In the Business of Dying: Questioning the Commercialization of Hospice

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> *In our society, some aspects of life are off-limits to commerce. We prohibit the selling of children and the buying of wives, juries, and kidneys. Tainted blood is an inevitable consequence of paying blood donors; even sophisticated laboratory tests cannot supplant the gift-giving relationship as a safeguard of the purity of blood. Like blood, health care is too precious, intimate, and corruptible to entrust to the market.*[1]

Introduction

The hospice movement in the United States is approximately 40 years old. During these past four decades, the concept of holistic, multidisciplinary care for patients (and their families) who are suffering from a terminal illness has evolved from a modest, grassroots constellation of primarily volunteer-run and community-governed endeavors to a multimillion dollar industry where the surviving nonprofits compete with for-profit providers, often publicly traded, managed by M.B.A.-trained executives, and governed by corporate boards. The relatively recent emergence of for-profit hospice reflects an increasing commercialization of health care in the United States, the potentially adverse impact of which has been well documented.[2] Here we refer to the general threats against medicine's ethical foundations that are made by health care organizations attempting to marry the "fundamental objective" of commerce, i.e., "achieving an excess of revenue over costs" so as to ensure profits for owners and investors, with the delivery of quality care to vulnerable consumers who are often compromised in their ability to make decisions.[3] In the case of hospice, of course, the "customer" suffers from a terminal condition, which intensifies ethical concerns regarding the priority of the patient's needs (ahead of profit-taking), the importance of dealing with patients "honestly, competently, and compassionately," and the avoidance of any conflicts of interest "that could undermine public trust in the altruism of medicine."[4]

Infusing these ethical reflections, as is always the case either explicitly or implicitly in considerations of health care policy in the United States, are business concerns about how best to deliver services consistent with notions of free market competition and entrepreneurialism.[5] As capitalism's proponents have argued,

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profit incentives and commercial freedoms have promoted efficiencies and innovations across a wide diversity of industries.[6] Health care, however, is unlike other commodities, and the U.S. market for health services is not an unadulterated market of purely private players. Rather, the health care of a nation is a matter of public concern, and taxpayers underwrite many of the direct costs.[7] Desires to lower overall health care costs — always in tension with a variety of ethical considerations relating to individual patient care and public health — are theoretically shared by all participants and stakeholders in the U.S. system, including patients, providers, investors, regulators, and taxpayers. Yet, the extent to which the Medicare hospice benefit and corresponding proliferation of hospice service providers has resulted in overall systemic cost savings in the end-of-life context (as was envisioned by the original policymakers) remains contested.[8]

Although published research in this area is limited, evidence indicates, as one would expect given the pressures to deliver a return on investment, that for-profit facilities, and especially publicly-traded chain providers, generate higher revenues than their nonprofit competitors. These cost savings and profit margins appear to flow primarily from business decisions relating to selective recruitment of a longer-term, increasingly non-cancerous, population of Medicare patients and the payment of lower salaries and benefits to less-skilled staff.

However, specific financial comparisons between for-profit and nonprofit hospice providers have been more conclusive. Although published research in this area is limited, evidence indicates, as one would expect given the pressures to deliver a return on investment, that for-profit facilities, and especially publicly-traded chain providers, generate higher revenues than their nonprofit competitors.[9] These cost savings and profit margins appear to flow primarily from business decisions relating to selective recruitment of a longer-term, increasingly non-cancerous, population of Medicare patients and the payment of lower salaries and benefits to less-skilled staff.[10] Additionally, large chain hospice providers may realize further increased revenues as a result of efficiencies in their administration of regulatory processes and delivery of services across multi-state locations.[11]

Many patients and families experience hospice as a preferred pathway to dying well and a social consensus regarding the merits of hospice has been reached among many over the last few decades.[12] This same time period has also been marked by the emergence of for-profit medicine and commercial interests as dominant trends in U.S. health care, which we address in Part I. In the last decade, this general trend in the direction of "market-driven medicine" has prompted the rapid rise of the for-profit hospice industry, as discussed in Part II of this article. Given the individual and social value that the nonprofit hospice sector has proven to be and the conflicting interests inherent in for-profit medicine, we wonder whether the original philosophy of hospice as embodied in its earliest nonprofit and community-based manifestations is potentially threatened by a creeping commercialism across the entire hospice industry. Indeed, hospice has always been "an attempt to transform the harmful practices of medicine-driven technology and profit" into a "compassionate caring" that restores a "sincere empathy, respect, and spiritual significance to the complex business of relieving suffering at the end of life."[13] Accordingly, Part III of this article raises critical questions rooted in ethical concerns that will require continuing vigilance and further study as the hospice industry confronts increasing pressures to provide holistic, quality care, and pain management for those who are dying, while balancing commercial considerations related either to maintaining merely sustainable margins in an increasingly competitive market or to satisfying investors and shareholders who seek to realize maximum profits from Medicare's per diems.

Part I: The Emergence of For-Profit Health Care

Observers of the practice of medicine in America have been sounding alarms about the creeping commercialization of U.S. health care for at least the last 30 years. Writing in 1980, Arnold Relman, then editor of the *New England Journal of Medicine*, described what he alarmingly viewed as the "new medical-industrial complex" of for-profit corporations in the business of providing health care services to patients.[14] Dr. Relman was particularly concerned about the emergence of proprietary hospitals and nursing homes, as well as home care, diagnostic laboratory, and hemodialysis services.[15]

Hemodialysis, in fact, presented a "particularly interesting example of stimulation of private enterprise by public financing of health care."[16] Relman was referring to the rapid expansion of the patient population receiving long-term hemodialysis following Congress's decision in 1972 to cover treatment of end-stage renal disease under Medicare.[17] Fueled by the flow of federal funds, the for-profit dialysis industry mushroomed from nearly non-existent in the early 1970s to a 40% market share by 1980.[18] By 2002, 75% of dialysis services were provided by private, for-profit facilities, and early fears about compromises in patient care were being realized in the form of increased risk for premature patient death.[19] Similarly, more recent research seems to confirm that Medicare erythropoietin (or EPO, a drug used to treat anemia resulting from kidney disease) reimbursements — the second-largest source of dialysis facility income — are incentivizing large, for-profit chain facilities to administer dosages of the drug in excess of the clinical guidelines.[20]

The conflicting interests inherent in the incentive structures of for-profit health care endeavors demand careful scrutiny. This is particularly important in the end-of-life hospice context.

Writing for the Institute of Medicine in 1983, Bradford Gray outlined the controversy surrounding the widespread emergence of for-profit medicine during the 1970s.[21] Proponents of the investor-owned trend in health care heralded the efficiencies, innovations, and fiscal discipline associated with business management practices designed to grow market share and maximize profits consistent with free market principles.[22] Critics, however, argued that large and enduring percentages of uninsured and underinsured Americans evidenced market failure. They argued that conflicts of interest are constitutive of for-profit business models that are premised upon financial incentives designed to encourage ever-expanding consumption of finite and expensive goods.[23] Such conflicts of interest have, for example, resulted in well-documented cases of unnecessary medical services and treatments, often bloating systemic health care costs at tax-payers' expense.[24] In extreme cases, pressures to meet profit goals and satisfy investor expectations have resulted in fraud prosecutions of for-profit health care providers, most infamously realized in the cases of Tenet Healthcare and Healthcare Corporation of America (HCA), although the nonprofit sector has not been immune from government prosecution arising out of illicit reimbursement practices.[25] It is precisely because of congressional cost concerns related to fraudulent billing and other improper over-utilization of Medicare-reimbursable services that anti-kickback legislation, the Stark laws, enforcement of the False Claims Act, and other regulatory efforts have proliferated from the mid-1970s through the most recent health care reforms of 2010.[26]

Additionally, the emergence over the last 30 years of for-profit health providers has prompted concerns about whether ownership status has any correlation to the quality of care provided. On this point the case of nursing homes is illustrative. Relatively consistent data indicate that differences in care do exist between for-profit and nonprofit nursing home providers "as measured by staffing ratios, quality-of-care and quality of life deficiencies, advance care planning discussions, complaints per home, and, in some cases, adverse health outcomes."[27] The conflicting interests inherent in the incentive structures of for-profit health care endeavors demand careful scrutiny. This is particularly important in the end-of-life hospice context, to which we now turn our attention.

Part II: Rise of the For-Profit Hospice Industry

The modern hospice movement traces its origins to the mid-20th century work of physician Dame Cicely Saunders, who founded St. Christopher's Hospice in 1967 in a suburb of London.[28] The hospice concept was imported to America by Florence Wald, the dean of the Yale School of Nursing, who invited Dame Saunders to teach the concepts of holistic treatment of patients' physical, spiritual, and psychological well-being at Yale in the late 1960s. At the same time, the work of Dr. Elizabeth Kubler-Ross was recalibrating social understandings of death and arguing that perhaps death did not have to be seen as the failure of medicine to keep a patient alive.[29] Out of Kubler-Ross's work, the "right" of patients to participate in decisions impacting their death process began to gain traction.[30]

All of this, of course, emerged during a time in which physician paternalism was still the dominant ethos and emerging end-of-life medical technologies were fostering liminal conditions — "twilight zones of suspended animation where death commences while life, in some form, continues"[31] — in which the possibility of postponing death was creating novel bioethical dilemmas.

Nevertheless, the earliest American hospices were "small, volunteer dominated community-based programs which provided spiritual support and palliative care to terminal patients and their families," and they began to spread rapidly during the 1970s.[32] While fewer than 60 hospices existed in 1978, that number had expanded to over 400 by 1981 and the movement soon captured the attention of policymakers in Washington.[33]

Congress created the Medicare hospice benefit in 1982 for patients diagnosed as "terminally ill."[34] To qualify for the benefit, a patient's "attending" physician, as well as the hospice physician, must certify that the patient has "a life expectancy of 6 months or less."[35] For hospice providers caring for a terminally ill patient, the federal benefit pays a fixed per diem.[36] The amount of the daily rate is determined by the appropriate category of care required by the patient: (1) routine home care; (2) continuous home care; (3) inpatient respite care; or, (4) general inpatient care. Importantly, however, the daily rate is paid by Medicare regardless of the services actually provided by the hospice provider on any given day and even if no services are provided. Services covered include nursing care, physician services, pain management, medical social services, counseling (including bereavement services), physical therapy, occupational therapy, speech-language pathology, dietary counseling services, and homemaking services.[37]

According to Greer and Mor, leaders of the pioneering National Hospice Study, this legislation emerged at the behest of dual constituencies: care givers and entrepreneurs.[38] Care givers, particularly non-M.D. professionals, desired a legal mandate requiring that hospice services be built around interdisciplinary teams, including volunteers, spiritual counselors, and other "low-technology providers."[39] Entrepreneurs, on the other hand, envisioned the development of "profit-making hospice chains" and lobbied for the benefit on the basis that it would create a new opportunity to further the competitive, proprietary interests that Relman had characterized as the emerging "new medical-industrial complex" just two years earlier.[40] As early as 1985, Greer and Mor worried that the "smaller, volunteer-oriented hospices, which have contributed significantly to the image of hospice in our country, may be unable to survive in a commercialized environment."[41]

Throughout the 1990s, the per diem rates paid by Medicare steadily increased, as end-of-life issues, including advanced directives and palliative care, received greater attention from researchers, health care practitioners, and public policy officials. By 2006, approximately 40% of Medicare beneficiaries who died were cared for during their final days or weeks of life under the auspices of a hospice program where specialists working in interdisciplinary teams treated their symptoms, relieved their pain, and provided a range of therapeutic services and other types of support, including, housekeeping duties for those electing to die at home.[42]

As originally conceived, there was "a strong expectation that hospice services would result in lower costs to the Medicare program than conventional medical interventions at the end of life."[43] Yet, as with every other sector of the health care economy, hospice costs have risen at alarming rates in recent years. According to the Government Accountability Office, between 1992 and 2002, "Medicare payments for hospice care increased fivefold, to about $4.5 billion,...the number of Medicare patients increased fourfold, to approximately 640,000,...[and] the number of Medicare-participating hospices grew by almost 90 percent to 2,275.[44]

Just six years later, hospice expenditures more than doubled to exceed $11 billion, Medicare beneficiaries receiving hospice services (for increasingly longer periods of time) topped one million, and the number of hospice locations rose to greater than 3,300, with for-profit providers accounting "almost entirely" for this increase.[45] In fact, from 2001 to 2008, the for-profit hospice industry grew 128 percent, while the nonprofit hospice sector only grew by 1 percent and government-owned hospice grew by 25 percent.[46] The result of these trends is that now approximately 52 percent of hospices are for-profit, 35 percent are nonprofit, and 13 percent are owned by the government.[47]

Given this shifting ownership landscape and the forecasts for continued growth in patient population and federal reimbursements, we are troubled by the potential for ethical compromises as the delivery of hospice services becomes an increasingly commercial endeavor. To those concerns we now turn.

Part III: Questioning the Commercialization of Hospice

As originally conceived, hospice was marked by a holistic approach to patient care, animated by altruistic motivations that placed ultimate priority on care for the dying individual and her family. The concept has been accepted and embraced by large segments of the American public and policymakers because its hallmark practices are understood to be rational and compassionate components of end-of-life health care. Yet, the increasing dominance of for-profit providers, beholden to the expectations of investors, introduces a profit-making concern that threatens to compete with patient care for ultimate priority. Perhaps the dual goals of profit-taking and care-giving can be aligned theoretically in ways that neither would be compromised. But in the actual business practices of for-profit managers and care decisions of for-profit providers, there is at a minimum some cause for heightened scrutiny.

How Do For-Profit Hospice Providers Market Their Services and Recruit Their "Customers"?

In recent years the media have begun to report anecdotally about the manner in which some hospice providers have so successfully grown their business. For instance, VITAS Hospice Services, LLC, the largest provider of hospice services in the United States (operating 46 facilities across 15 states and the District of Columbia), reportedly sends its patient recruiters into nursing homes equipped with pens and coffee cups for staff and then pays a commission to those recruiters who successfully sign-up patients for VITAS's services.[48] A rival hospice provider was indicted for allegedly paying nursing home operators $10 per day to assist in patient recruitment efforts and paying physicians $89 a month to certify patients as hospice eligible without examining the patient or reviewing medical records.[49] The extent to which some hospice providers may be employing "community education representatives"[50] to market hospice services and recruit hospice patients demands vigilance in the form of either industry self-policing or government oversight.[51] In fact, the latter option was recommended in 2009 by the Medicare Payment Advisory Commission (MedPAC), which said the Office of Investigator General should investigate "financial relationships between hospices and long-term care facilities [ ] that may represent a conflict of interest and influence admissions to hospice;...the appropriateness of enrollment practices...; [and] the appropriateness of hospice marketing materials and other admissions practices."[52]

Hospice-eligible patients, by definition, are facing a relatively imminent death. In this context, many patients and their family-member advocates are experiencing myriad emotions potentially compromising their judgment and ability to comprehend the implications of entering into hospice. Given these heightened vulnerabilities, potential hospice candidates are more susceptible to unscrupulous marketing techniques and over-promising with regard to services that will be provided. If a patient recruiter stands to personally benefit in the form of a commission or bonus for reaching and maintaining enrollment goals,[53] such an incentive potentially conflicts with the candor required for a potential hospice patient to make an informed decision about whether to forego continued curative medical treatments, a necessary condition of enrollment in hospice.

Moreover, concerns exist over whether hospice providers, regardless of ownership structure, intentionally select patients who are likely to have longer lengths of stay and thus result in the generation of greater revenues. Because of Medicare's current payment policy, which pays the same flat rate per diem (regardless of the patient's specific terminal illness), a tempting incentive is created to target patients who will require less expensive care over a longer period of time. As a 2009 MedPAC report to Congress noted, "A strong correlation exists between length of hospice stay and profitability.... The concern is that some new hospice providers, which are predominantly for-profit, may be pursuing a business model based on maximizing length of stay and thus profitability."[54] The 2008 MedPAC report found that "hospices with longer lengths of stay are more profitable [because] length of stay in a for-profit hospice is about 45% longer than the length of stay in a not-for-profit facility."[55] While seemingly counterintuitive, it turns out that the longer a patient remains in hospice, the less costly it is for the provider to care for her because over the course of a lengthy hospice arrangement, the patient's baseline of necessary care becomes less rigorous and time intensive. The current Medicare policy makes sense if one considers that hospice was designed to offer only palliative, not curative, treatment. When the Medicare benefit was created in 1982, the concept of palliative medicine was not disease specific.[56] Therefore, while the revenue from federal reimbursements remains constant, costs associated with patient care do not.[57] As Lindrooth and Weisbrod illustrate, hospice costs during approximately the first four days of patient care are relatively high, due to the additional time required to transition a patient and relevant family members into the hospice program and attend to their emotional and physical needs. Likewise, a patient's final days prior to death are relatively more time and resource intensive, and therefore more costly.

During the intervening time period, however, costs of care are relatively lower and constant. Of course, these intermediary costs escalate in the context of patients requiring more expensive palliative care, such as chemotherapy, radiation, or recreational services, which explains why hospice providers needing to keep investors satisfied, seeking to realize a profit, or simply struggling to maintain a margin that will sustain the organization's mission, are rationally tempted to selectively recruit patients with non-cancer diagnoses, for example.[58] This "U-shaped" cost function and linear revenue stream creates a "financial incentive for all hospices…to maximize the duration" of a patient's stay in order to distribute the higher costs at the beginning and end of treatment and increase overall profits.[59]

Although MedPAC has called for an adjustment to the reimbursement structure that would pay relatively more per day for those higher costs associated with the entrance of a patient into hospice and for those higher costs associated with the patient's death, these payment changes will not be implemented before 2013.[60] Meanwhile, the current per diem paid by Medicare remains constant throughout a patient's stay, regardless of how much time is actually devoted to patient care and the delivery of hospice services.[61] Without changes to the current reimbursement structure, coupled with measures to ensure greater accountability in the use of these benefits, we are concerned about the potential for a more dominant hospice provider to serve selectively a higher percentage of patients with a non-cancer diagnosis. The patient population at such a hospice could thereby average significantly longer and more lucrative periods of time during which the provider would realize a great return on the Medicare per diem payments for those patients, while potentially shifting a disproportionate share of the more costly short-term patients to hospice providers with a broader commitment to a community beyond those with an ownership interest.[62]

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While all hospice providers, regardless of ownership status, are incentivized to "game" the system according to the current reimbursement policy, Lindrooth and Weisbrod analyzed admission data at 104 for-profit and 534 religious nonprofit hospice providers over a three-year period in an effort to determine whether patterns of patient selection could be identified. Their data demonstrate that for-profit hospices — more so than the religious nonprofit hospices they also studied — respond to the Medicare reimbursement incentive by selectively admitting patients with primary diagnoses, recent curative care, and ages that would suggest probabilities for a longer life trajectory, and correspondingly higher profits.[63]

Additional data published by Lorenz et al. examined 67 for-profit hospices and 109 nonprofit hospices operating in California to determine whether patterns in patient population could be determined.[64] This study concluded that for-profit hospice providers treat a disproportionate number of patients who were either previously in a long-term care facility and/or suffer with a non-cancer diagnosis. Moreover, these researchers confirmed that a higher percentage of for-profit patients do in fact remain in hospice longer than 90 days.[65]

Longer stays, of course, are not intrinsically problematic. Indeed, getting a patient into hospice for a longer and more managed death process can be more conducive to the holistic and comprehensive care for both patient and family that hospice promises. Recent research also suggests greater systematic cost savings can result from longer stays in hospice.[66] Moreover, a variety of reasons unrelated to fraudulent or nefarious practices may explain differences in enrollment patterns, including a good faith effort on the part of for-profit providers to include terminal, non-cancer patients who have been traditionally under-represented among hospice populations.[67]

Do Commercial Concerns Compromise the Quality of Care Delivered by Hospice Providers?

Interdisciplinary, coordinated care has been a hallmark of the hospice philosophy of holistic end-of-life care since the movement's inception. Moreover, government reimbursement via Medicare is conditioned upon the hospice organization's provision of a team that includes at least one physician, one registered nurse, and one social worker.[68] The inclusion of such expertise is necessary to coordinate the medical, psychological, and social components of hospice care "core services" as described in federal law, which pursuant to an individual patient's written plan, must include availability to physician services, skilled nursing care, dietary or nutritional services, psychological counseling (including bereavement therapy), spiritual care, and medical social services.[69] "Noncore" services include physical therapy, speech therapy, occupational therapy, continuous home care, and household/homemaker services.[70] Hospice providers, however, have discretion with regard to staffing specifics.

At least one study has demonstrated that staffing patterns do differ among hospice providers in ways that correlate to ownership status, although no correlations established patterns of adverse or compromised patient care.[71] The research noted above by Lorenz et al. examining California hospices in the late 1990s also found that for-profit hospices provided a mix of overall less-skilled nursing care, but failed to establish whether quality of patient care in general suffered as a result of these staffing decisions.[72] In fact, this same study found "no significant difference in the actual number of skilled nursing visits per patient day provided by for-profit hospices (0.33) versus not-for-profit hospices (0.35)."[73]

More recent data from researchers at Yale found "substantial variation by hospice ownership type in the patterns of interdisciplinary staff."[74] Again, while correlations to adverse impact on quality of care were not proven, the study did find that for-profit hospice facilities typically employ less expensive labor, including fewer registered nurses, fewer medical social workers, and fewer clinicians.[75]

In addition to staffing differences, other research suggests that patterns of care do differ among hospice providers with different ownership structures, although, again, evidence of wide-spread adverse or compromised patient care does not exist.[76] However, when adjustments are made for differences in patient diagnosis, disability, gender, and other variables, patients of for-profit hospices have been shown to receive significantly fewer types of services than do patients of nonprofit hospices, including continuous home care and bereavement services. Due to the difficulties in assessing the relative value of specific services to individual patients, even these limited studies fail to establish an overall diminished quality of care at for-profit providers. However, these findings did prompt one set of researchers to speculate regarding how differences in "origin" influence the hospice endeavor:

> One possible interpretation [for why for-profits provide a narrower range of services when compared with nonprofit hospices] is that the different patterns of care are the result of the differing origins of the for-profit and nonprofit hospice. The traditional, nonprofit hospice emerged as a philosophy of care that emphasized psychosocial support, spiritual care, the use of volunteers and family, and symptom management. The for-profit hospices that have emerged more recently, however, might not be as strongly rooted in this traditional hospice philosophy.[77]

To be clear, Carlson et al. are not suggesting that evidence exists of inferior care at for-profit hospice providers. Rather, these researchers are highlighting the reality that a more commercialized, entrepreneurial approach to hospice may privilege business practices and financial responsibilities to investors in ways that challenge their concomitant commitment to ethical health services and duties to patients. Again, while the financial bottom line driving for-profit hospice providers is the creation of profits, this pressure may not be all that different from that facing the nonprofit hospice provider attempting to bolster enough revenues not only to keep the doors open, but also to expand services and maintain competitive employee compensation. The quote above by Carlson et al., however, reminds us that business management principles focused on increasing market share, reducing labor costs, and creating economies of scale may become problematic to the extent they threaten to compromise the death experience of the patient, i.e., the "traditional hospice philosophy." To be sure, more data examining potentially negative correlations between business practices and patient care are needed.

Conclusion

Charles F. von Gunten, editor-in-chief of the *Journal of Palliative Medicine*, recently opined that perhaps "there really is no difference in the care delivered by hospices of differing tax status," and therefore, on the question of profit versus not-for-profit, he concluded: "Who cares?"[78] Von Gunten's position was bolstered by the recognition that current data defining quality and measuring outcomes in the realm of hospice support neither the demonization nor the canonization of either ownership structure. To be sure, our review of the literature confirms the necessity of more sophisticated studies of business practices and patient care throughout the hospice industry, with a keen eye trained on how ethical issues are addressed when they intersect with commercial interests and financial incentives.

The concerns raised in this article, particularly regarding recruitment of patients and patterns of patient care, are intended to highlight ethical conflicts suggested by an increasingly commercialized health services marketplace that is infused with large sums of federal money accompanied by increased regulatory oversight. Yet, a number of questions suggest the importance of continued research, deliberation, and oversight in this area: Will the patient's experience of hospice services (as envisioned by Dame Saunders, i.e., marked by a fundamentally altruistic system of organization and governance) be compromised by the practices of profit-driven competition and additional costs associated with government regulation?[79] What non-financial costs may be borne by patients, their family, and hospice providers if the hospice industry's traditional emphasis on principles of community welfare maximization cannot be reconciled to more individual notions of profit maximization? How, in ways that are not unnecessarily paternalistic, will the hospice industry guard against the exploitation of an unsuspecting population that is particularly vulnerable? The challenge for medical professionals, health care businesspersons, academic researchers, policymakers, and government regulators going forward will be to address these questions in a manner that will preserve the spirit of hospice as it was originally envisioned and as it has come to be understood, experienced, and relied upon by much of the public.

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References

1. S. Woolhandler and D. U. Himmelstein, "When Money Is the Mission – The High Costs of Investor-Owned Care," *New England Journal of Medicine* 341, no. 6 (1999): 444-446, at 446. Making a similarly impassioned argument five years later, Woolhandler and Himmelstein highlighted concerns that are particularly salient in the context of hospice: "Investor-owned care embodies a new value system that severs the community roots and Samaritan traditions of hospitals, makes physicians and nurses into instruments of investors, and views patients as commodities." S. Woolhandler and D. U. Himmelstein, "The High Costs of For-Profit Care," *Canadian Medical Association Journal* 170, no. 12 (2004): 1814-1815.
2. See A. S. Relman, "Medical Professionalism in a Commercialized Health Care Market," *JAMA* 298, no. 22 (2007): 2668-2670; A. R. Jonsen, "A Note on the Notion of Commercialism," *Cambridge Quarterly Healthcare Ethics* 16, no. 4 (2007): 368-373, at 369 ("In our culture, medicine has, for the most part, been a commercial activity [except when monks were its practitioners] and has, as such, always presented moral problems."); J. J. Fins, "Commercialism in the Clinic: Finding Balance in Medical Professionalism," *Cambridge Quarterly Healthcare Ethics* 16, no. 4 (2007): 425-432, at 425 ("There is a palpable malaise in American medicine as clinical practice veers off its moorings, swept along by a new commercialism that is displacing medical professionalism and its attendant moral obligations."); W. S. Andereck, "Commodified Care," *Cambridge Quarterly Healthcare Ethics* 16, no. 4 (2007): 398-406 (examining the characteristics of healthcare commodification in the context of medical care and exploring its effects on the doctor-patient relationship); L. R. Churchill, "The Hegemony of Money: Commercialism and Professionalism in American Medicine," *Cambridge Quarterly Healthcare Ethics* 16, no. 4 (2007): 407 (exploring the cultural meaning attached to money and its pervasive force throughout medical research, education, and the delivery of health services); M. A. Rodwin, "Medical Commerce, Physician Entrepreneurialism, and Conflicts of Interest," *Cambridge Quarterly Healthcare Ethics* 16, no. 4 (2007): 387-397 (tracing the historical development of medical commerce in the United States from the late 18th century through the early 21st century, and arguing that the primary problem of commercialism in medicine today is the conflict of interest that arises when loyalty to patients and the exercise of independent professional judgment is compromised by physician entrepreneurship); J. Needleman, "A Philosopher's Reflection on Commercialism in Medicine," *Cambridge Quarterly Healthcare Ethics* 16, no. 4 (2007): 433-438, at 437 (2007) (advocating for reflection among physicians as to "how…the money factor…impact[s] the human values often assumed to define the art of medicine, understood as the work of always and in everything giving first priority to the health and well-being of the individual patient[.]"); J. H. McArthur and F. D. Moore, "The Two Cultures and the Health Care Revolution," *JAMA* 277, no. 12 (1997): 985-989 (arguing that while traditions of commercialism and professionalism both share a central role in the evolution of social institutions in the United States, "threats" exist to the "quality and scope of medical care" when "the tradition of medical professionalism is overtaken by the commercial ethic and by corporations seeking profit for investors from clinical care of the sick.").
3. *Id.* (McArthur and Moore), at 986. See also I. R. Byock, "Ethics from a Hospice Perspective," *American Journal of Hospice & Palliative Care* 11, no. 4 (1994): 9-11, at 9 ("Ethical considerations are central to hospice practice. Unlike many areas of medicine in which it is the occasional case that presents an apparent ethical dilemma, care at the end of life is full of ethically poignant and emotionally charged situations." The potentially crippling impact of illness upon patients seeking information and making decisions about their health care is comprehensively summarized by M. A. Hall and C. E. Schneider in "Patients as Consumers: Courts, Contracts, and the New Medical Marketplace," *Michigan Law Review* 106, no. 4 (2008): 643-689 ("Illness disables…pains…exhausts…erodes control…enforces dependence…disorients…baffles…terrifies…[and] isolates.").
4. See Relman, *supra* note 2, at 2668.
5. See Rodwin, *supra* note 2, at 387-395.
6. See generally R. Herzlinger, *Who Killed Health Care?* (New York: McGraw-Hill, 2007): at 211.
7. Eighty-five percent of all hospice care is paid by the government, either through Medicare or Medicaid reimbursements. J. Cetti, "Measure the Social Outcomes of Nonprofits," *Journal of Palliative Medicine* 12, no. 1 (2009): 12-13. As of 2008, the Medicare benefit cost the government $11.4 billion. National Association for Home Care and Hospice, *Hospice Facts and Statistics*, September 2009, *available at* <www.nahc.org/facts/hospicestats09.pdf> (last visited February 25, 2011).
8. See generally K. L. Cerminara, "Pandora's Dismay: Eliminating Coverage-Related Barriers to Hospice Care," *Florida Coastal Law Review* 11, no. 2 (2010): 107-154, at 153 ("Hospice care costs less than curative care . . ."); M. Ash and S. Arons, "Economic Parameters of End-of-Life Care: Some Policy Implications in an Era of Health Care Reform," *Western New England Law Review* 31, no. 2 (2009): 305-332, at 315-320 (summarizing the literature); D. H. Taylor Jr. et al., "What Length of Hospice Use Maximizes Reduction in Medical Expenditures Near Death in the US Medicare Program?" *Social Science &*

Medicine 65, no. 7 (2007): 1466-1478, at 1474 (finding no cost differences between hospice users and controls when looking at the entire last year of life, but finding clear evidence of savings for Medicare attributable to hospice during the period of time in the last year of life that hospice is actually used in the Medicare program); D. E. Campbell et al., "Medicare Program Expenditures Associated with Hospice Use," *Annals of Internal Medicine* 140, no. 4 (2004): 269-277, at 275 (finding that hospice is cost-neutral to cost-saving for persons who die of cancer, but generally adds cost for those who do not die of cancer); J. P. Harrison and D. Ford, "A Comprehensive Community-Based Model for Hospice Care," *American Journal of Hospice & Palliative Medicine* 24, no. 2 (2007): 119-125 ("appropriate use of hospice could generate savings of 46.5% during the last month of life, 17% during the last 6 months of life, and 10.4% during the last year of life"); M. B. Buntin and H. Huskamp, "What Is Known about the Economics of End-of-Life Care for Medicare Beneficiaries," *Gerontologist* 42, no. 3 (2002): 40-48 (summarizing the literature).

9. M. J. McCue and J. M. Thompson, "Operational and Financial Performance of Publicly Traded Hospice Companies," *Journal of Palliative Medicine* 8, no. 6 (2005): 1196-1206.
10. See *infra* Part III.
11. See McCue and Thompson, *supra* note 9.
12. K. A. Lorenz et al., "The Evidence for Improving Palliative and End of Life Care: A Systematic Review," *Annals of Internal Medicine* 148, no. 2 (2008): 147-159; J. M. Teno et al., "Family Perspectives on End-of-Life Care at the Last Place of Care," *JAMA* 291, no. 1 (2004): 88-93; R. D. Brumley, S. Enguidanos, and D. A. Cherin, "Effectiveness of a Home-Based Palliative Care Program for End-of-Life," *Journal of Palliative Medicine* 6, no. 5 (2003): 715-724; D. S. Greer and V. Mor, "An Alternative in Terminal Care: Results of the National Hospice Study," *Journal of Chronic Diseases* 39, no. 1 (1986): 9-26.
13. L. T. Cotter, "Continuing the Spiritual Transformation of the Hospice Movement," *American Journal of Hospice and Palliative Medicine* 24, no. 4 (2007): 257-258.
14. A. S. Relman, "The New Medical-Industrial Complex," *New England Journal of Medicine* 303, no. 17 (1980): 963-970, at 963.
15. Although the hospice movement was gaining considerable traction by 1980, the concept of for-profit entities offering hospice services was not yet on the radar. This would begin to change in 1983 with the passage of the Tax Equity and Fiscal Responsibility Act of 1982. See *infra* notes 28-47 and accompanying text.
16. See Relman, *supra* note 14, at 965.
17. *Id.*
18. *Id.* Although not as rapidly, the for-profit hospice industry would likewise experience dramatic growth during the decades following Congress's decision to create a Medicare hospice benefit. See *infra* notes 43-47 and accompanying text.
19. P. J. Devereaux et al., "Comparison of Mortality Between Private For-Profit and Private Not-For-Profit Hemodialysis Centers: A Systematic Review and Meta-Analysis," *JAMA* 288, no. 19 (2002): 2449-2457.
20. M. Thamer et al., "Dialysis Facility Ownership and Epoetin Dosing in Patients Receiving Hemodialysis," *JAMA* 297, no. 15 (2007): 1667-1674.
21. B. H. Gray, "An Introduction to the New Health Care for Profit," in B. H. Gray, ed., *The New Health Care for Profit* (Washington, D. C.: National Academy Press, 1983): at 8.
22. M. M. Hasan, "Let's End the Nonprofit Charade," *New England Journal of Medicine* 334, no. 16 (1996): 1055-1057.
23. E. D. Kinney, "For Profit Enterprise in Health Care: Can It Contribute to Health Reform?" *American Journal of Law & Medicine* 36, nos. 2 & 3 (2010): 405-435, at 428-29.
24. J. F. Blumstein, "The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy," *American Journal Law & Medicine* 22, no. 2-3 (1996): 205-231, at 207. Professor Blumstein cites numerous studies confirming the overutilization that results from perverse economic incentives. See, generally, Office of the Inspector Gen., Dept. of Health & Human Serv., *Financial Arrangements Between Physicians and Health Care Businesses*, Medicare & Medicaid Guide ¶ 37,838, at 19,933 (May 1989) ("The Medicare patients of referring physicians who owned clinical laboratories received forty-five percent more clinical laboratory services than all Medicare patients in general."); General Accounting Office, *Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny*, GAO/HHS-95-2, at 10 (1994); and B. J. Hillman et al., "Frequency and Costs of Diagnostic Imaging in Office Practice – A Comparison of Self-Referring and Radiologist-Referring Physicians," *New England Journal of Medicine* 323, no. 23 (1990): 1604-1608, at 1604 ("Studies of the use of diagnostic imaging equipment done in 1990 and 1994 showed that patients of physicians who had an ownership interest in such equipment utilized some equipment 400% more than the patients of nonowning physicians."); J. M. Mitchell and E. Scott, "Physician Ownership of Physical Therapy Services: Effects on Charges, Utilization, Profits, and Service Characteristics," *JAMA* 268, no. 15 (1992): 2055-2059, at 2057 ("Physicians having ownership interests in physical therapy clinics or radiation therapy centers similarly recommended patient visits to such facilities fifty percent more than did other physicians.") Additionally, Marc Rodwin's book, *Medicine, Money, and Morals: Physicians' Conflicts of Interests* (1993) includes copious evidence of ways in which physician self-interest results in Medicare abuse. For example, see Rodwin at 97 (citing a December 17, 1987, personal letter from Jim Codo, a medical laboratory salesperson who claimed that "where a high percent of Medicare recipients reside, there is a correspondingly high percent of physicians invested in laboratory ownership arrangements. The government in allowing such [practices]...might as well issue the physician owners their own money press. The physician controls the demand for services, owns the supply of the services, and is guaranteed payment for services by the government.") and 215 (citing to 18 published studies by academic researchers and government regulators between 1970 and 1992 as evidence "that physicians who make referrals to medical facilities that they either own or have a financial interest in recommend more (or more expensive) medical tests and procedures than do physicians without a financial interest.").
25. K. Eichenwald, "HCA Is Said to Reach Deal on Settlement of Fraud Case," *New York Times*, December 18, 2002, at A1 (reporting on an agreement with the Justice Department to pay more than $880 million to settle a long-running inquiry into accusations of health care fraud). See also E. T. Wood, "Feds Win $19.4M in Lawsuit over Renal Care Group Medicare Practices," *NashvillePost.com* website, March 23, 2010, *available at* <http://www.nashvillepost.com/news/2010/3/23/feds_win_194_million_in_lawsuit_over_renal_care_group_medicare_practices> (last visited February 25, 2011). The most egregious example of for-profit fraud specifically in the hospice industry would be that involving SouthernCare Hospice Press Release, *Frohsin & Barger, LLC, Alabama Hospice Provider Settles Whistleblower Lawsuit for $24.7 Million*, January 16, 2009) (on file with authors). As for fraud in the nonprofit sector, the False Claims Act Legal Center lists St. Barnabas Healthcare and its chain of eight nonprofit hospitals in New Jersey, as 23rd on its list of top False Claim Act fraud feasors since 1986. See <http://www.taf.org/top20/htm> (last visited January 20, 2011). For a specific hospice example, see also D. Frantz, "Hospice Boom Is Giving Rise to New Fraud," *New York Times*, May 10, 1998, at A1 (reporting on an indictment of Joseph A. Kirschenbaum and his "not-for-profit" hospice Samaritan Care that allegedly defrauded Medicare out of $28.5 million).
26. See generally, J. E. Perry, "An Obituary for Physician-Owned, Specialty Hospitals," *Health Lawyer* 23, no. 2 (December 2010): 24-34.
27. M. D. A. Carlson, W. T. Gallo, and E. H. Bradley, "Ownership Status and Patterns of Care in Hospice: Results from the National Home and Hospice Care Survey," *Medical Care*

42, no. 5 (2004): 432-438, at 432 (citing W. E. Aaronson, J. S. Zinn, and M. D. Rosko, "Do For-Profit and Not-For-Profit Nursing Homes Behave Differently?" *Gerontologist* 34, no. 6 (1994): 775-786; C. Harrington et al., "Does Investor Ownership of Nursing Homes Compromise the Quality of Care?" *American Journal of Public Health* 91, no. 9 (2001): 1452-1455; E. H. Bradley and C. W. Walker, "Education and Advance Care Planning in Nursing Homes: The Impact of Ownership Type," *Nonprofit and Voluntary Sector Quarterly* 27, no. 3 (1998): 339-357; B. A. Weisbrod and M. Schlesinger, "Public, Private, Nonprofit Ownership and the Response to Asymmetric Information: The Case of the Nursing Homes," in S. Rose-Ackerman, ed., *The Economics of Nonprofit Institutions* (New York: Oxford American Press, 1986); S. Y. Chou, "Asymmetric Information, Ownership and Quality of Care: An Empirical Analysis of Nursing Homes," *Journal of Health Economics* 21, no. 2 (2002): 293-311. See generally V. R. Comondore et al. "Quality of Care in For-Profit and Not-For-Profit Nursing Homes: Systematic Review and Meta-Analysis," *BMJ* 339, no. 7717 (2009): 381-384.

28. See R. E. Enck, "Hospice – Palliative Medicine: A Look Back and Into the Future," *American Journal of Hospice and Palliative Medicine* 26, no. 6 (2009): 429-431.
29. E. Kubler-Ross, *On Death and Dying* (New York: Scribner Classics, 1997): at 31.
30. D. S. Greer, "Hospice: From Social Movement to the Health Care Industry," *Transactions of the American Clinical and Climatological Association* 97 (1986): 82-87.
31. *Rasmussen v. Fleming*, 741 P.2d 674, 678 (Ariz 1987).
32. See Greer, *supra* note 30, at 83.
33. See Enck, *supra* note 28, at 429.
34. *Tax Equity and Fiscal Responsibility Act of 1982*, Pub. L. No. 97-248, § 122, 96 Stat. 324 (1982).
35. 42 C.F.R. § 418.22(b) (2009).
36. 42 C.F.R. § 418.302 (2009).
37. 42 C.F.R. § 418.64-.106 (2009).
38. D. S. Greer and V. Mor, "How Medicare Is Altering the Hospice Movement," *Hastings Center Report* 15, no. 5 (1985): 5-9, at 5-6.
39. *Id.*
40. *Id.* and Relman, *supra* note 14.
41. See Greer and Mor, *supra* note 38.
42. J. K. Iglehart, "A New Era of For-Profit Hospice Care – The Medicare Benefit," *New England Journal of Medicine* 360, no. 26 (2009): 2701-2703, at 2701.
43. Medicare Payment Advisory Commission, *Rep. to the Congress on Medicare Payment Policy*, March 2009. But see *supra* note 8.
44. U.S. Gov't Accountability Office, GAO-05-42, *Medicare Hospice Care: Modifications to Payment Methodology May Be Warranted 1* (October 2004).
45. MedPAC, "Report to Congress: Medicare Payment Policy," *Hospice*, March 2010, at 141; MedPAC, "Report to Congress: Reforming the Delivery System, Evaluating Medicare's Hospice Benefit," June 2008, at 216.
46. *Id.* (MedPAC 2010), at 147. Approximately 1600 for-profit hospice programs currently operate in the United States compared to 1200 not-for-profit hospice organizations. C. F. von Gunten, "Profit or Not-For-Profit: Who Cares?" *Journal of Palliative Medicine* 11, no. 7 (2008): 954.
47. See MedPAC (2010), *supra* note 45, at 147.
48. D. Koehn, "The Business of Hospice Gets Corporate Attention," *Tampa Tribune*, January 18, 2004, at 1. Such practices are reminiscent of pharmaceutical industry tactics. See *infra* note 51.
49. See also D. Frantz, "Hospice Boom Is Giving Rise to New Fraud," *New York Times*, May 10, 1998, at A1.
50. B. Moos, "Business of Dying Undergoes Change: For-Profit Firms Enter Small Agencies' Turf as Hospice Care Grows," *Dallas Morning News*, May 22, 2005, at 1D.
51. Prior evidence of a variety of unsavory marketing tactics employed by pharmaceutical company representatives provides a cautionary tale, well documented by Dr. Marcia Angel, former editor of the *New England Journal of Medicine*, in her 2004 book *The Truth about the Drug Companies*. The hard sell, questionably accurate information, and gift incentives can go a long way toward building market share, but not necessarily toward empowering a potential patient to make a decision that is in her best interest and consistent with the hospice philosophy.
52. See MedPAC (2010), *supra* note 45, at 144 and 147. The report notes that financial incentives "may have led to inappropriate utilization of the benefit among some hospices."
53. *Landis v. Hospice Care of Kansas*, 2010 U.S. Dist. LEXIS 129484, *6 (D. Kan. Dec. 7, 2010) (alleging business practices at Hospice Care of Kansas that included "setting aggressive census targets for each HCK branch office; staff incentives and monetary bonuses for meeting the aggressive census targets; threatening staff with terminations or reductions in hours if the census fell below targets; instructing staff to inaccurately document the condition of patients to make them appear appropriate for hospice and to avoid detection . . .; implementing procedures that delayed the discharge or made it difficult to discharge ineligible patients; challenging or ignoring staff and physician recommendations to discharge patients; and disregarding or ignoring compliance concerns raised by an outside consultant" and resulted in "admission, retention, and submission of claims to Medicare for patients that were ineligible for the hospice benefit."
54. See Iglehart, *supra* note 42, at 2702 (citing to *Medicare Payment Advisory Commission, Rep. to the Congress on Medicare payment policy* [March 2009]); M. W. Wachterman et al., "Association of Hospice Agency Profit Status With Patient Diagnosis, Location of Care, and Length of Stay," *JAMA* 305, no. 5 (2011): 472-479 (citing H. A. Huskamp et al., "Providing Care at the End of Life: Do Medicare Rules Impede Good Care?" *Health Affairs* 20, no. 3 (2001): 204-211).
55. Kaiser Health News, "MedPAC Approves Recommendation to Revise Medicare Reimbursement System for Hospice Care Providers," January 12, 2009, *available at* <http://www.kaiserhealthnews.org/daily-reports/2009/january/12/dr00056387> (last visited February 25, 2011).
56. R. C. Lindrooth and B. A. Weisbrod, "Do Religious Nonprofit and For-Profit Organizations Respond Differently to Financial Incentives? The Hospice Industry," *Journal of Health Economics* 26, no. 2 (2007): 342-357, at 344.
57. H. A. Huskamp et al., "Variation in Patients' Hospice Costs," *Inquiry* 45, no. 2 (2008): 232-244, at 241 ("Our results suggest that average per day costs were markedly higher for stays of one or two days than for longer stays, and that total costs for longer stays increased at a decreasing rate as the length of stay increased.")
58. See Wachterman, *supra* note 54, at 477-78; K. A. Lorenz et al., "Cash and Compassion: Profit Status and the Delivery of Hospice Services," *Journal of Palliative Medicine* 5, no. 4 (2002): 507-514.
59. See Lindrooth and Weisbrod, *supra* note 56, at 345; see also Wachterman, *supra* note 54, at 472 (citing A. Gruneir et al., "Hospice Care in the Nursing Home: Changes in Visit Volume from Enrollment to Discharge among Longer-Stay Residents," *Journal of Pain Symptom Management* 32, no. 5 (2006): 478-487; K. Carney et al., "Hospice Costs and Medicare Reimbursement: An Application of Break-Even Analysis," *Nursing Economics* 7, no. 1 (1989): 41-48; N. Nicosia et al., "The Medicare Hospice Payment System: A Consideration of Potential Refinements," *Health Care Financing Review* 30, no. 4 (2009): 47-59; L. Cheung et al., *The Costs of Hospice Care: An Actuarial Evaluation of the Medicare Hospice Benefit* (New York: Milliman USA, 2003).
60. See MedPAC (2010), *supra* note 45, at 146.
61. *Id.* (summarizing the March 2009 Commission recommendations).
62. See Wachterman et al., *supra* note 54, at 478 (finding that hospice agencies, depending on profit status, do differentially

enroll patients with dementia and other noncancer diagnoses, resulting in patterns of patient selection that leave "nonprofit hospice agencies disproportionately caring for the most costly patients – those with cancer and those tending to begin hospice very late in their course of illness; as a result, those hospices serving the neediest patients may face difficult financial obstacles to providing appropriate care in this fixed per-diem payment system.")

63. See Lindrooth and Weisbrod, *supra* note 56, at 351-355. See MedPAC (2010), *supra* note 45, at 151 ("[P]roviders that exceeded the hospice cap, appeared to have a higher prevalence of long-stay patients across all diagnoses, suggesting some patient selection may be at work.").
64. See Lorenz, et al., *supra* note 58, at 511.
65. Accord Wachterman, *supra* note 54, at 478 ("For-profit hospices had significantly more patients with stays exceeding 365 days and fewer patients with stays less than 7 days."). See generally S. Ohri, *Essays in Health Economics* (2007) (unpublished Ph.D. dissertation, Univ. of CA, Irvine) (on file with authors).
66. D. H. Taylor Jr. et al., "What Length of Hospice Use Maximizes Reduction in Medical Expenditures Near Death in the U.S. Medicare Program," *Social Science & Medicine* 65, no. 7 (2007): 1466-1476, at 1470. See also K. L. Cerminara, "Hospice and Health Care Reform: Improving Care at the End of Life" (unpublished manuscript on file with authors at 32-33) (summarizing literature justifying longer patient stays).
67. B. M. Kinzbrunner, "For Profit vs. Not-for-Profit Hospice: It Is the Quality That Counts," *Journal of Palliative Medicine* 5, no. 4 (2002): 483-485, at 484.
68. 42 U.S.C. Sec. 1395x (dd) (2) (B).
69. 42 U.S.C. Sec. 1395x (dd) (1) (A) – (H); Code of Federal Regulations 418.64.
70. Code of Federal Regulations 418.70 – 418.78.
71. M. D. A. Carlson, W. T. Gallo, and E. H. Bradley, "Ownership Status and Patterns of Care in Hospice: Results from the National Home and Hospice Care Survey," *Medical Care* 42, no. 5 (2004): 432-438.
72. See Lorenz et al., *supra* note 58, at 511-512. See also S. M. O'Neill, S. L. Ettner, and K. A. Lorenz, "Paying the Price at the End of Life: A Consideration of Factors That Affect the Profitability of Hospice," *Journal of Palliative Medicine* 11, no. 7 (2008): 1002-1008. This follow-up study published in 2008 found that for-profit hospice providers incur lower costs than non-profit providers and that some of these cost savings may be attributable to differences in staffing. However, differences in quality outcomes could not be identified, and the researchers called for future research examining "variation in [length-of-stay, nursing intensity, and provider skill mix] with patient clinical outcomes." *Id.*, at 1007.
73. See Kinzbrunner, *supra* note 67, at 484.
74. E. J. Cherlin et al., "Interdisciplinary Staffing Patterns: Do For-Profit and Nonprofit Hospices Differ?" *Journal of Palliative Medicine* 13, no. 4 (2010): 389-394, at 393.
75. See Cherlin et al., *supra* note 74, at 393. These findings are echoed by empirical data in "Economic Incentives in the Hospice Care Setting: A Comparison of For-Profit and Nonprofit Providers," an unpublished manuscript by K. Noe and D. A. Forgione dated December 17, 2009 (on file with the authors).
76. See Wachterman, *supra* note 54, at 478 ("… we are unable to assess the relationship between profit status and quality of care."); Carlson, Gallo, and Bradley, *supra* note 71, at 435; D. E. Foliart, M. Clausen, and C. Siljestrom, "Bereavement Practices among California Hospices: Results of a Statewide Survey," *Death Studies* 25, no. 5 (2001): 461-67.
77. See Carlson, Gallo, & Bradley, *supra* note 71, at 437.
78. C. F. von Gunten, "Profit or Not-for-Profit: Who Cares?" *Journal of Palliative Medicine* 11, no. 7 (2008): 954. Accord R. P. Gates, "Where Do We Go from Here?" *American Journal of Hospice & Palliative Care* 14, no. 2 (1997): 95 ("Many people thought, and still believe, that 'for profit' hospice cannot remain true to the hospice visions. I believe those people have been proven wrong.").
79. See Cerminara, *supra* note 66 (discussing provisions of The Patient Protection and Affordable Care Act that will require stricter monitoring processes designed to hold hospice providers more accountable, but which may also result in compliance burdens too great for small, rural hospice providers to satisfy).