The Corporatization of Hospice

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Merger Waves

- Periods with high merger and acquisition activity
- There have been seven major merger waves in the in the US
- These periods are characterized by cyclic activity—that is, high levels of mergers followed by periods of relatively fewer deals
- These waves occurred between 1897-1904, 1916-1929, 1965-1969, 1984-1989, 1991-1999, 2003-2007, and 2011-present
- Why do they happen?

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

Strategy: 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

Private Equity

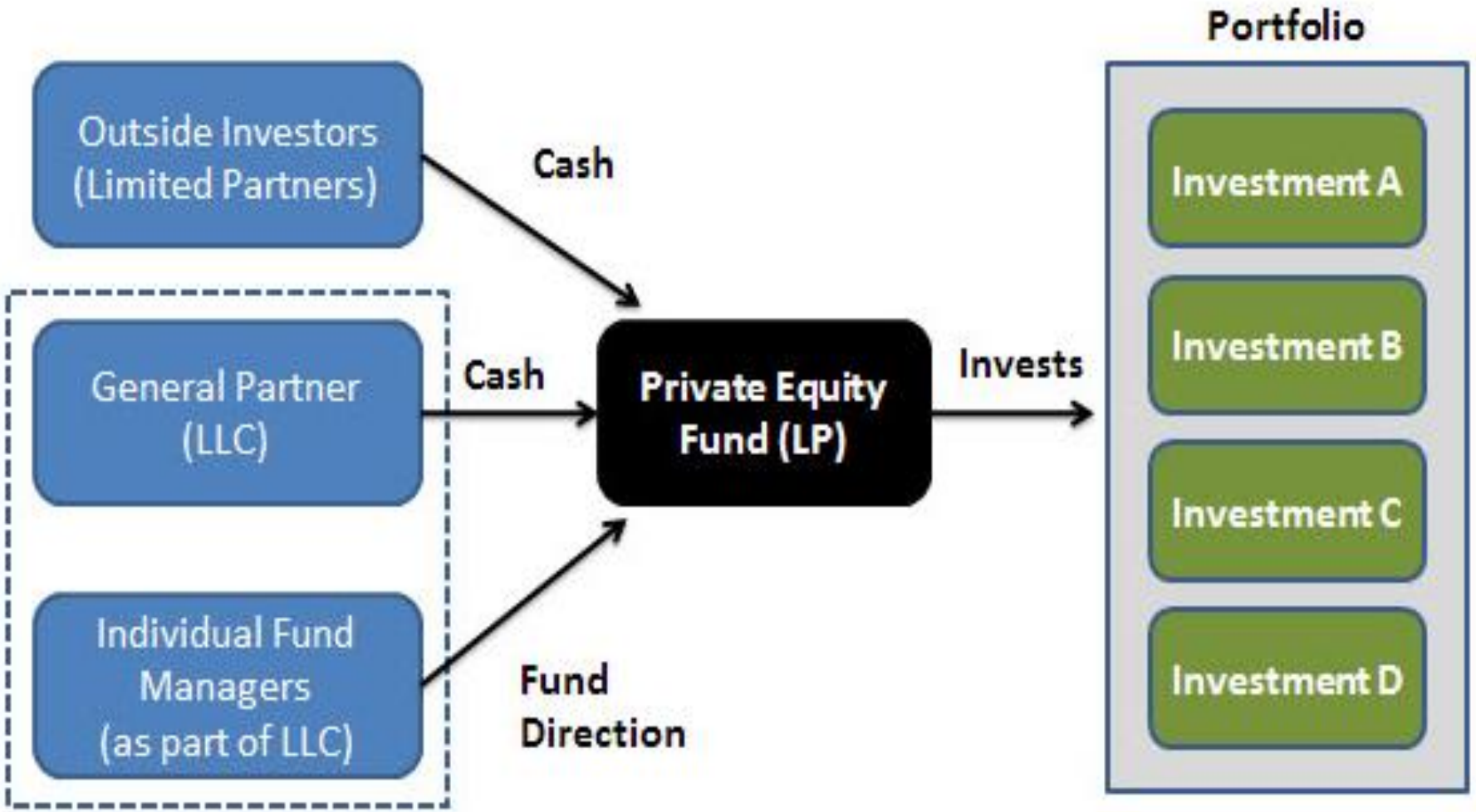
- Private investors that invest capital in private companies
- Receive controlling equity stake that is not tradeable on a public stock exchange
- How does it work?

PE Goals

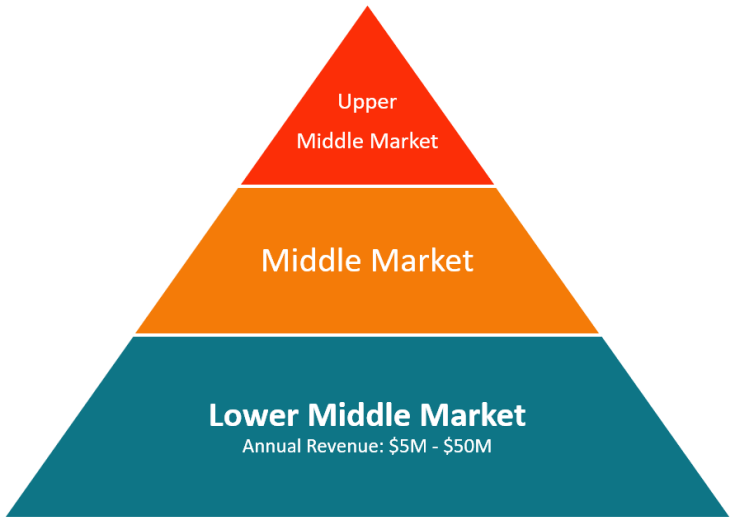
- Control majority of economic and voting interest
- Restructure financial, governance, and operational characteristics to increase profit
- Sell in 3 to 7 years
- ROI of around 20%

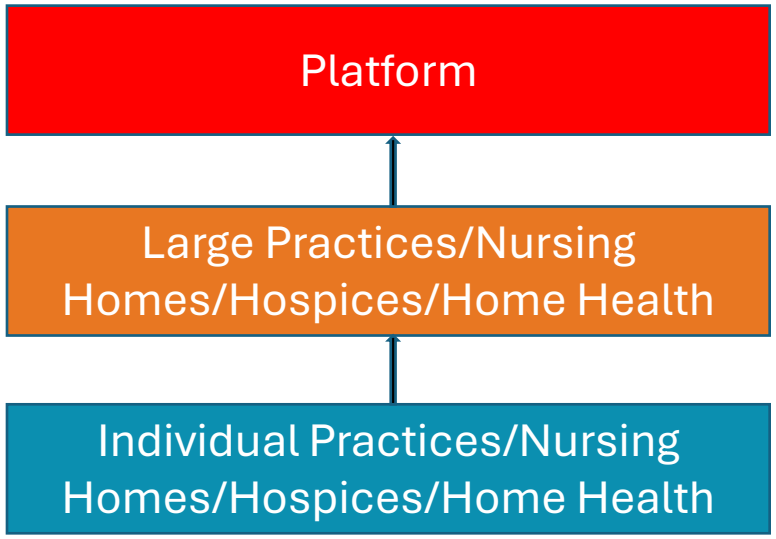
Private Equity Structure

What Does Each Party Bring to the Table?



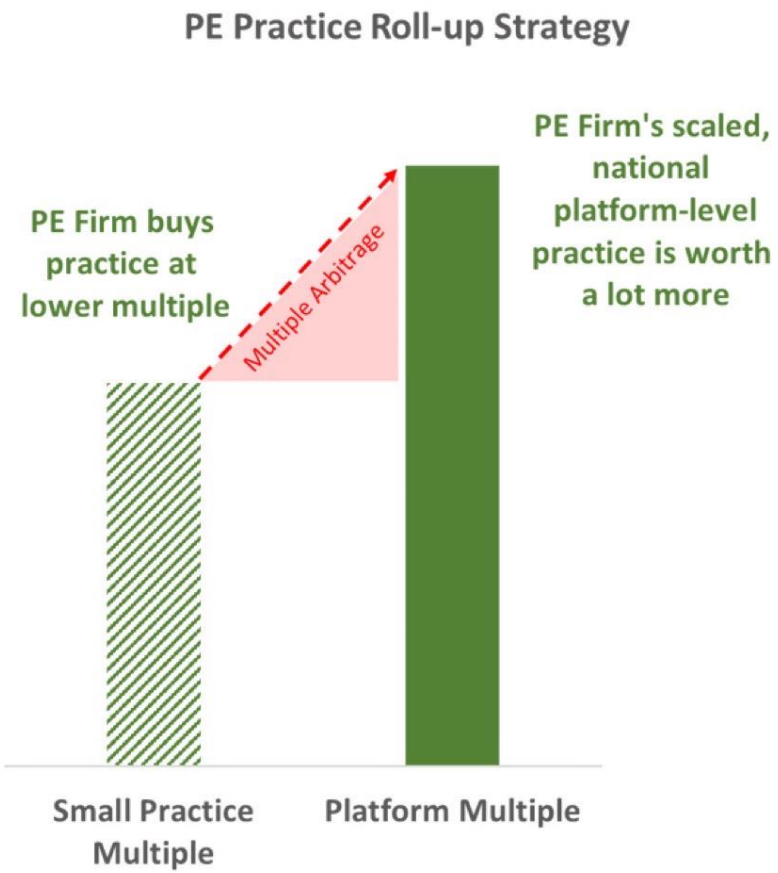
PE Markets


Upper
Middle Market
Middle Market
Lower Middle Market
Annual Revenue: $5M - $50M

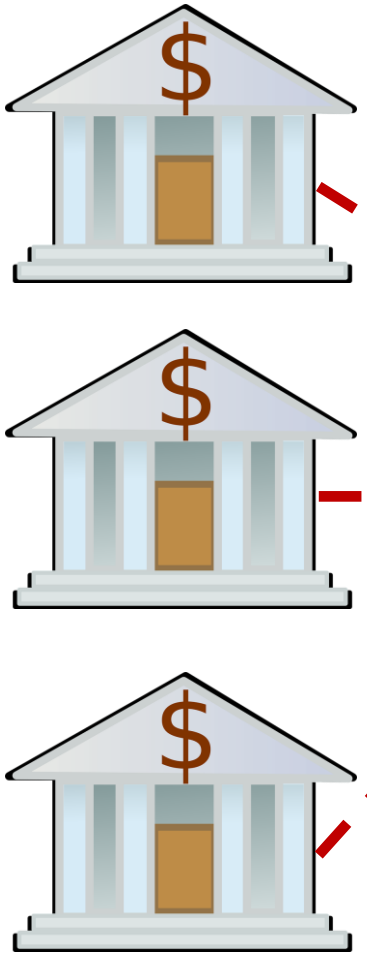

Platform
Large Practices/Nursing Homes/Hospices/Home Health
Individual Practices/Nursing Homes/Hospices/Home Health

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



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)

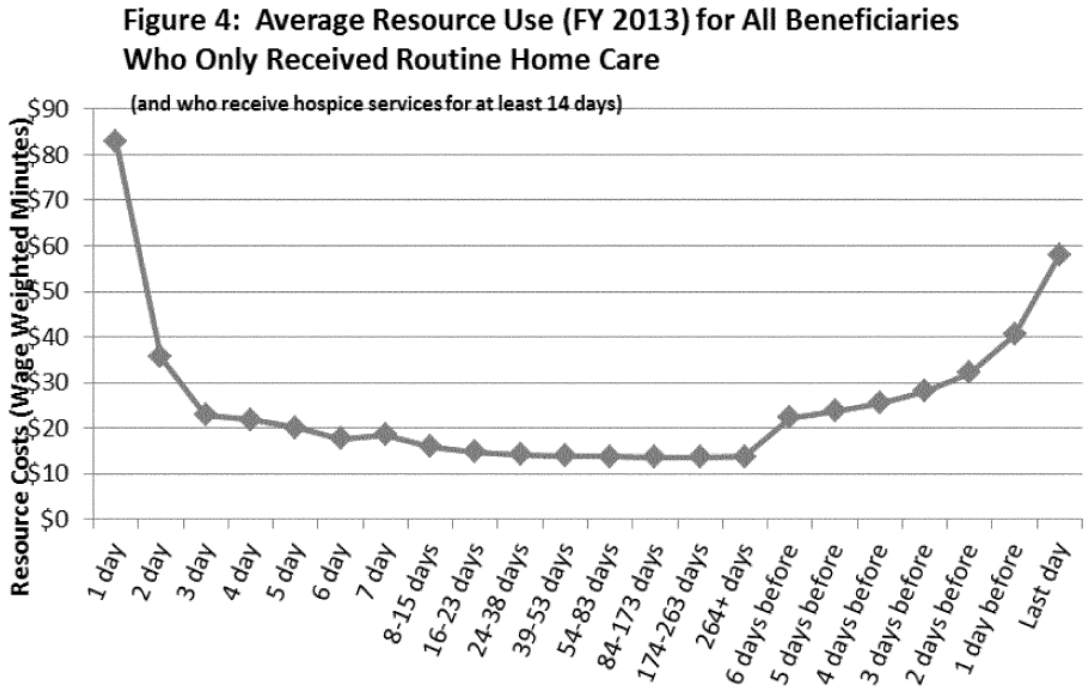
Target for Acquisition

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: 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

Hospice 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

Research Letter | Health Care Policy and Law

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

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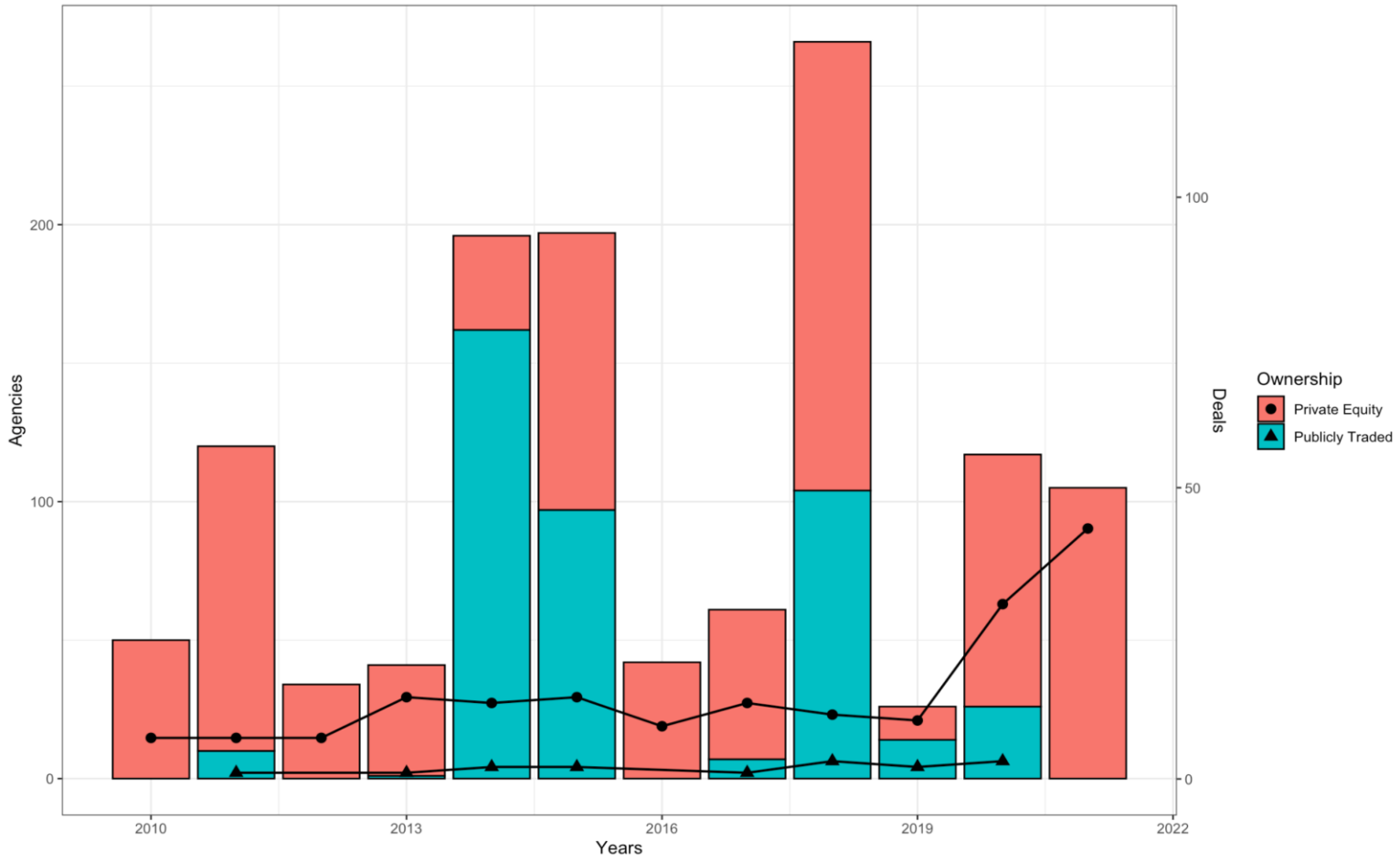
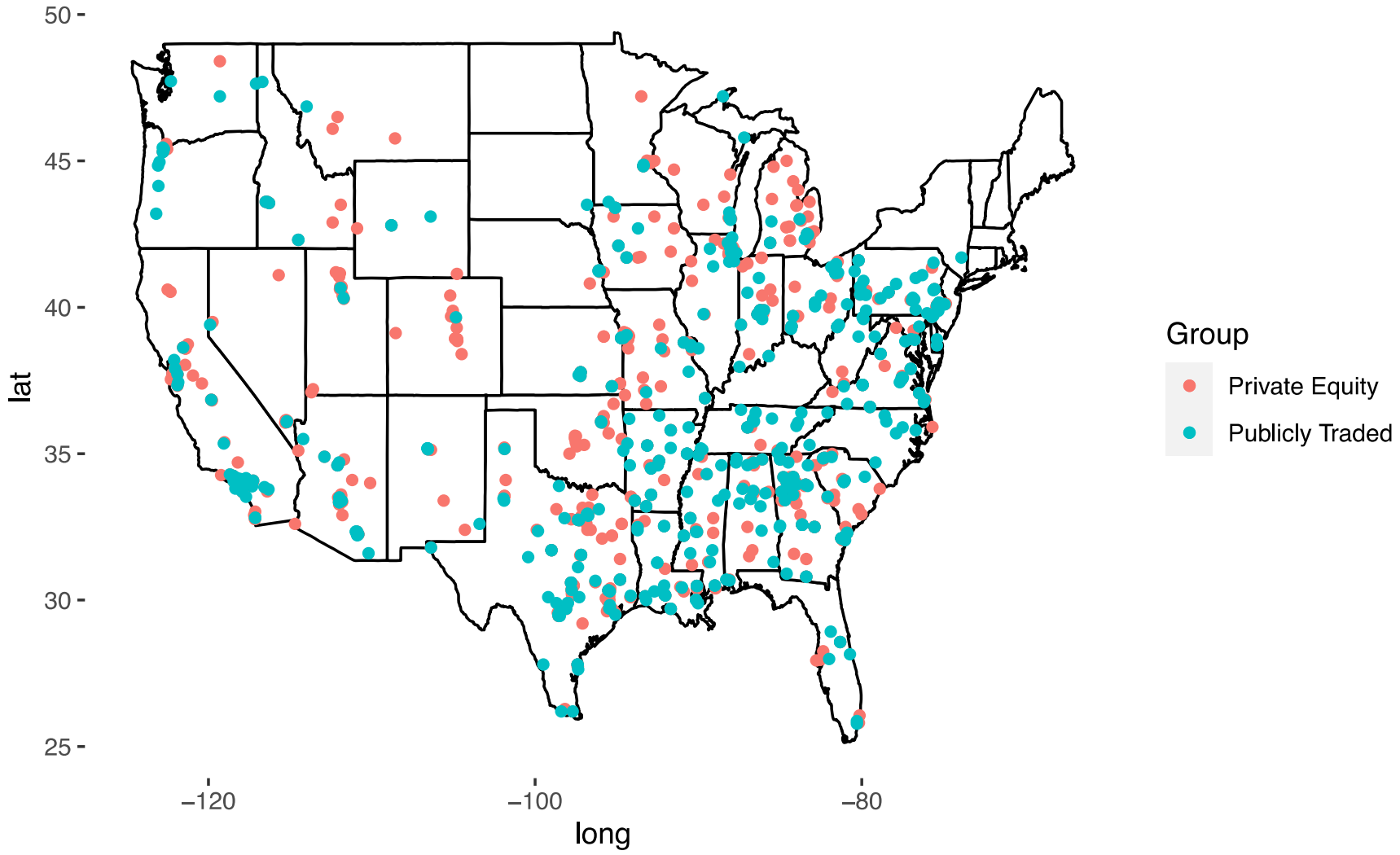
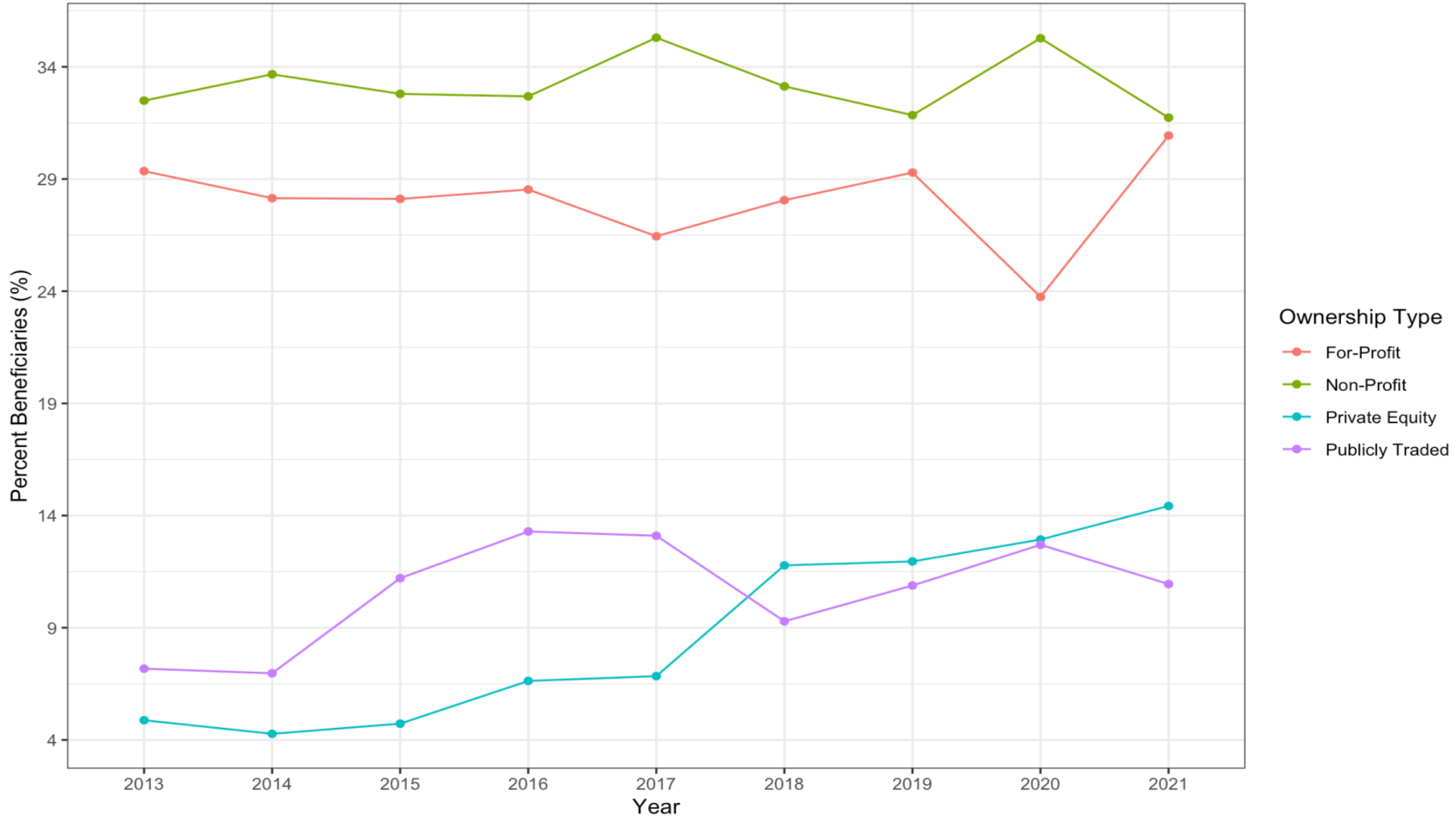
Number of Private Equity and Publicly Traded Deals and Agencies, 2010-2022

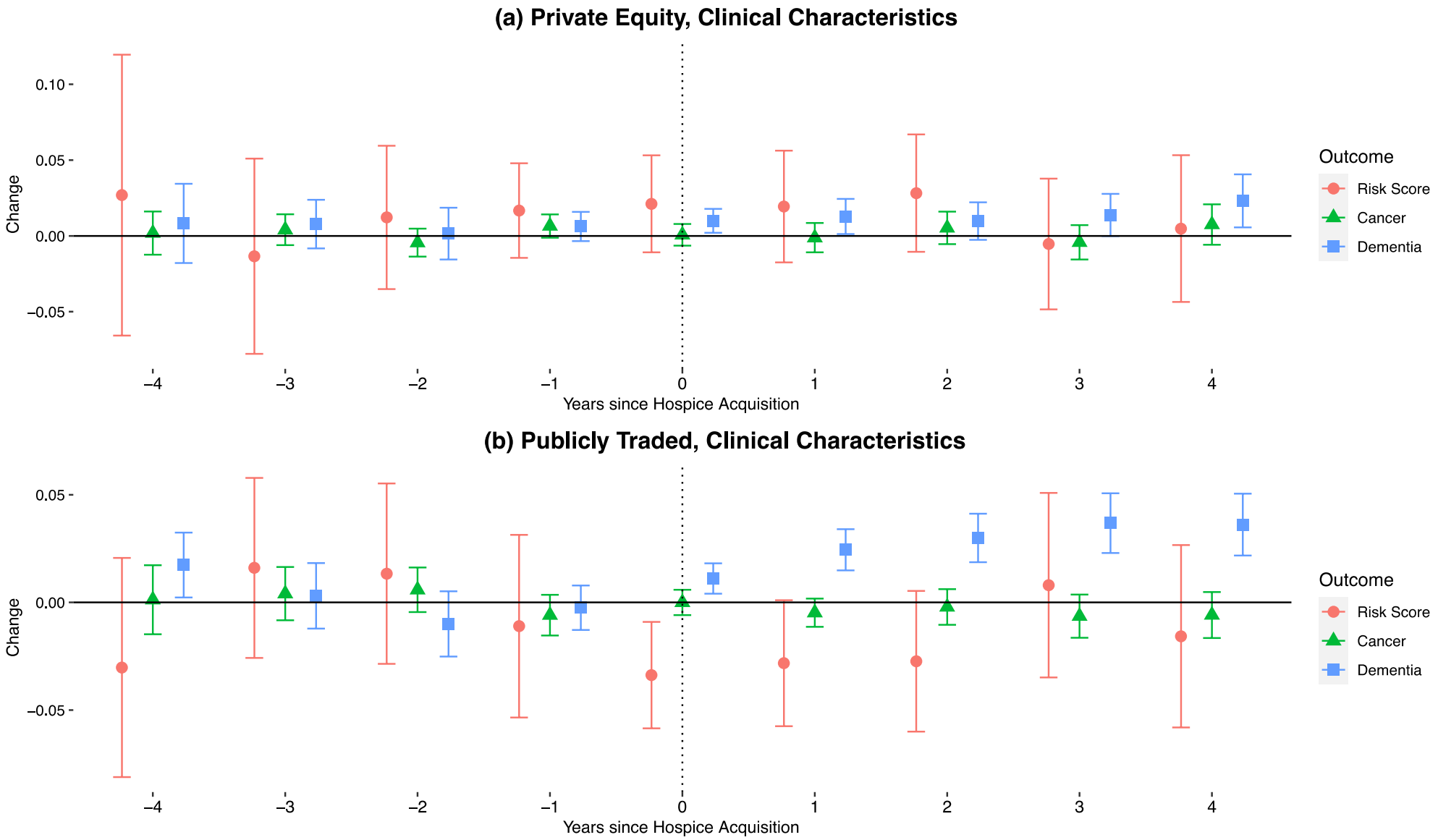


Prevalence of Hospice Agencies Acquired by Private Equity Firms and Publicly Traded Corporations in 2021



Percent of Medicare Fee-for-Service Beneficiaries Who Received Care From Hospice Agencies Owned by Private Equity Firms and Publicly Traded Corporations, 2013-2021



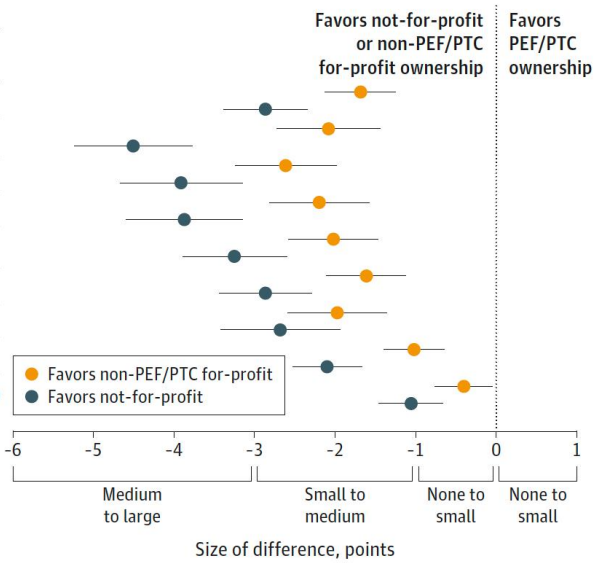


Braun, R.T., Unruh, M.A., Stevenson, D.G., Prigerson, H., Fernandez, R., Yeo, L. Casalino, L.P. Private Equity and Publicly Traded Corporations in Hospice Care: Associations with Patient Characteristics and Site of Care. JAMA Network Open. doi: 10.1001/jamanetworkopen.2023.34582.

Adjusted Differences in Caregiver-Reported Hospice Quality Between PE/PTC Hospice Ownership and Other Ownership Categories

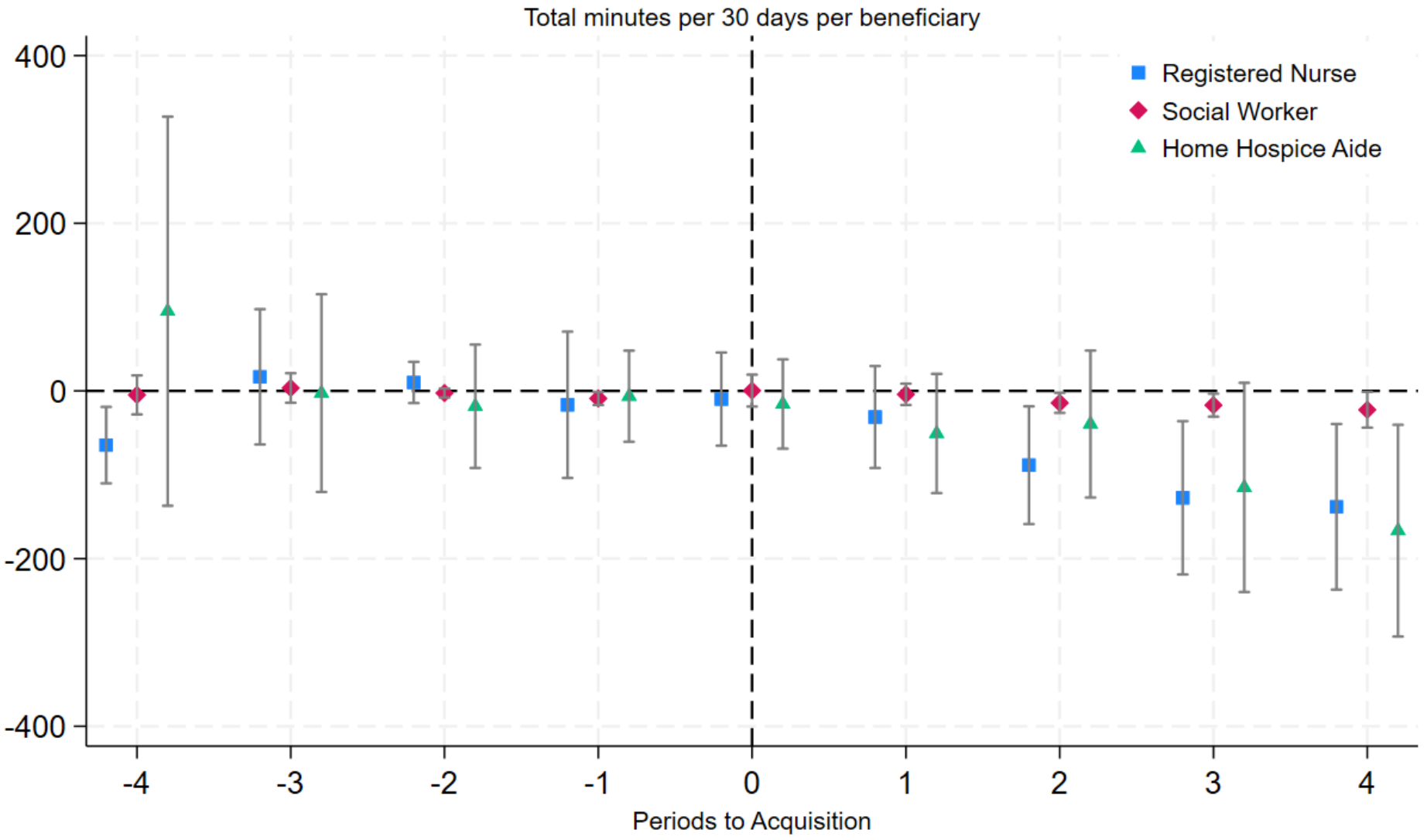
Figure. Adjusted Differences in Caregiver-Reported Hospice Quality Between PEF/PTC Hospice Ownership and Other Ownership Categories

Measures	Estimate (95% CI)	
	Not-for-profit vs PEF/PTC ownership	Non-PEF/PTC for-profit vs PEF/PTC ownership
Summary measure	-2.86 (-3.38 to -2.34)	-1.68 (-2.12 to -1.24)
Willingness to recommend	-4.50 (-5.23 to -3.77)	-2.08 (-2.72 to -1.44)
Getting timely care	-3.91 (-4.67 to -3.15)	-2.61 (-3.24 to -1.98)
Rating of hospice	-3.87 (-4.59 to -3.15)	-2.19 (-2.81 to -1.57)
Getting help for symptoms	-3.24 (-3.89 to -2.59)	-1.97 (-2.58 to -1.36)
Hospice team communication	-2.86 (-3.44 to -2.29)	-1.61 (-2.10 to -1.13)
Getting hospice care training	-2.68 (-3.42 to -1.93)	-2.02 (-2.57 to -1.46)
Treating family member with respect	-2.10 (-2.53 to -1.67)	-1.02 (-1.40 to -0.65)
Getting emotional and religious support	-1.06 (-1.45 to -0.66)	-0.40 (-0.75 to -0.053)



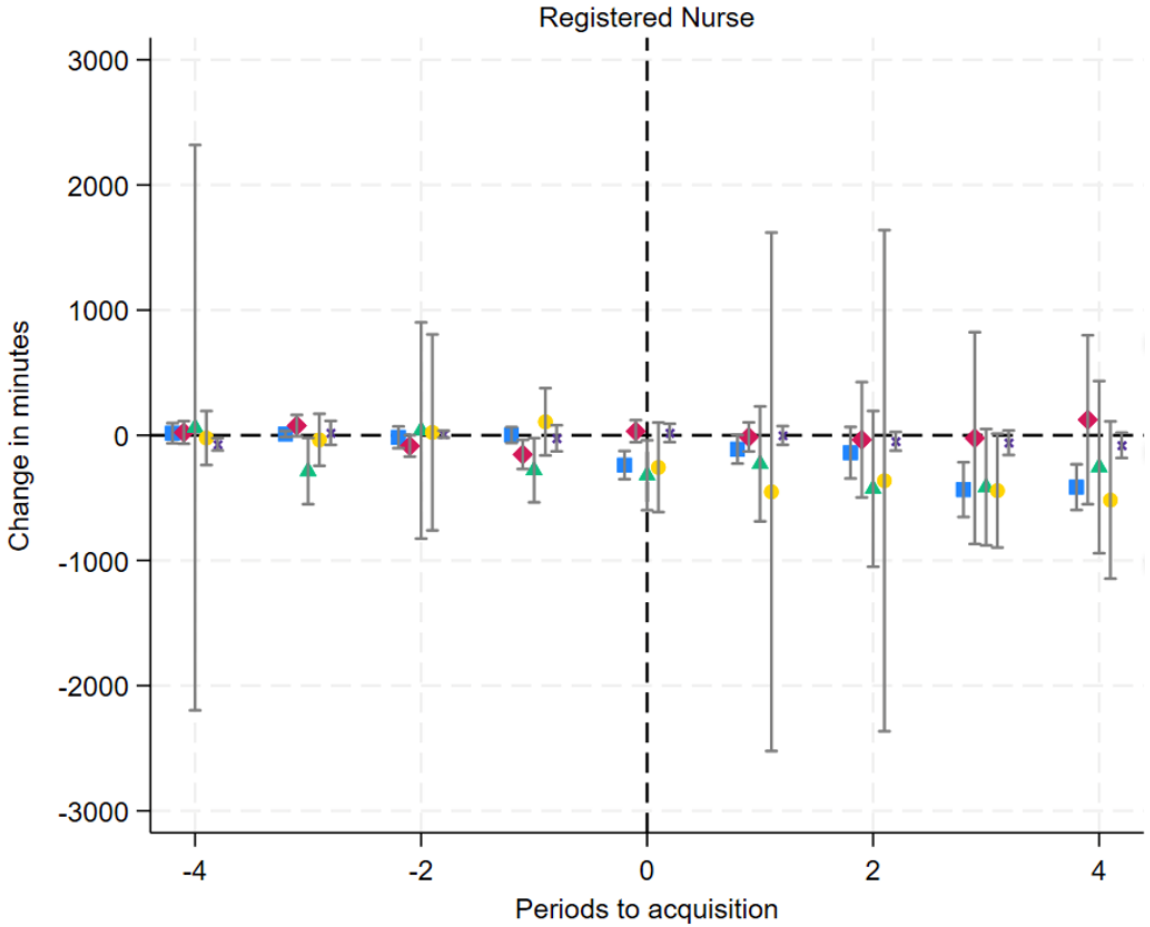
Blue circles indicate regression-estimated differences in top-box scores between private equity firm (PEF)/publicly traded company (PTC) ownership and not-for-profit ownership across measures. Orange circles indicate regression-estimated differences in top-box scores between PEF/PTC ownership and non-PEF/PTC for-profit ownership. The error bars represent 95% CIs. Negative values are due to the association between PEF/PTC ownership and lower top-box scores. The sample included 705 PEF/PTC-owned hospices, 768 not-for-profit–owned hospices, and 1203 non-PEF/PTC for-profit hospices. The Centers for Medicare & Medicaid Services (CMS) reports agency-level scores adjusted for mode of survey administration and case-mix (including primary diagnosis, decedent age, respondent education, and hospice length of stay). The multivariable linear regression models in the current study adjusted for the following additional covariates: average Area Deprivation Index of service area, rurality of service area, facility type, years in operation, size, and CMS region.

Soltoff, A., Unruh, M.A., Stevenson, D.G., Kavalieratos, D., Braun, R.T.*, Association Between Caregiver Assessments of Quality and Hospice Ownership by Private Equity Firms and Publicly Traded Companies. *JAMA*. Published online November 18, 2024. doi:10.1001/jama.2024.20546.



DO NOT CIRCULATE: Wen J, Soltoff A,, Stevenson DG, Kavalieratos D, Unruh MA, Braun RT. Association of Private Equity and Publicly Traded Company Investment in Hospice Agencies With Medicare Claims-Based Outcome Measures. *Under review.*

RN Minutes by Acquirer



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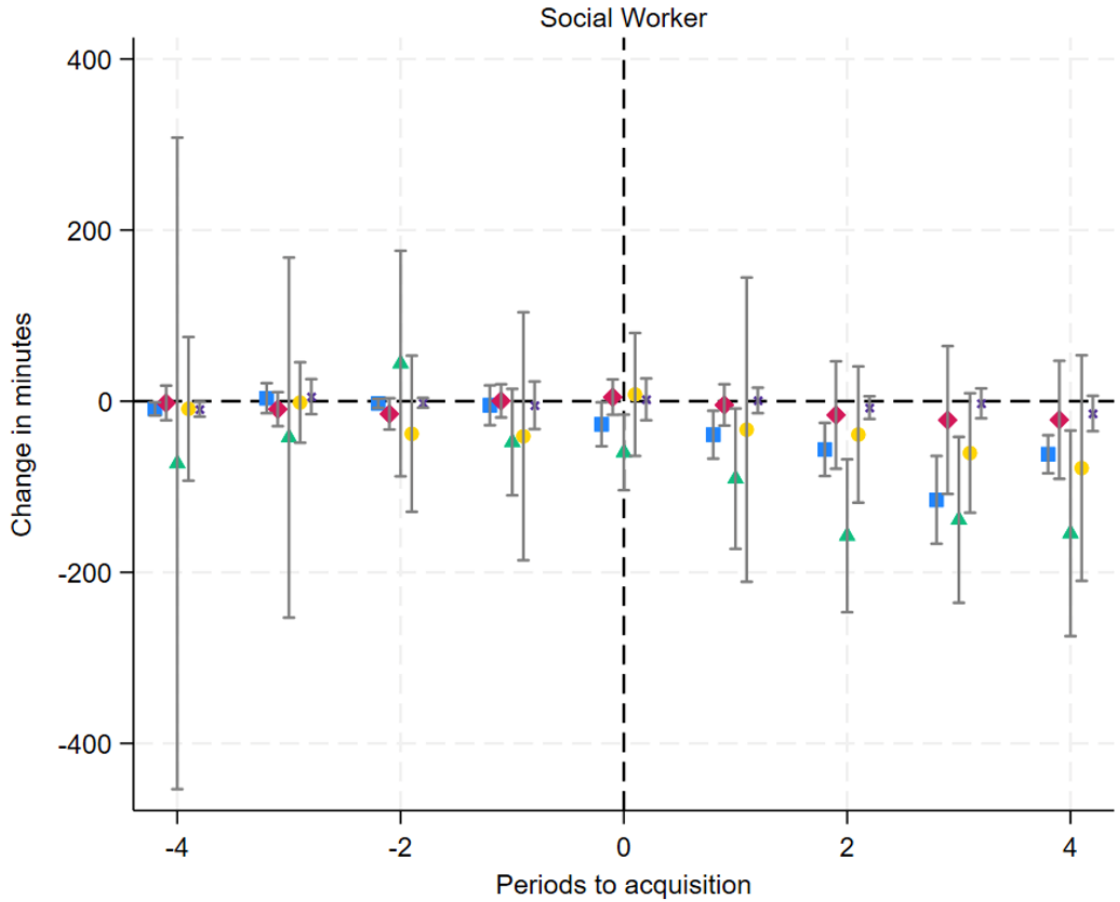
Social Worker Minutes by Acquirer



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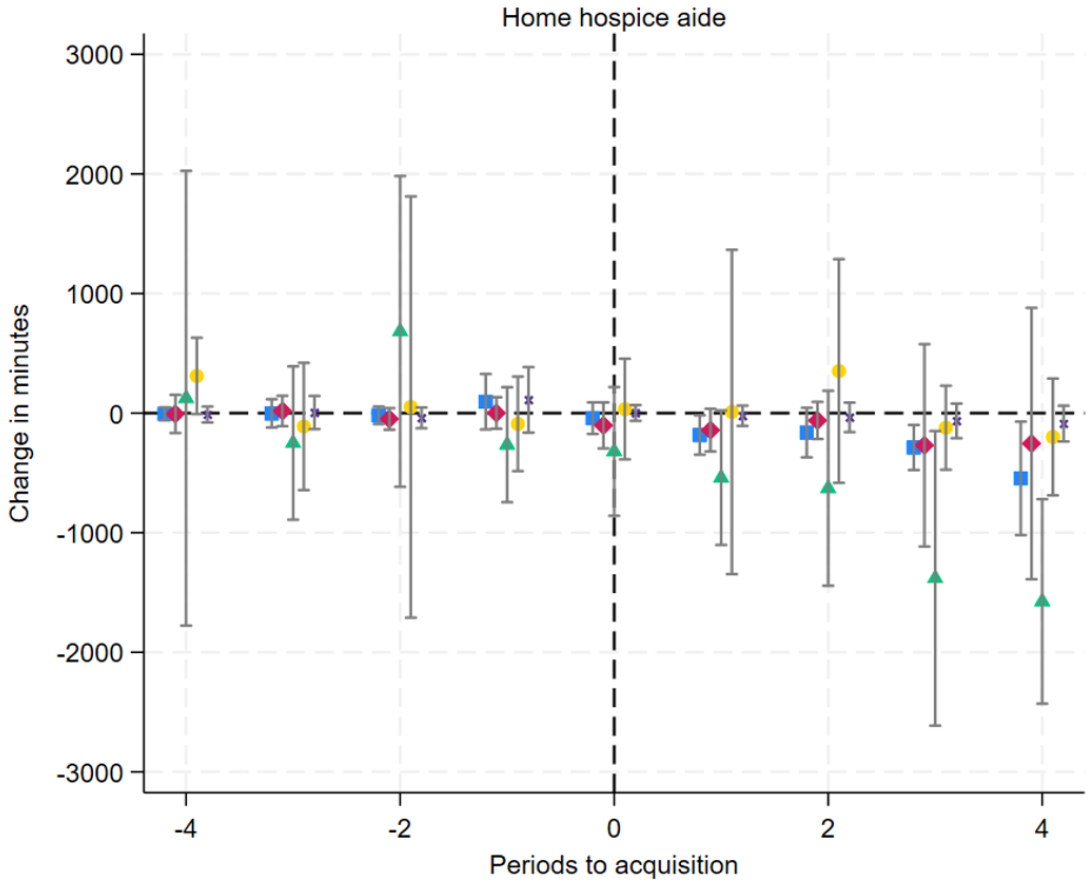
Home Hospice Aide Minutes by Acquirer



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Discussion

- Private equity is a large player across the healthcare sector
- The jury is still out on their advantages and disadvantages
- Important to explore heterogeneity of deals
  - No two acquirers are the same
  - This may be driving the "average treatment effect"
- Improve oversight and transparency
- Include policies that incorporate capital market dynamics—policymaking focused on a small percentage of the industry (private equity) can unintentionally sever access to capital (especially in nursing homes).