Understanding & Reforming Long-Term Care in the U.S.: Ownership Transparency

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“You have to know the past to understand the present.”

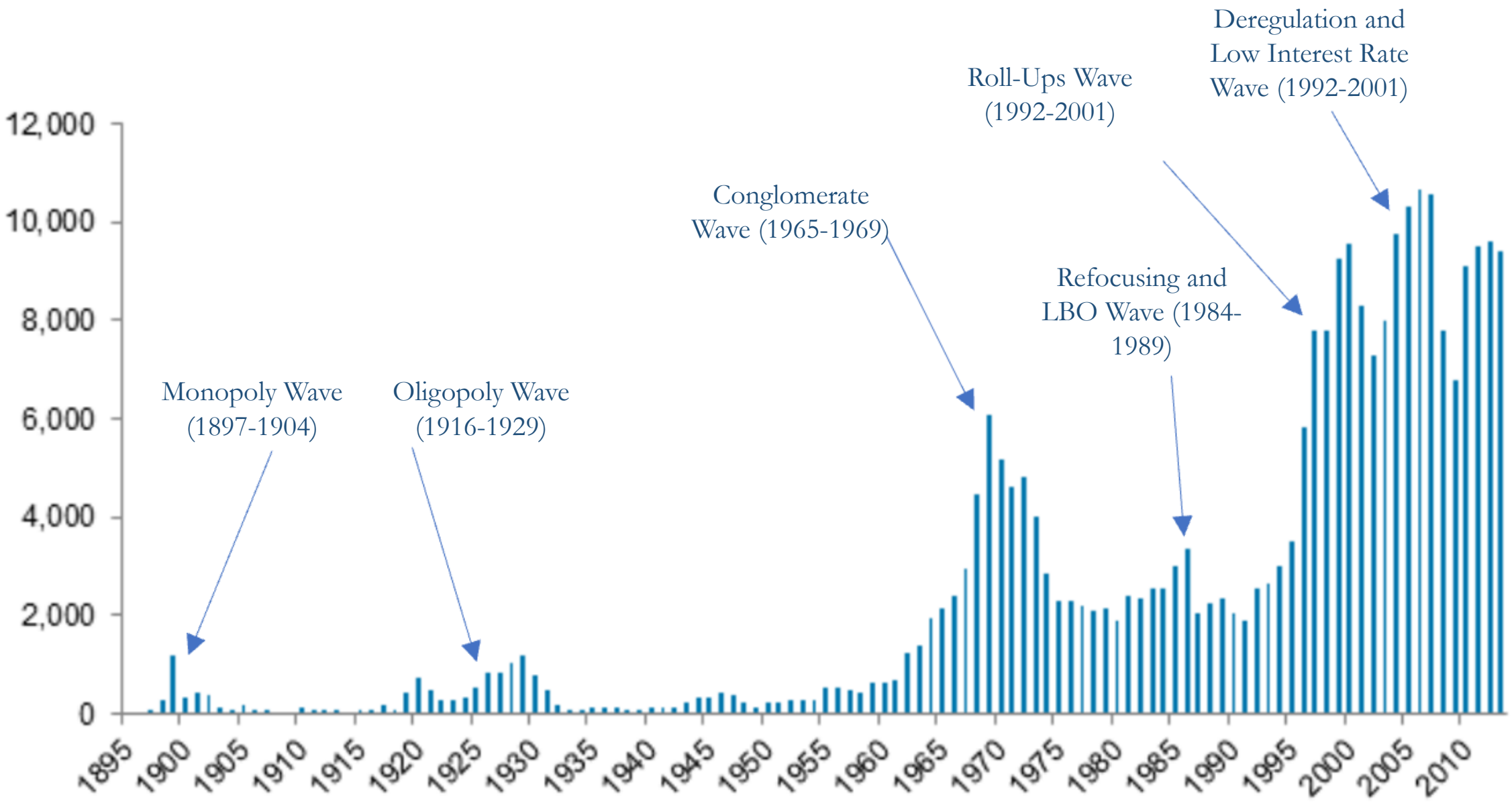
-Dr. Carl Sagan

Merger Wave Causes Are Due To "Shocks"

- **Economic Shocks**
  - Economic expansion that motivates companies to expand to meet the rapidly growing aggregate demand in the economy
- **Regulatory Shocks**
  - Occurs through deregulation that may have prevented previous corporate combinations
- **Technological Shocks**
  - Major changes in existing industries can create new and fragmented industries
  - Firms do not have the time to adapt quickly and thus, increase their adaptation speed by acquiring
- **Other reason(s)**: When a company's shares are priced above their fair value, the organizations can capitalize on this by going through an acquisition in which they buy targets with overvalued shares
- All these shocks do not singularly bring on a merger wave, but in combination, followed by large amounts of capital liquidity are necessary for a merger wave to take hold

Motivations to Consolidate

- Growth!
- Healthcare organizations seeking to expand are faced with 2 strategies for growth:
  - Through internal or de novo growth
  - Through mergers and acquisitions
- Internal growth:
  - May be slow and an uncertain process
  - Organizations are at risk of competitors rapidly taking a large market share and any competitive advantages are dissipated by the actions of the competitor
- The only solution is to acquire another organization that has established facilities, resources, and services in place


Deregulation and Low Interest Rate Wave (1992-2001)
Roll-Ups Wave (1992-2001)
Conglomerate Wave (1965-1969)
Refocusing and LBO Wave (1984-1989)
Monopoly Wave (1897-1904)
Oligopoly Wave (1916-1929)
12,000
10,000
8,000
6,000
4,000
2,000
0
1895
1900
1905
1910
1915
1920
1925
1930
1935
1940
1945
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1975
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1985
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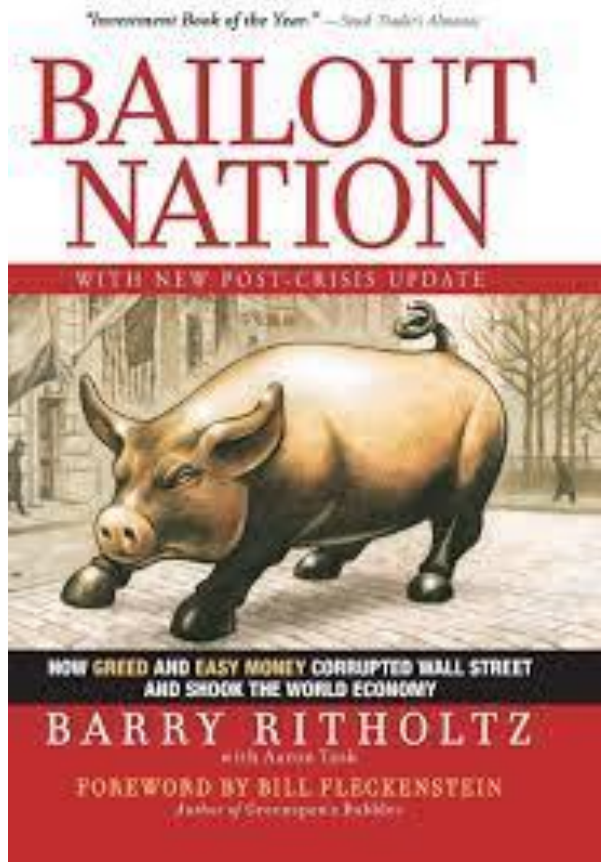
1995
2000
2005
2010

Are we in a wave now?

"I am hard-pressed to recall when any sort of bubble was accurately identified in real time on the cover of a major media publication. If anything, the opposite is true."

-Barry Ritholtz, , Co-founder, Chairman, and CIO of Ritholtz Wealth Management



Antitrust

- Sherman Antitrust Act of 1890
  - Cornerstone of all US antitrust laws
- Section 1: prohibits all contracts, combinations, and conspiracies in restraint of trade
- Section 2: prohibits any attempts or conspiracies to monopolize a particular industry
- Government or injured party can file suit under this law and the court can decide the appropriate punishment
- Was it effective?

Antitrust

- Clayton Act of 1914
  - Intended to strengthen the Sherman Act while proscribing certain business practices
- Clarified which business practices unfairly restrain trade and reduce competition
- The bill did not address the problem of the lack of enforcement agency charged with the specific responsibility for enforcing the antitrust laws
- Section 7:
  - "No corporation shall ***acquire*** the whole or any part of the stock, or the whole or any part of the assets, of another corporation where in ***any line of commerce*** in ***any section of the country*** the effect of such an acquisition may be to substantially lessen competition or tend to create a ***monopoly***."
- Only focused on the acquisition of stocks, not asset acquisitions—loophole closed in 1950

Antitrust

- Federal Trade Commission Act of 1914
  - Created in response to the Sherman Act not giving the government an effective enforcement agency to investigate and pursue antitrust violations nor did they have the resources
- Established the FTC—which enforces FTC Act of 1914 and the Clayton Act
- Celler-Kefauver Act of 1950—"asset loophole" from Clayton Act
  - Also prohibited vertical and conglomerate mergers when they were shown to reduce competition (more on this later)
  - Previous mergers only focused on horizontal mergers

Antitrust

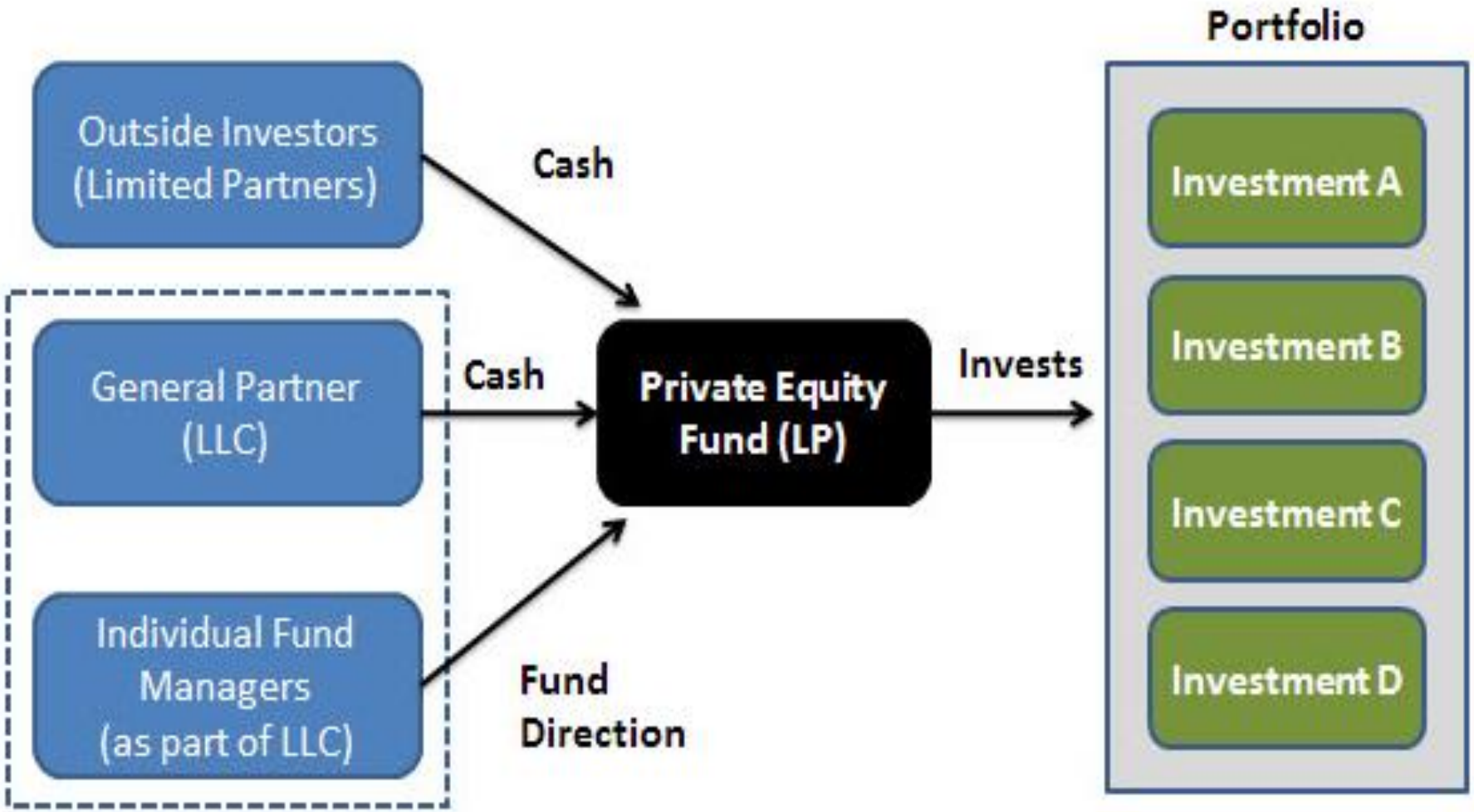
- Hart-Scott-Rodino Antitrust Improvements Act of 1976 (HSR)
- Increased FTC and DOJ enforcement power
- Prior to HSR, FTC and DOJ did not have the power to require the competitors (third parties) of the merging companies to provide them with private economic data
- Allows FTC and DOJ to review proposed M&A in advance
- Established size-of-transaction threshold
  - Must file if the transaction is valued at $101 million or greater
  - Unintended consequences?
    - Stealth consolidation (more on this later)

Private Equity

- Private investors that invest capital in private companies
- Receive controlling equity stake that is not tradeable on a public stock exchange
- How does it work?

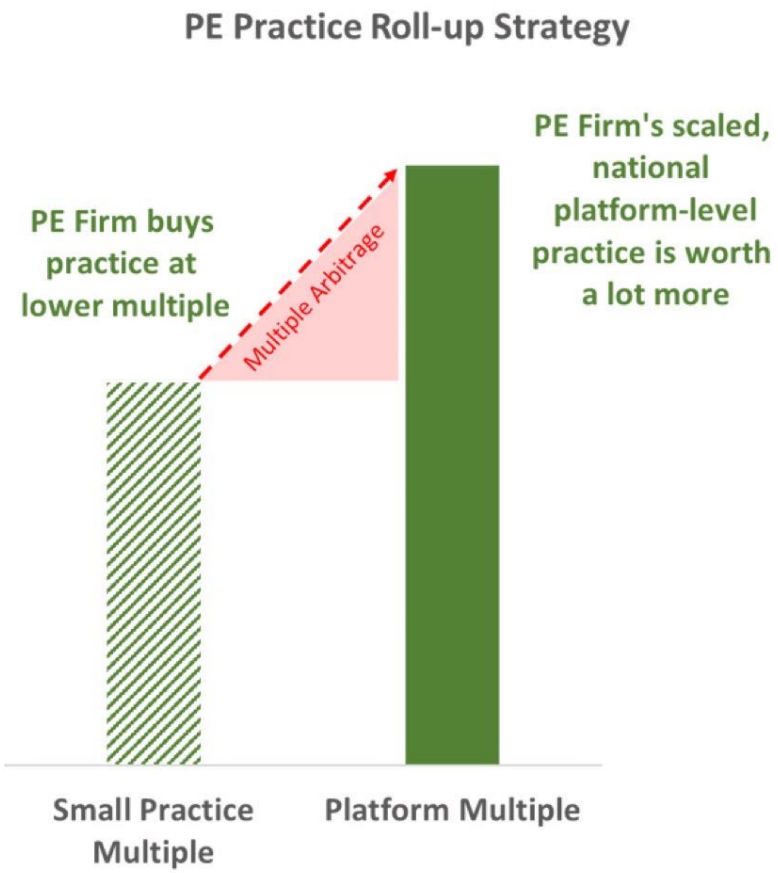
Private Equity Structure

What Does Each Party Bring to the Table?



Roll-up Acquisitions

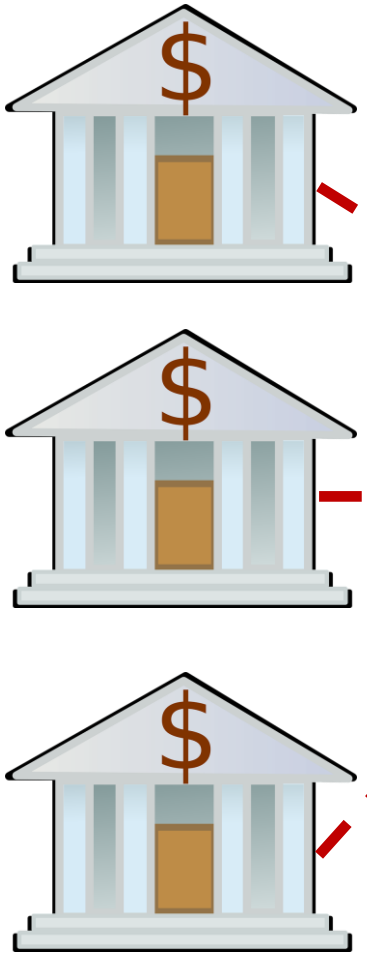
- EBITDA (earnings before interest, taxes, depreciation, and amortization)
  - proxy for operating cash flow
- PE focuses on fragmented markets to consolidate
- Generally, acquires a "platform practice" first
  - PE firms usually pay 8 to 12 times EBITDA for a platform practice
  - Uses the platform practice to recruit new clinicians and acquire smaller practices
  - Smaller practices 2 to 4 times EBITDA
  - Smaller practice now becomes the value of the platform practice



General Deal Terms

- **Before** private equity **buyout** of practice, **profits** are **distributed** to vested providers at the end of the year
- Private equity pays a higher acquisition price in exchange for the current physician owners agreeing to work for a lower annual salary has **tax advantages**:
  - Allows the physicians selling the practice to convert some salary income (taxed at ordinary income rates and subject to payroll taxes) into long-term capital gains (taxed at preferential rates)
- If a vested physician leaves before expiration of contract, their equity becomes worthless
- **Noncompete and nondisclosure clauses** in physician contracts that preclude physicians from practicing in areas where the private equity firm operates for a duration of time
  - Some states have outlawed this practice
  - Some states enforce these clauses, recognizing that a medical group also has a legitimate interest in retaining its patients and recouping its investment
  - The Biden Administration has ordered the FTC to eliminate these clauses

How Are Deals Financed?



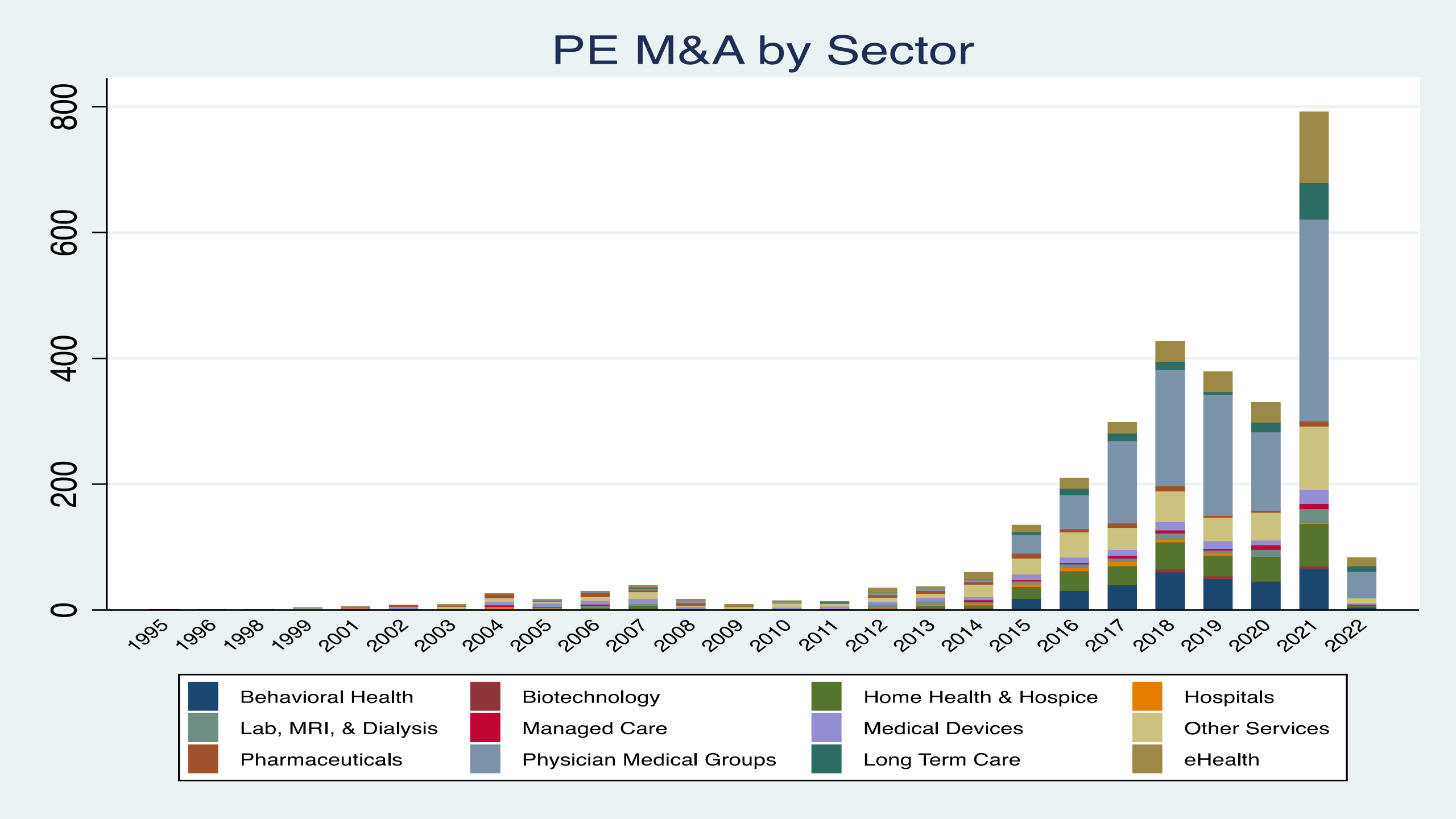
Lender(s)

Investment Bank (Arranger)

Target's Valuation:	$1.0 B
Private Equity's Equity:	$500 M
Capital Needed to Raise:	$500 M
Target Sold:	$2.0 B
Returned to Lender(s):	$500 M
Private Equity's Profit:	$1.5 B

Private Equity Firm (Sponsor)

Target for Acquisition


PE M&A by Sector
0
200
400
600
800
1995
1996
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1999
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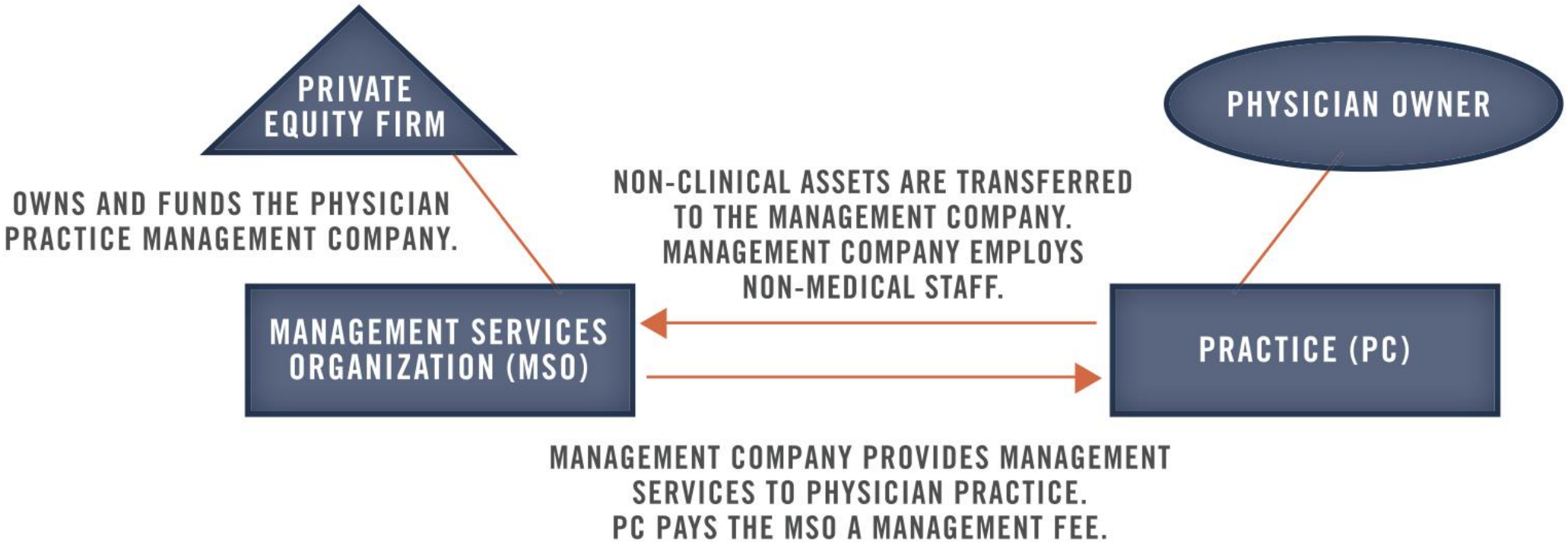
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
Behavioral Health
Biotechnology
Home Health & Hospice
Hospitals
Lab, MRI, & Dialysis
Managed Care
Medical Devices
Other Services
Pharmaceuticals
Physician Medical Groups
Long Term Care
eHealth


PRIVATE EQUITY FIRM
PHYSICIAN OWNER
OWNS AND FUNDS THE PHYSICIAN PRACTICE MANAGEMENT COMPANY.
NON-CLINICAL ASSETS ARE TRANSFERRED TO THE MANAGEMENT COMPANY. MANAGEMENT COMPANY EMPLOYS NON-MEDICAL STAFF.
MANAGEMENT SERVICES ORGANIZATION (MSO)
PRACTICE (PC)
MANAGEMENT COMPANY PROVIDES MANAGEMENT SERVICES TO PHYSICIAN PRACTICE. PC PAYS THE MSO A MANAGEMENT FEE.

Why are providers selling their practices?

- Infusion of capital
- Administrative relief
- Standardization and knowledge transfer
- Improve market share against competitors
- More autonomy than selling to hospital or health plan
- Share in profits after PE firm sells (the "second bite of the apple")
- Improve payment with health plans
- Increase marketing budget to gain more self-pay patients
- Financial synergy
- Operational efficiency

Controversy

- **Young physicians** may work for decades at an income level discounted from preacquisition levels
  - They face significant buy-ins to profit from second sale
  - High turnover
- **Market failures and loopholes**
  - Surprise billing
  - Led to the No Surprise Billing Act
  - Medicare's payment for physician-administered drugs under Part B is tied to a percentage of the drug's average sales price
    - Incentives for physicians to prescribe the more expensive drug among competing options
  - Ophthalmology drugs to treat wet macular degeneration are very expensive and comprise of 15% of Part B's total costs
- **Stealth Consolidation**
  - Hart-Scott-Rodino Act mandates that all mergers and acquisitions must be reported to the federal government if the deal value is above $101 M
  - Anti-trust concerns
- **Increased risks of overutilization, overbilling, or upcoding**
- **Replacement of physicians with advanced practitioners**

Evidence

- Nursing Homes (Private Equity and REITs)
- Hospice

“As Wall Street firms take over more nursing homes, the quality in those homes has gone down and costs have gone up. That ends on my watch.”

-Joe Biden, President of the United States at the State of the Union

CMS Nursing Home Ownership File

- A list of ownership information for currently active nursing homes

CMS.gov

JAMA Health Forum

Original Investigation

Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents

Robert Tyler Braun, PhD; Hye-Young Jung, PhD; Lawrence P. Casalino, MD, PhD; Zachary Myslinski, MD; Mark Aaron Unruh, PhD

Abstract

IMPORTANCE Private equity firms have been acquiring US nursing homes; an estimated 5% of US nursing homes are owned by private equity firms.

OBJECTIVE To examine the association of private equity acquisition of nursing homes with the quality and cost of care for long-stay residents.

DESIGN, SETTING, AND PARTICIPANTS In this cohort study of 302 private equity nursing homes with 9632 residents and 9562 other for-profit homes with 249 771 residents, a novel national database of private equity nursing home acquisitions was merged with Medicare claims and Minimum Data Set assessments for the period from 2012 to 2018. Changes in outcomes for residents in private equity–acquired nursing homes were compared with changes for residents in other for-profit nursing homes. Analyses were performed from March 25 to June 23, 2021.

EXPOSURE Private equity acquisitions of 302 nursing homes between 2013 and 2017.

MAIN OUTCOMES AND MEASURES This study used difference-in-differences analysis to examine the association of private equity acquisition of nursing homes with outcomes. Primary outcomes were quarterly measures of emergency department visits and hospitalizations for ambulatory care–sensitive (ACS) conditions and total quarterly Medicare costs. Antipsychotic use, pressure ulcers, and severe pain were examined in secondary analyses.

Key Points

Question Is private equity acquisition of nursing homes associated with the quality or cost of care for long-stay nursing home residents?

Findings In this cohort study with difference-in-differences analysis of 9864 US nursing homes, including 9632 residents in 302 nursing homes acquired by private equity firms and 249 771 residents in 9562 other for-profit nursing homes without private equity ownership, private equity acquisition of nursing homes was associated with higher costs and increases in emergency department visits and hospitalizations for ambulatory sensitive conditions.

Meaning This study suggests that more stringent oversight and reporting on private equity ownership of nursing homes may be warranted.

ASPE
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

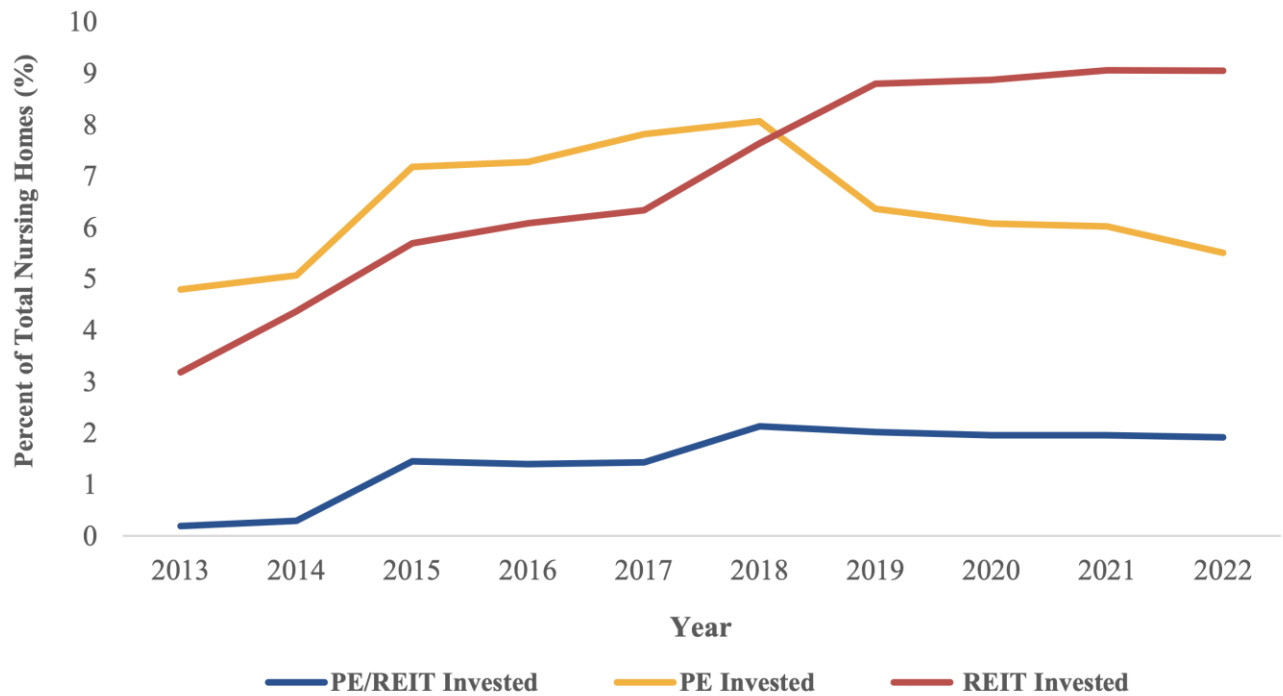
RESEARCH BRIEF

November 13, 2023

TRENDS IN OWNERSHIP STRUCTURES OF U.S. NURSING HOMES AND THE RELATIONSHIP WITH FACILITY TRAITS AND QUALITY OF CARE (2013-2022)

Population Health Sciences

Exhibit 1: PE, REIT, and PE/REIT Invested Facilities by Year, 2013-2022



*Data sourced from CASPER, S&P Capital IQ, and Irving Levin Associates Health Care M&A Transaction Data. Categories are not mutually exclusive, meaning that PE/REIT facilities (where there is joint PE and REIT investment) are also counted in the PE and REIT categories.

Table 2. Changes in Quality and Costs for Long-Stay Nursing Home Residents After PE Firm Acquisition Compared With For-Profit Nursing Homes Without PE Firm Ownership[a]

Outcome	Pooled sample, 2012-2018, No. (%)[b]	Preacquisition period, 2012				Postacquisition period, 2018			Differential change				Relative change, %[c]
		All	PE	For-profit	Unadjusted difference	PE	Non-PE	Unadjusted difference	Unadjusted (95% CI)	*P* value	Adjusted (95% CI)	*P* value	
Quality measures													
Emergency department visit (n = 2 383 491)	336 072 (14.1)	15.3	15.3	15.3	0	20.1	18.1	2.0	2.0 (1.0 to 4.0)	.01	1.7 (0.3 to 3.0)	.02	11.1
Hospitalization (n = 2 383 491)	412 344 (17.3)	11.5	10.4	11.5	−1.1	14.6	14.5	0.1	1.2 (0.01 to 2.3)	.04	1.0 (0.2 to 1.1)	.003	8.7
Cost measure													
Total costs (n = 2 383 491), mean (SD), $	8050.00 (9.90)	6972.04 (39.60)	7066.26 (208.72)	6968.43 (40.30)	97.83 (212.60)	8818.60 (126.30)	8626.75 (24.84)	191.85 (28.72)	94.02 (−392.42 to 580.50)	.85	270.37 (41.53 to 499.20)	.02	3.9

Abbreviation: PE, private equity.

[a] Linear regressions were used for estimation. All models included the following covariates: age group (65-69, 70-74, 75-79, 80-84, and ≥85 years), race and ethnicity (Black, White, other non-White race [Asian, Hispanic, North American Native, and other]), sex, dual eligibility for Medicare and Medicaid, indicators for 66 chronic and disabling conditions used for risk adjustment (see eTable 2 in the Supplement for a list of the chronic conditions), activities of daily living score at initial assessment (range, 1-28, where a higher score indicates a greater need for assistance with activities of daily living)), and severe cognitive impairment (scores >3 on the 4-point Cognitive Function Scale). Nursing home characteristics included occupancy rate, an indicator for multifacility affiliation, total number of beds, and terciles of the distributions of the percentage of patients covered by Medicare and the percentage covered by Medicaid. Other covariates included fixed effects for quarter, year, nursing home, Hospital Referral Region, and Hospital Referral Region interaction with year. The unit of analysis is at the resident-quarter level. Standard errors were adjusted for clustering at the level of the nursing home.

[b] The pooled sample consists of all resident observations from 2012 to 2018.

[c] Relative changes were derived from the sample by dividing the adjusted estimates for all outcomes by the unadjusted mean of the outcomes in the preacquisition period (2012).

What is a REIT?

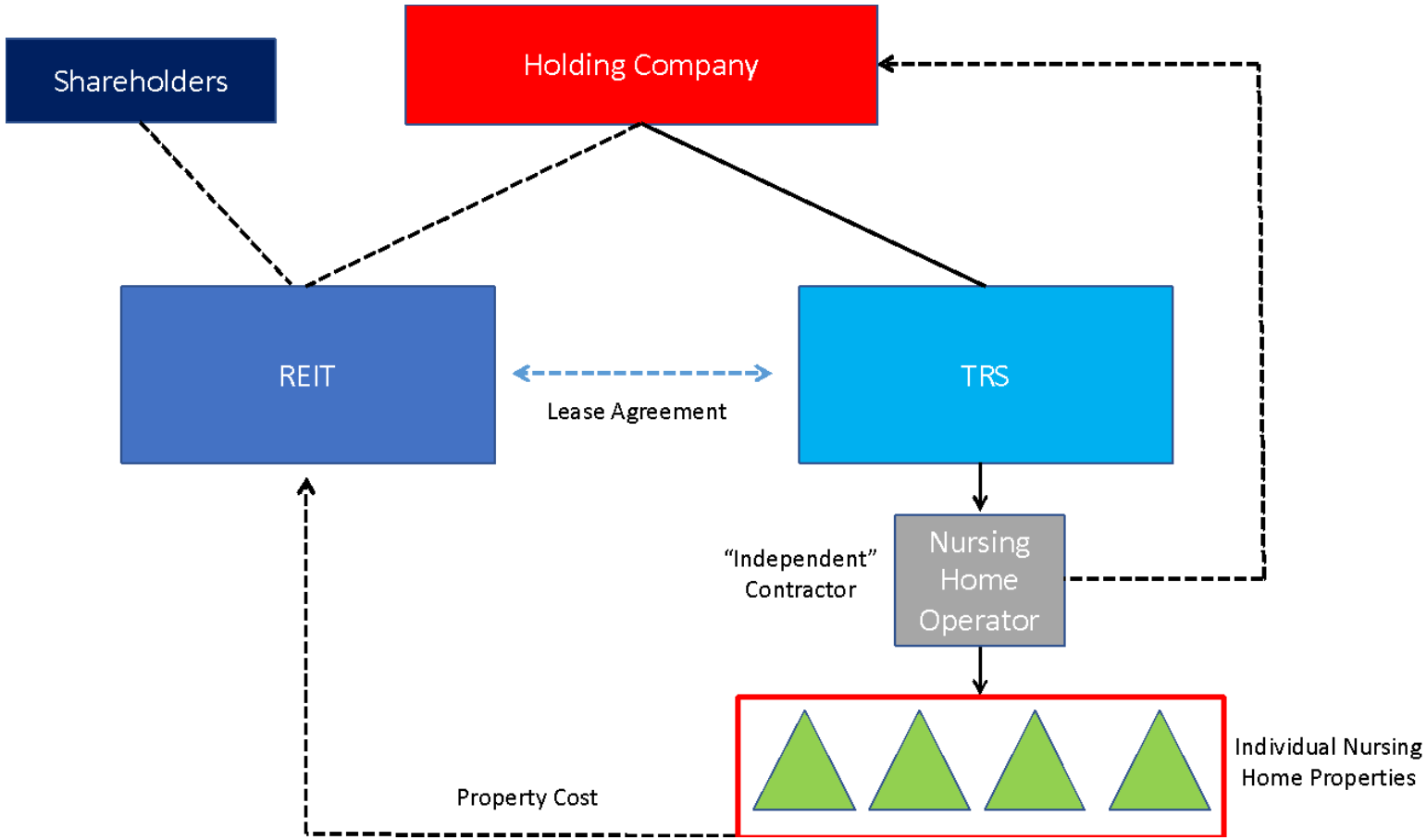
- For-profit public or private corporation
- Invests in or fully owns income-producing properties
- Pass-through entities
  - Tax exemptions if REITs satisfy a series of requirements related to sources of income and assets
  - This includes disbursing 90% of taxable income to shareholders annually in the form of dividends
  - If requirements not met, they may lose tax-preferred status
- What if a facility is not affiliated with a REIT?
  - What is the most valuable asset of a nursing home?

REIT Structure

- **Triple-Net Leasing Agreement (NNN)**
- REIT acquires the nursing home operator's property and then rents it back to the operator under a long-term lease (landlord-tenant relationship)
- More traditional model
- Operator pays all expenses of the property, including taxes, building insurance, and maintenance
  - In addition to rent and utility costs paid to the REIT by the operator
- Prohibited from directly operating and collecting revenue from nursing home operations

- **REIT Investment Diversification and Empowerment Act of 2007 (RIDEA)**
- Used to generate additional management contracting revenue for the REIT
- Allowed to collect TAXABLE revenue from nursing home operations
- REIT leases it property at "arms-length" to a Taxable REIT Subsidiary (TRS), which the REIT owns
- The TRS then contracts with an "independent nursing home operator"
- Like in NNN, operator pays all property expenses
- REIT/TRS receives management fee for dedicating employees and time managing the property and providing operational guidance.
- Operator typically receives a fixed operating fee and can receive incentive payments if profitability targets are achieved.

Simplified RIDEA Structure



Leases

- Rent Escalators
  - Typically, 2%-6% a year or tied to an inflation index

Impact of Inflation

Our rental income in future years will be impacted by changes in inflation. Several of our lease agreements provide for an annual rent escalator based on the percentage change in the Consumer Price Index (but not less than zero), subject to minimum or maximum fixed percentages that range from 1.0% to 5.0%.

Inflation

During the years ended December 31, 2015 and 2014, and for the period from January 11, 2013 (Date of Inception) through December 31, 2013, inflation has not significantly affected our operations because of the moderate inflation rate; however, we expect to be exposed to inflation risk as income from future long-term leases will be the primary source of our cash flows from operations. We expect there to be provisions in the majority of our tenant leases that will protect us from the impact of inflation. These provisions will include negotiated rental increases, reimbursement billings for operating expense pass-through charges, and real estate tax and insurance reimbursements on a per square foot allowance. However, due to the long-term nature of the anticipated leases, among other factors, the leases may not re-set frequently enough to cover inflation.

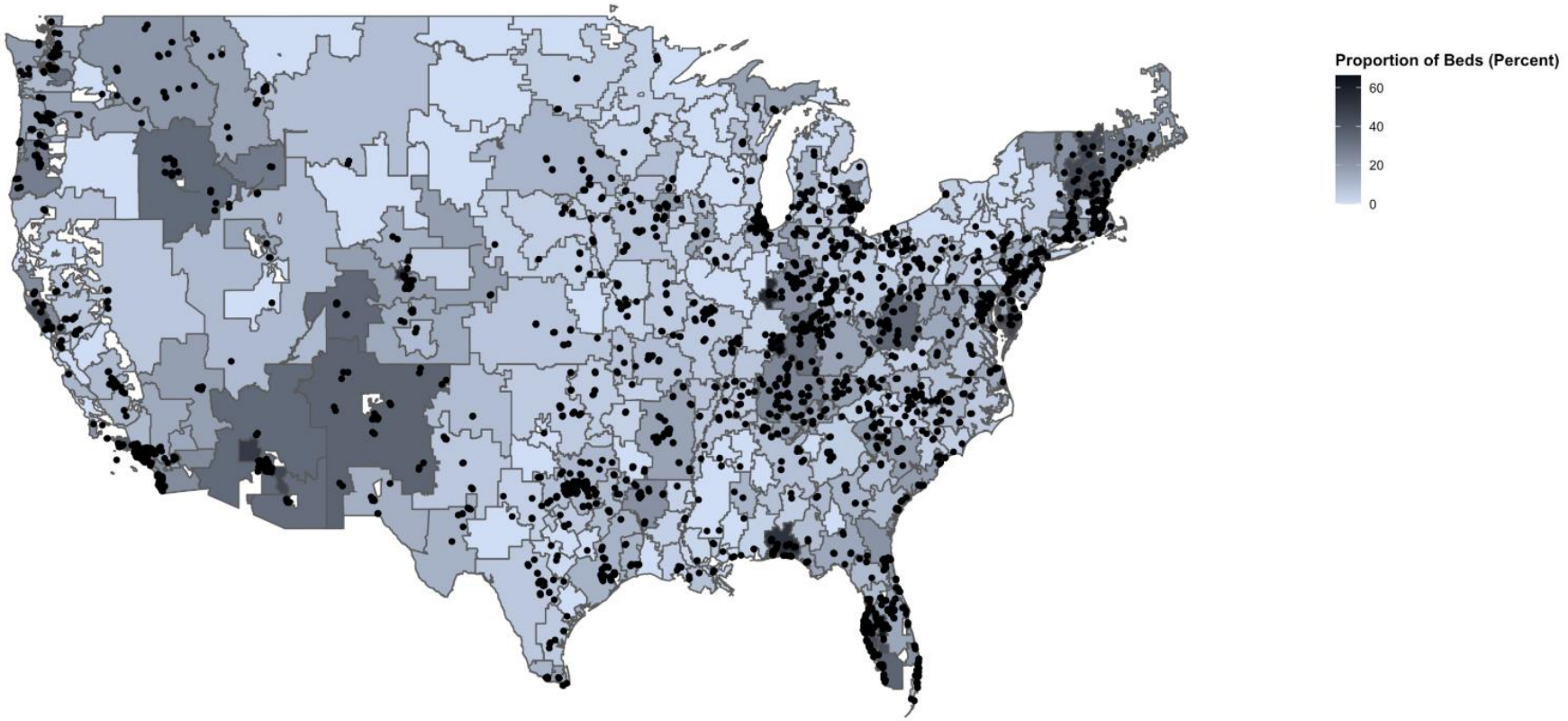
Advantages for Nursing Homes

- Master Lease Agreement
  - Reduces operator's financial risk
- REITs can help create efficiencies
  - Proprietary IT infrastructure
  - Layers of quality performance monitoring
  - Facilitate group purchasing
  - Operational expertise
- Infusion of Capital—to conceivably improve quality of care
- Operator can focus on brand strength, market-share growth, customer experience, and clinical care
  - Does not have to focus on real estate

Disadvantages that put operators at risk

- Rent escalations
- Rising cost to operate
- Poor reimbursement
- NNN structure minimizes risk to REIT—lease revenue remains consistent regardless of operator's financial performance and inflation
- Under RIDEA structure—financial incentives may not align with resident care
- Critics argue these complex ownership structures limit REIT liability
  - Piercing the corporate veil

Nursing Homes with Active REIT Investment and Proportion of Beds by Hospital Referral Region (2021)



Top 5 Nursing Home Operators in REIT-owned Facilities	Unique Facilities	Percent
Genesis Healthcare LLC	275	14.36
Ensign Group INC	120	6.27
Trilogy Management Services LLC	103	5.40
HCR Manor Care Services LLC (now ProMedica)	78	4.07
Consulate Health Care LLC (CMC II LLC)	70	3.70

Top 5 REITs
Omega Healthcare Investors Inc (n=835)
Welltower Inc (n=307)
Caretrust REIT Inc (n=207)
Sabra Health Care REIT Inc (n=170)
Griffin-American/Northstar (n=103)

Outcome	Unadjusted		Adjusted		
	Unadjusted Difference from Pre- and Post-acquisition (95% CI)	P-Value	Difference-in-Difference* (95% CI)	Relative Change, %	P-Value
Health Deficiencies (Score) (n=36,869)	0.21 (-0.01, 0.43)	0.06	0.14 (0.01 to 0.26)	14.20%	0.03
RN Hours/Resident Day (n=38,276)	-0.13 (-0.23, -0.03)	0.01	-0.09 (-0.12 to -0.06)	-11.85%	0.00
LPN Hours/Resident Day (n=38,150)	0.01 (-0.11, 0.13)	0.86	-0.03 (-0.07 to 0.01)	-3.62%	0.11
CNA Hours/Resident Day (n=38,289)	0.05 (-1.31, 1.41)	0.94	-0.06 (-0.26 to 0.13)	-2.62%	0.53
Total Hours/Resident Day (n=38,451)	-0.03 (-1.42, 1.35)	0.96	-0.14 (-0.35 to 0.07)	-3.64%	0.20

*Data sourced from LTCFocus, CMS Care Compare, CASPER, S&P Capital IQ, and Irving Levin Associates Health Care M&A Transaction Data. Sample sizes differ slightly based on missingness in variables of interest.

Exhibit 3.2: (*continued*)					
Outcome	Unadjusted		Adjusted		
	Unadjusted Difference from Pre- and Post-acquisition (95% CI)	P-Value	Difference-in-Difference* (95% CI)	Relative Change, %	P-Value
Health Deficiencies (Score) (n=48,179)	0.13 (-0.05, 0.31)	0.17	0.15 (0.05, 0.26)	14.48%	0.01
RN Hours/Resident Day (n=49,847)	-0.03 (-0.10, 0.04)	0.45	-0.04 (-0.07, -0.01)	-6.67%	0.00
LPN Hours/Resident Day (n=49,697)	0.03 (-0.06, 0.12)	0.56	-0.00 (-0.04, 0.04)	0.00%	0.94
CNA Hours/Resident Day (n=49,819)	0.07 (-0.87, 1.02)	0.88	-0.08 (-0.22, 0.06)	-3.40%	0.29
Total Hours/Resident Day (n=50,033)	0.08 (-0.89, 1.05)	0.87	-0.11 (-0.28, 0.05)	-2.89%	0.19

*Data sourced from LTCFocus, CMS Care Compare, CASPER, S&P Capital IQ, and Irving Levin Associates Health Care M&A Transaction Data. Sample sizes differ slightly based on missingness in variables of interest.

Implications

- An estimated 12% of nursing homes have REIT investment
- Substitution of labor after REIT-investment
  - Unknown whether this impacts resident care at this time
- Not all deals are the same
- Organizational-level ownership
  - CMS currently focuses only on facility-level (just as important)
- A need for longitudinal CMS ownership data
  - Needs to be regularly audited
- A standard way to define institutional investors (i.e., private equity, REITs, venture capital, etc.)
  - SEC filings of Form D may be a standardized way
  - Rule 503 of Regulation D of the Securities Act of 1933

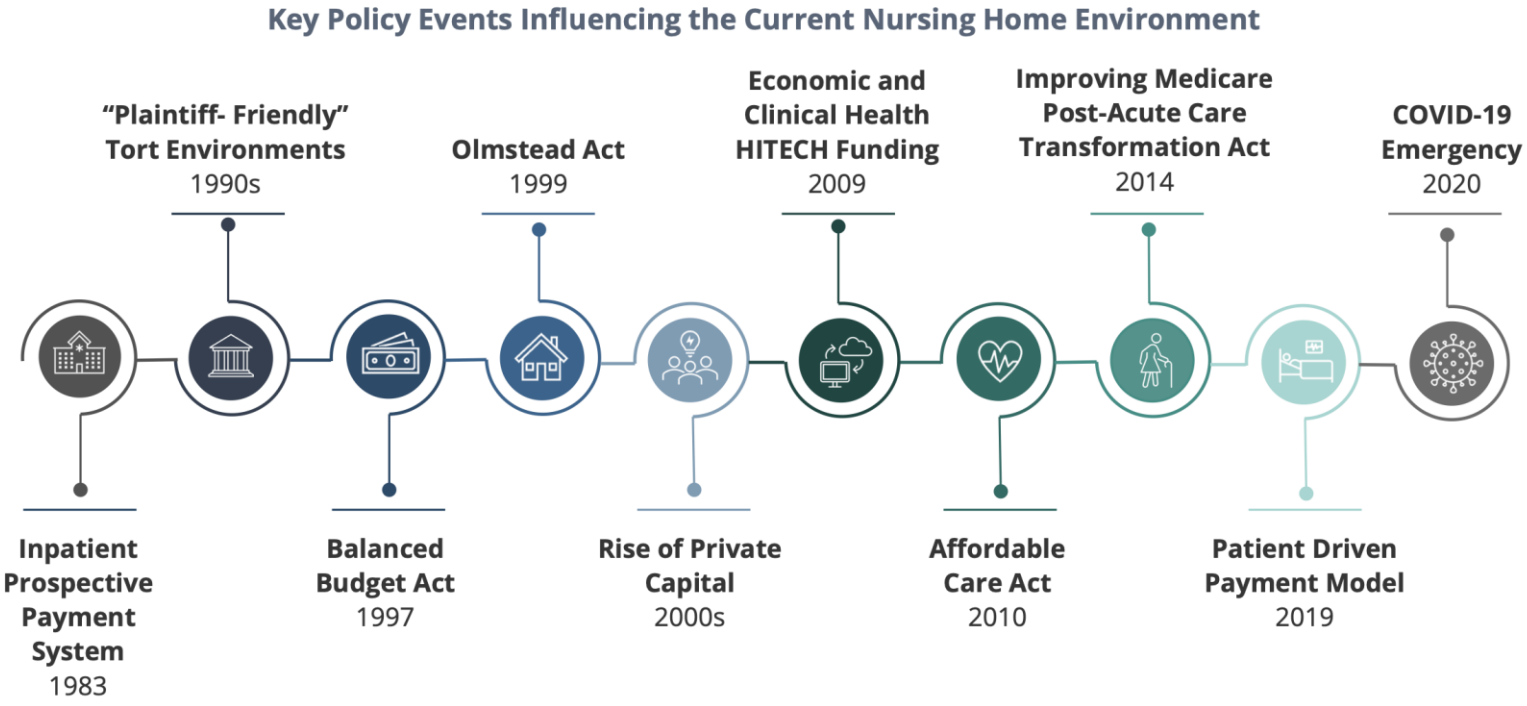
What makes nursing homes different from other healthcare settings?

- Only Medicaid long-term care benefit that federal law requires state Medicaid programs to offer
- Only care environment in which healthcare dollars (through Medicaid) fund housing
- More than half of their revenue from federal and state government sources (Medicare via fee-for-service (FFS) and Medicare Advantage, and Medicaid) and deliver medical and long-term care benefits within the same building

Challenges

- Increasingly serving a more complex patient population
- Battling increasing hiring and retention costs
- Struggling amidst an increasingly tighter reimbursement environment

Nursing Homes—How did we get here?



ATI Advisory Services: Key Characteristics of U.S. Nursing Homes – A Databook , June 2022

Capital Options

- Banks
- Tax-exempt bonds (non-profits)
- HUD 232 loans
  - Often lender of last resort
  - Slow, laborious process
- Institutional investment: Private equity and Real Estate Investment trusts (REITs)
- What is a nursing home to do with poor government policy, declining reimbursements, and a more complex case-mix?

Research Letter | Health Care Policy and Law

May 3, 2021

Acquisitions of Hospice Agencies by Private Equity Firms and Publicly Traded Corporations

Robert Tyler Braun, PhD[1]; David G. Stevenson, PhD[2,3]; Mark Aaron Unruh, PhD[1]

» Author Affiliations | Article Information

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Original Investigation | Health Policy

September 25, 2023

Changes in Diagnoses and Site of Care for Patients Receiving Hospice Care From Agencies Acquired by Private Equity Firms and Publicly Traded Companies

Robert Tyler Braun, PhD[1]; Mark A. Unruh, PhD[1]; David G. Stevenson, PhD[2]; Holly G. Prigerson, PhD[3]; Rahul Fernandez, MS[1]; Leah Z. Yao, MD[1]; Lawrence P. Casalino, MD, PhD[1]

» Author Affiliations | Article Information

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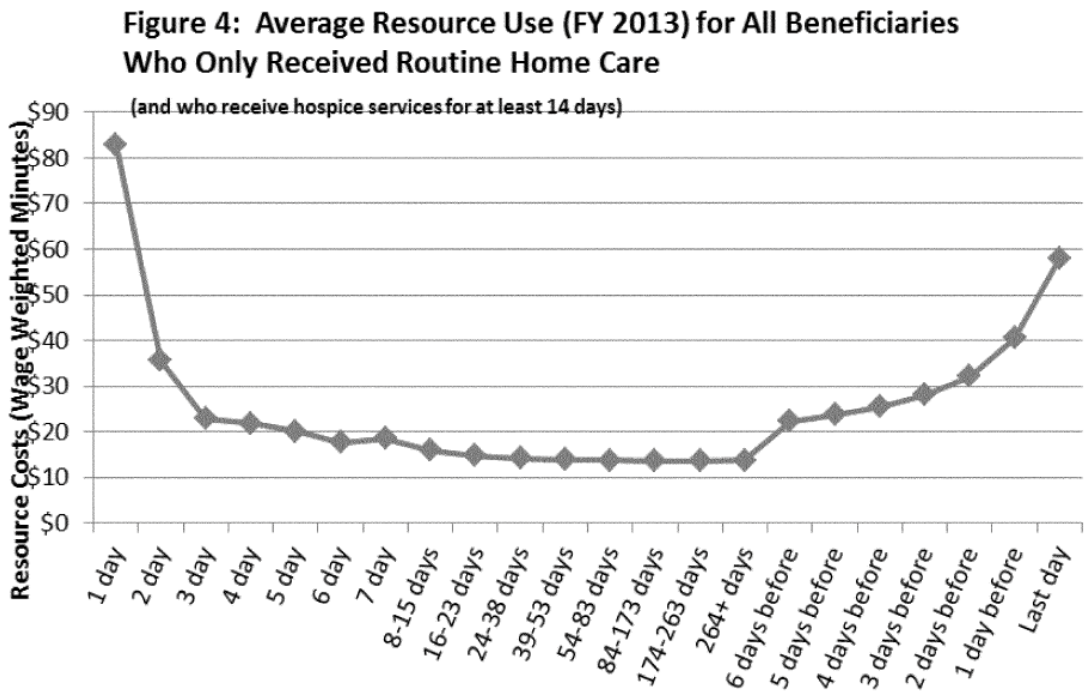
Population Health Sciences

Introduction: Basics of hospice Medicare reimbursement structure

- Per diem rate for each beneficiary, irrespective of the actual services provided on a given day
- Levels of care:
  - Routine Home Care
  - Continuous Home Care
  - Inpatient Respite Care
  - General Respite Care
- U-shaped pattern of utilization



Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements; Final Rule

Introduction: Institutional Investors in Hospice Care

- Hospices are appealing to institutional investors due to the stable Medicare payments, relatively easy market entry, and minimal capital requirements
- Benefits (?): economies of scale through clinical standardization, quality improvement, and integrated systems, thereby enhancing care and profitability while reducing clinicians' administrative burdens
- Cons (?): prioritize short-term, above-market returns, potentially affecting patient care by reducing operational cost and selectively enrolling and targeting those requiring less complex care and longer hospice stays, such as dementia patients and nursing home residents
- For-profits tend to provide more care to patients with a clinical condition of ADRD and to fewer cancer patients relative to non-profits
    - ADRD patients tend to have longer lengths of stay
- For-profits and non-profits provide hospice in different places of care (i.e., personal home, nursing home, assisted living, etc.)
    - Referral ties tend to be different

Introduction: Profit Levers

- Profit-maximization
- Divest after extracting profit or maximize profit in the short term
- How to maximize profit?
  - Increasing net service revenue
    - Strengthening referral ties
    - Selectively targeting more profitable patients that require less complex care and are associated with longer lengths of stay
  - Decreasing operating costs
    - Cutting nursing wage costs
- What could this lead to?

Introduction

- From 2010 to 2021:
  - 178 PE deals involving 853 agencies
  - 15 PTC deals involving 421 agencies
- PE and PTC owned agencies were in the lower 48 states
  - Texas, California, and Georgia had the most acquisition activity

Figure: The Number of Deals and Agencies Acquired by Private Equity Firms and Publicly Traded Corporations, 2013-2021

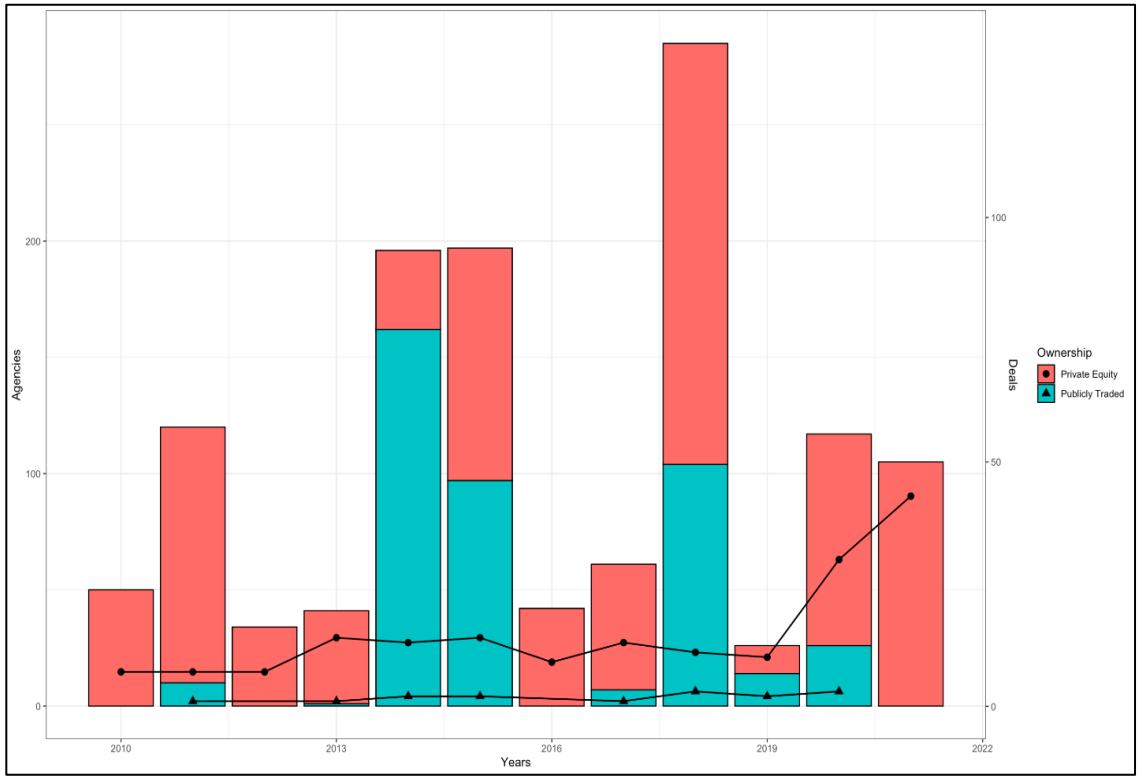
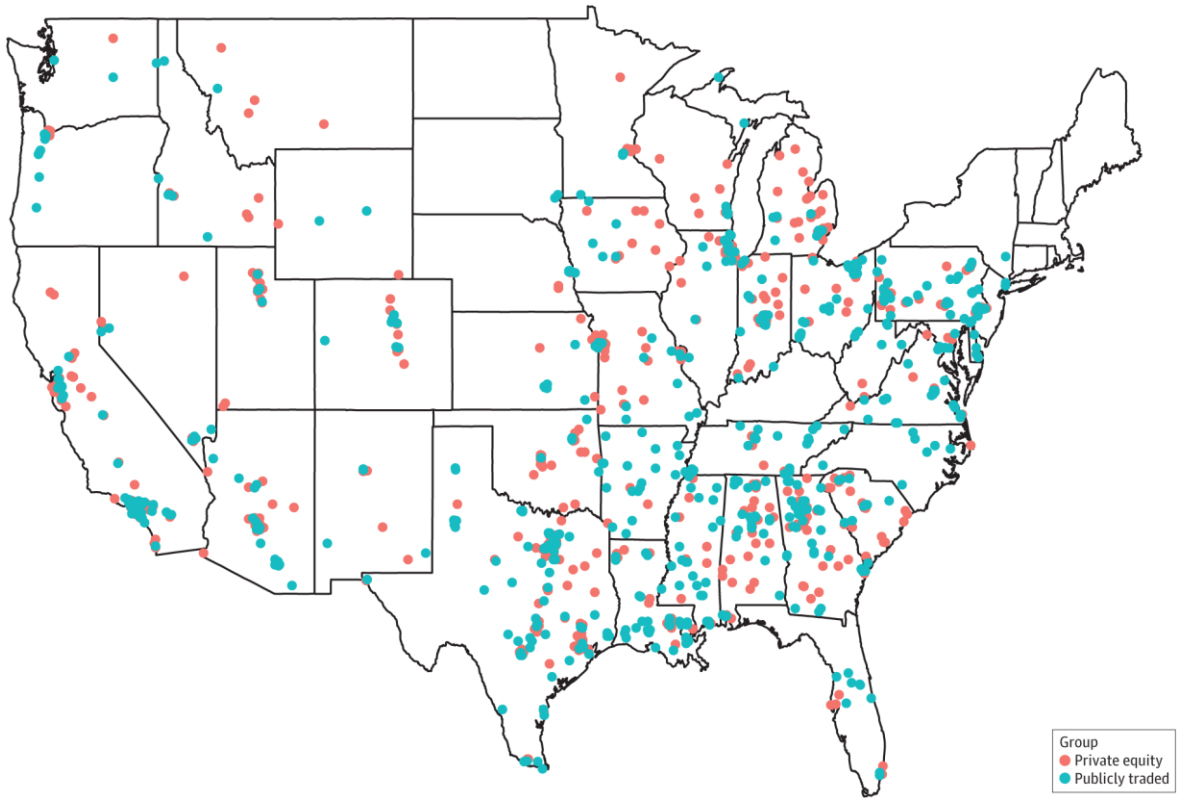


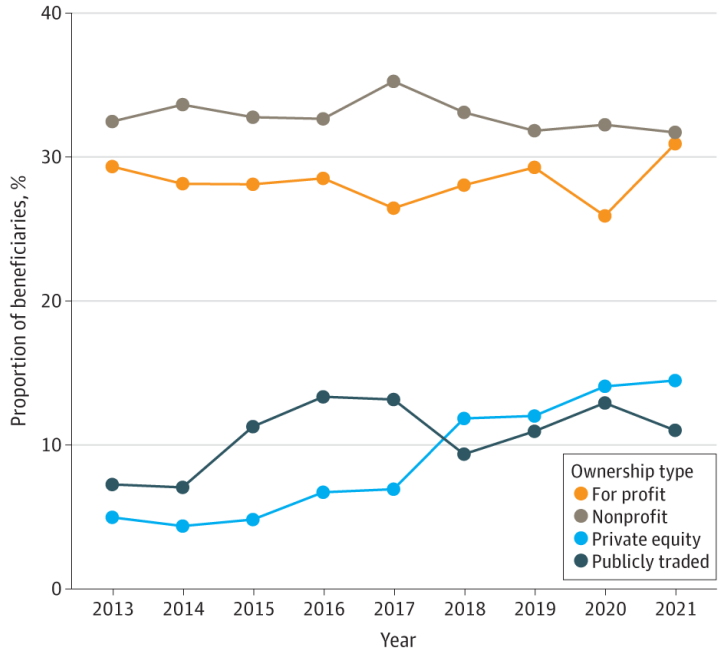
Figure: Geographical Distribution of U.S. Hospices Owned by Institutional Investors



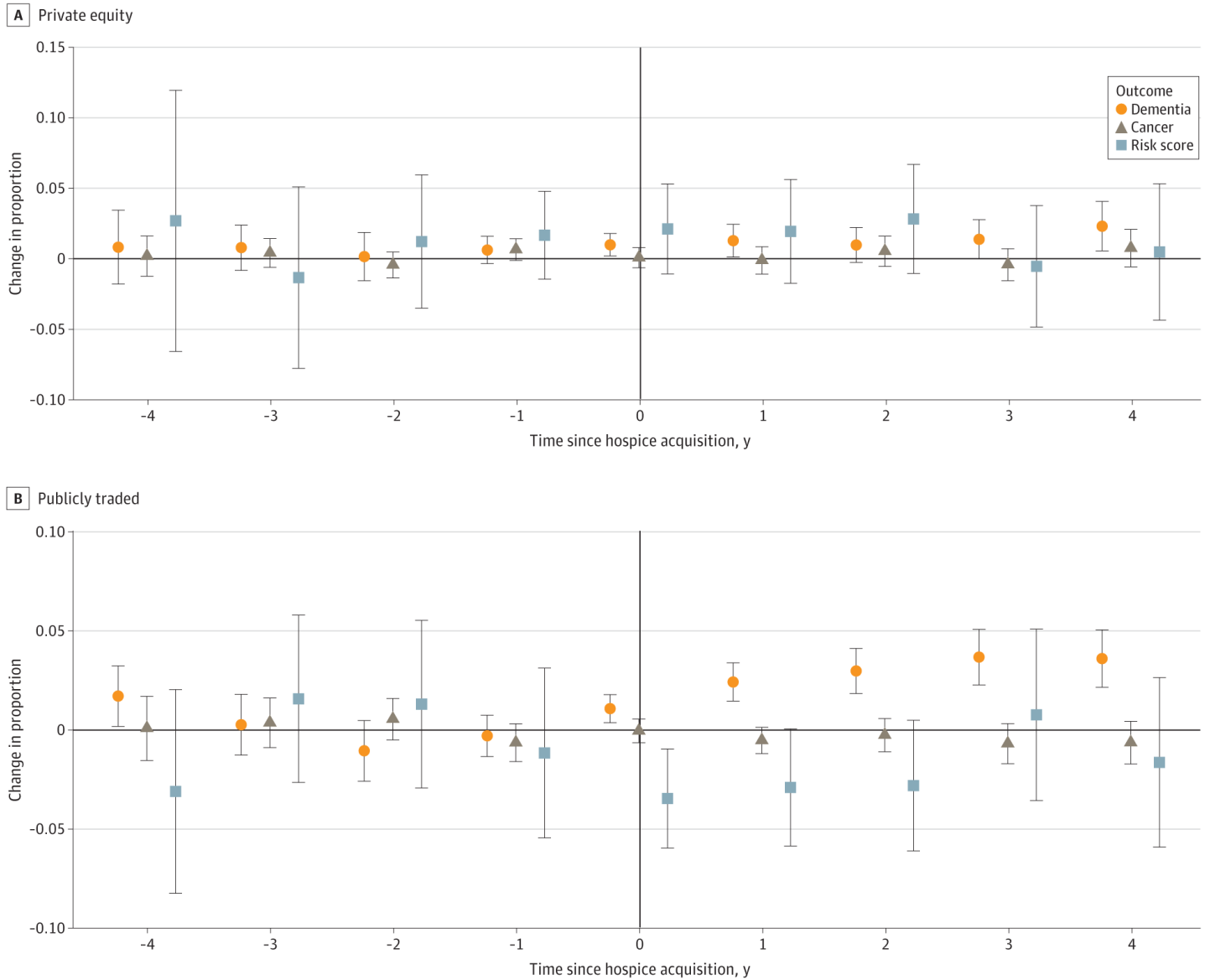
Introduction

- In 2019, 16% of Medicare beneficiaries received hospice care from private equity (PE) or publicly traded companies (PTC) owned hospices
- In 2021, this grew to 25.5%
  - 14.5% in PE
  - 11.0% in PTC

Figure: Percent of Medicare Enrollees, by Ownership



Source: Irving Levin, Medicare PAC PUF 2013-2020


A
Private equity
0.15
0.10
0.05
0
-0.05
-0.10
Change in proportion
-4
-3
-2
-1
0
1
2
3
4
Time since hospice acquisition, y
Outcome
Dementia
Cancer
Risk score
B
Publicly traded
0.10
0.05
0
-0.05
-0.10
Change in proportion
-4
-3
-2
-1
0
1
2
3
4
Time since hospice acquisition, y

Implications

- Policymakers might need to consider additional regulatory safeguards:
  - enhanced monitoring and reporting of patient demographics, clinical conditions, and outcomes following acquisitions
  - stringent oversight on changes in staffing and wage costs following acquisitions
  - improved reporting of ownership data
- More investigation into payment reforms to remove patient selection incentive based on length of stay