹ After the merger’s collapse, Vitas refocused on hospice services and filed preliminary documents with the U.S. Securities and Exchange Commission to become a publicly traded corporation. Even during its diversification experiment, Vitas’s net revenue increased from \$102 million to \$214 million from 1992 to 1996.⁶⁰ Between 1990 and 1995, Medicare

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payments to hospices exploded from \$318 million to \$1.9 billion.⁶¹ Vitas's fortunes tracked this expansion; from fiscal 1994 to fiscal 1996, the Company's revenue increased by 44% from 148.5 million to \$213.9 million.⁶² Notwithstanding this growth, Vitas fell into arrears on its payments due to Chemed in 1999 and 2000.⁶³ In 1996, the growth in hospice was slowed briefly during the Department of Health and Human Services' "Operation Restore Trust" initiative, which focused on the enrollment of patients whose care was legally ineligible for hospice reimbursement.⁶⁴ Although no formal action was commenced against Vitas, a preliminary review of 530 long-stay patients indicated that the "vast majority" of the files did not support patient eligibility for hospice.⁶⁵ Vitas abandoned the IPO in late 1998 and in 2001, formed Vitas Hospices Services, LLC, 10 days before amending its investment agreement with Chemed to issue a third warrant to purchase 1,636,000 additional shares of Vitas common stock in addition to extending the life of the 1991 warrants.⁶⁶ Chemed completed its acquisition of Vitas in 2003 (with an effective date in February 2004), after a third party unsolicitedly offered Vitas a buyout price in the low \$20-a-share range.⁶⁷

IV. Selling Hospice Before and After the Chemed Takeover

The corporate, investment and regulatory environment that shapes (and is shaped by) Vitas reveals practices aimed at selling more end-of-life care to the government via patients, families and caretakers who double as the source of crucial patient referrals. From the beginning, Vitas has clearly communicated to investors that its business model was dependent upon subtly and flagrantly influencing the persons and institutions that facilitate enrollment and longevity in hospice care. Initial eligibility must be certified by two physicians who affirm that the patient has a diagnosis of six months or less to live if a disease runs its normal course. After initial certification, only the hospice medical director's certification is necessary for indefinite renewal of 60-day eligibility periods, a change that accompanied the 1997 Budget Omnibus Reconciliation Act. The two-physician requirement initially envisioned a check imposed by a doctor *449 who had a previous relationship with the patient and could effectively assess the patient's probable demise, especially in the case of cancer. Over time, this initial "attending physician" requirement has been diluted so that while only doctors of medicine and doctors of osteopathy may officially certify (or re-certify) a patient as having a terminal illness, there is no bar to both physicians being hospice employees and regulations strongly suggest that a nurse practitioner (who may also be a hospice employee) will often influence the certification determination.⁶⁸ Similarly, federal regulations leave hospices to devise their own policies with respect to who comprises a patient's family for purposes of all communications.⁶⁹ So while the informed consent of a patient or his or her representative (defined exclusively under state law) is a requirement for Medicare participation, the scope of marketing and selling activities is much wider than just the patient and has become a core part of the commercialized hospice industry.

Vitas has conveyed to investors the wide berth given for marketing activities and put policies and personnel in place to influence the people and institutions surrounding hospice enrollment. Vitas admits that "the admission decision may be influenced by the Company's efforts to increase awareness of the benefits of timely enrollment in hospice programs"⁷⁰ and that "one of the Company's objectives is to increase awareness and acceptance of hospice services among medical professionals in order to increase both admissions and length of stay in its hospice programs."⁷¹ This is true not only for enrollment and length of stay but also for Medicare's much higher reimbursed "continuous" or "crisis" care category: "The Company believes that further growth is available ... [through] greater availability of continuous care to help patients remain at home when their symptoms and conditions require intense levels of care"⁷² Vitas has also long recognized the wide network of potentially influential people who might sway the hospice decision: "Each of these sources [physicians, nurses, discharge planners, social workers, clergy, nursing home administrators, and directors of nursing

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and managed care organizations and other third party payors] contacts a Company admission coordinator at the time it is determined that the patient's and his or her family's needs may best be met through hospice care.”⁷³

After Chemed assumed full control of Vitas between 2003 and 2004, communications to investors became more opaque but nevertheless emphasized the importance of Vitas's referral network. In its 2003 annual report, Chemed noted that “[i]n general, Vitas offers all levels of hospice care in a given market. In each of its markets, Vitas employs an active community relations effort that involves relationship building and hospice education activities, the extensive education of referral sources, and print and radio media initiatives. This broad-based approach has helped Vitas increase market share and achieve consistent historical revenue growth.”⁷⁴ Beginning in 2005, it adopted vaguer language which remained more or less standard to the present day:

Vitas' success is heavily dependent on referrals from physicians, long-term care facilities, hospitals and other institutional health care providers, managed care companies, insurance companies and other patient referral sources in the communities that its hospice locations serve, as well as on its ability to maintain good relations with these referral sources. Vitas' referral sources may refer their patients to other hospice care providers or not to a hospice provider at all. Vitas' growth and profitability depend significantly on its ability to establish and maintain close working relationships with these patient referral sources and to increase awareness and acceptance of hospice care by its referral sources and their patients. We cannot assure you that Vitas will be able to maintain its existing relationships or that it will be able to develop and maintain new relationships in existing or new markets. Vitas' loss of existing relationships or its failure to develop new relationships could adversely affect its ability to expand or maintain its operations and operate profitably. Moreover, we cannot assure you that awareness or acceptance of hospice care will increase or remain at current levels.”⁷⁵

Information about the persons and institutions surrounding potential hospice enrollees are collected, coded, distilled, systematized and cross-referenced across a range of ultimately financial accountability factors so that Vitas decision-makers may closely track employee and overall business performance.⁷⁶ In its 2004 10-K, it disclosed that:

Vitas' information systems infrastructure supports all its operations, including clinical operations, billing and collections, accounts payable and claims processing, financial reporting, human resources and compliance. The system is built upon a proprietary business enterprise application. At the corporate level, management uses this application to monitor and evaluate the various operating, clinical and employee performance measures. At the program level, it provides *450 detailed information on referral sources, patients and staffing for patient management, as well as staff scheduling and management.⁷⁷

In many ways, therefore, Vitas as a hospice provider has adopted, translated, and implemented practices introduced and honed in other health care service sectors like pharmaceutical sales, nursing homes, and home health service providers, and the division between these sectors and hospice is neither sharp nor easily regulated. Vitas's behavior is thus not explicable merely as a manifestation of a for-profit versus a non-profit hospice, although its search for investment and bank financing has certainly influenced its trajectory. Just as influential have been persons and corporate governance relationships which have introduced alternative business models, information from other health care sectors, and decision makers, who sit at the nexus of one or more health care service delivery firms and who may shape business decisions even if they do not strictly control the hospice provider.

V. The False Claims Act Allegations

The government's allegations against Vitas detail the various policies and structures the firm implemented to enroll ineligible patients, keep ineligible patients on hospice, and direct patients into higher reimbursement rate services.⁷⁸ At their most benign, these corporate structures relieved families with elderly or infirm (although not necessarily terminally ill) relatives from the emotional and resource burdens associated with their care. At their most pernicious, Vitas's alleged practices display various forms of coercion applied to patients, families, health care institutions, and medical personnel to convince people and families in vulnerable positions to forego curative treatment.⁷⁹

In its complaint, the government alleges that Vitas aggressively marketed hospice to patients, patients' families, and sources of referrals such as doctors and hospitals, often as a general form of skilled elder care.⁸⁰ It persuaded patients and families by mischaracterizing the availability of "continuous" or "crisis" care, a strategy foreshadowed as early as Vitas's 1997 IPO filings. Hospice employees misled patients by referring to continuous care as "intensive comfort care" and represented that Medicare would routinely cover round-the-clock care in the absence of acute symptoms.⁸¹ In fact, hospice employees stated that "intensive comfort care" was available any time the patient was experiencing symptoms which "caus[ed] distress to the patient or family."⁸² When Vitas delivered on these promises, it did so by certifying patients as requiring continuous care when they did not.⁸³ Nurses routinely arrived at the homes or care facilities of continuous care patients to find the patients had left to attend social activities or were able to perform activities of daily living with little or no assistance.⁸⁴ Members of the medical staff were also ordered to begin continuous home care without a physician's order.⁸⁵ These practices were enabled by either willful or neglectful failures to educate employees as to continuous care eligibility criteria.⁸⁶

The marketing of continuous care represented only one aspect of a much broader sales agenda with graver implications for patient autonomy and welfare. Vitas trained its marketing employees to sell hospice care to patients and were given monthly admissions goals. Vitas employees received bonuses based on both the number of patient admissions and on the amount of *451 time patients remained in hospice.⁸⁷ Conversely, Vitas disciplined those who did not meet monthly goals.⁸⁸ Indeed, one manager stated that Vitas's company policy was to "sign everybody up" for hospice care.⁸⁹ Vitas marketing employees conceded that Vitas spent a significant amount of resources training its marketing employees on how to "sell hospice" to patients, patients' families, and referral sources for potential hospice patients.⁹⁰

Hospice enrollment was shaped not just by raw monetary incentives but also by top-down education and training materials. In order to ensure that patients would meet the medical criteria to be enrolled in hospice, Vitas either provided their medical staff with inadequate training or no training in the requirements for enrollment under Medicare.⁹¹ Physicians and nurses who were aware of the proper policies were encouraged to bend or ignore Medicare rules.⁹² Members of the medical staff were expected to enroll patients without regard for their life expectancy or medical necessity.⁹³ Once enrolled, they were strongly discouraged from discharging patients, even if they no longer qualified for hospice.⁹⁴ Vitas also employed field nurses to provide care to its hospice patients residing in skilled nursing facilities, assisted living facilities, and hospitals, but did not provide them adequate training on the eligibility requirements for the Medicare hospice benefit.⁹⁵ Vitas directed these untrained field nurses, as part of their job duties, to identify elderly people who were eligible for the Medicare hospice benefit, and to encourage the referral of elderly people to Vitas for end-of-life care.

The challenge these practices pose for patient autonomy speaks for itself. Health care professionals' ethical canons (often adopted as part of regulatory, statutory or judicially crafted duties) require them to protect a patient's right to complete and accurate information on all aspects of treatment and accurate information about the patient's condition.⁹⁶ Federal regulations require that hospice staff must provide full informed consent about hospice services.⁹⁷ If a patient has a chronic illness that is manageable, the nurse or doctor is obligated to explain what treatment options are available, that regular medications may be continued, even though the patient has a terminal illness. Patients with terminal illnesses are often in pain or intermittently aware, so that achieving informed consent would be challenging in many cases even from the most objective decision maker. Offering incentives to physicians, nurses, clergy and other health care professionals to recommend enrollment and mischaracterizing the services hospices may legally provide to family members applies extraordinary pressures to the informed consent principle.

During the earliest debates over federal reimbursement for hospice, the question of patient consent weighed heavily, and it was never adequately addressed and certainly not resolved.⁹⁸ Reporting on one of the early national surveys of hospice care, HHS Inspector General Richard Kusserow noted that informed consent principles around hospice admission were fiercely contested and that a reimbursement plan of any kind would distort hospice admissions practices then under study.⁹⁹ As the government's complaint notes, Vitas's strategy of "selling hospice" is inconsistent with current Medicare requirements because a patient who elects hospice care under the Medicare program also chooses to stop receiving curative care for his or her illness.¹⁰⁰ The tension between principles of informed consent, curative and palliative treatment continues to play out in federal hospice policy. In 2014, the Centers for Medicare and Medicaid Services announced a pilot program to allow patients diagnosed with advanced cancers, chronic obstructive pulmonary disease, congestive heart failure, and/or HIV/AIDS to seek both hospice and curative treatment.¹⁰¹

Conclusion

This article has taken a longitudinal view of the largest hospice provider in the United States, including its investment history, its corporate structure, and key inflection points in its growth. It has demonstrated that the commercialization of hospice care has resulted in the expansion of monetary and business incentives to the care network that used to work toward patient welfare free of these distorting influences. Moreover, the expansion of hospice care has grown hand in hand and borrowed commercial innovations from other health care sectors. Given the changing incentives of medical and non-medical professionals to refer patients and families to hospice providers, both federal conditions of participation and state informed consent law may need to require financial and other conflict-of-interest disclosures in the process of hospice enrollment to a greater extent and with greater effectiveness than now prevails. For hospice researchers, at least three additional conclusions may be drawn regarding the state of the academic literature on hospice provision in the United States. First, the current (and growing) fault line in the literature around for-profit and non-profit may conceal as much as it reveals about hospice practices and desired reforms. While for-profit status is a relevant inquiry, the corporate governance structure, overlapping directors, and cross-sector alliances and partnerships may have more to do with how hospices behave. This is especially true in the health care sector, where joint ventures between for-profit and nonprofit entities may be carefully structured so as to *452 conduct business as a for-profit firm would but still obtain tax exempt status. Second, laws and regulations have distributive effects on the market for hospice services. Therefore, hospice researchers should be more engaged with how changes in reimbursements, core services, interdisciplinary group requirements, definitions of relevant personnel, certification, and enforcement may be driven by efforts to shape specific services or national market presence. Indeed, the initial structure of hospice beginning in 1982 appeared to both distinguish it from then-existing providers of home health and other services and to advantage certain first-moving participants, like Vitas. Third, there is scant attention in the literature to the corporate and investment

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structures that surround hospice provision including the following: overlapping directors between hospice and other health care providers; contracts between hospice firms and other providers especially in the pharmaceutical, nursing home, and home health sectors; and scrutiny of merger and divestiture activity. Although this information will be most readily available from publicly traded firms subject to securities disclosure laws, state secretaries of state, IRS form 990s (for non-profit hospices), and growth in lawsuits under the False Claims Act are additional rich resources for hospice researchers.

Disclosure

The author's spouse is an attorney for the U.S. Government in the case styled *U.S. v. Vitas Hospice Servs., L.L.C.*, No. 4:13-cv-00449-BCW (W.D. Mo., May 2, 2013). The views expressed in the article and research supporting it are the author's alone.

Footnotes

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