



Preying on the Dying: Private Equity Gets Rich in Hospice Care

By Eileen Appelbaum and Rosemary Batt, with Emma Curchin*

May 2023



Center for Economic and Policy Research
1611 Connecticut Ave. NW
Suite 400
Washington, DC 20009

Tel: 202-293-5380
Fax: 202-588-1356
<https://cepr.net>

* Eileen Appelbaum is a Co-Director at the Center for Economic and Policy Research (CEPR). Rosemary Batt is the Alice Hanson Cook Professor of Women and Work, ILR School, Cornell University. Emma Curchin is a Research Assistant at CEPR.

Contents

Contents	2
Executive Summary	4
Reforming Hospice Policy	6
Introduction	7
Medicare Payment Model for Hospice Care	10
Table 1	11
Regulatory Framework	13
Lax Supervision, Generous Medicare Payments Lure For-Profit Hospice Agencies to California	15
Which Medicare Beneficiaries Receive the Medicare Hospice Benefit?	21
Table 2	22
Evolution of the Hospice Industry	23
Table 3	25
The Role of Private Equity in Hospice	26
Private Equity in Hospice: Advent International	27
PE Business Model	29
Figure 1	30
Untangling the Kindred at Home Acquisitions Timeline	32
Implications of For-Profit and PE Ownership for Patients and Families	37
Table 4	41
Gaming the System Has Potentially Serious Implications for Patient Outcomes	42
Curo Health Services: A Case Study of Private Equity in Hospice	44
Curo Ownership History	45
Curo's Business Model	46

How Curo Agencies Gamed the System	47
Policies to Rein in For-Profit and PE Excesses in Hospice Care	53
Medicare Needs New Policies to Address Bad Behavior by Hospice Agencies	54
A Three-Pronged Approach to Improving Regulation of Hospice Agencies	56
Conclusion	60
References	63

Acknowledgments

We are grateful to the Omidyar Network for generous funding of this study and to Dean Baker and Chris Jurgens for helpful comments on an earlier draft. We are especially grateful to the healthcare workers, unions, and professionals who gave their time and shared their knowledge and experiences with us.



Executive Summary

The goal of hospice services is to enable terminally ill patients to remain in their homes and engage in their normal activities to the fullest extent possible. Compassionate patient and family-centered care is intended to relieve the physical and emotional stress that come at the end of life. Since 1983, the Centers for Medicare and Medicaid Services (CMS) have provided a hospice benefit to Medicare and Medicaid enrollees who are expected to die within six months. CMS contracts with hospice agencies to provide the care. The difficulty in defining and measuring 'adequate hospice care' makes monitoring and enforcing these contracts difficult. Economists argue that when the quality of a service is ill-defined and enforceable contracts cannot be written, it may be desirable to have the service publicly provided. While this is often not possible, carefully designed regulations can provide assurances that contractors are fulfilling their responsibilities. Unfortunately, the regulations in hospice are not well-designed, and even the existing regulations lack strong enforcement.

The hospice industry began with small, nonprofit providers whose mission was to care for the dying and assure that they faced the end of life with dignity. But the industry has evolved in ways that CMS may not have been prepared for. Now, for-profit hospices dominate the industry, with Wall Street players, driven by the logic of profit maximization, buying up nonprofit agencies and consolidating them into large chains with hundreds of locations. For-profit hospice agencies report profit margins three times as high as those earned by nonprofits. Research shows that, on average, the quantity and quality of care suffer in for-profit hospices compared to nonprofit providers.

Indeed, loopholes built into the payment model used by CMS provide incentives for for-profit hospice agencies to game the system, legally stealing money from Medicare while degrading the quality of patient care. These loopholes create incentives for financial actors such as private equity to target hospice providers for buyouts. Lax and fragmented oversight facilitates consolidation of hospice agencies into large chains in this fragmented industry. Private equity firms were especially active in 2020 and 2021; in the fourth quarter of 2021, private equity was the dominant dealmaker, accounting for three quarters (18 out of 23) of hospice deals. Compared to for-profit providers, private equity owners have even more incentives to game the system



because they must service debt and deliver on their promise of outsized returns to their investors.

Too often, gaming the system spills over into fraud – charging Medicare for services that were not provided or illegally enrolling ineligible patients. The interrelationship between fraud and patient abuse suggests that patient care will suffer. Fraud and gaming the system can create real harms for patients. As we document in this report, a focus on profit maximization leads, on average, to fewer visits to hospice patients, inappropriate use of lower-skilled staff to care for patients, and recruitment of patients who are ineligible for hospice care and thus lose access to curative or emergency care. Unleashing incentives for profit maximization have not led to better outcomes for patients and families but rather, in many cases, quite the opposite.

Problems of asymmetric information – most patients and their caregivers have no prior experience with hospice care – further increase the difficulty of overseeing private hospice agencies. While moving hospice services into the public sector may not be feasible, enforcement of strong regulations can reduce improper behavior of agencies and improve patient care. Unfortunately, existing regulations are inadequate and enforcement of existing regulations by CMS and public health authorities has been lax, providing opportunities for dishonest hospice agencies, including some of those owned by private equity, to skirt the regulations. As a result of this lack of enforcement, waste, abuse and fraud are rampant in this industry.

Reforming Hospice Policy

We propose a three-prong approach to hospice policy reform to reduce fraud, reduce opportunities to game the system, and assure that more of Medicare payments are directed to providing patients and their families high quality care. The first prong consists of strengthening and enforcing policies that are already on the books. For example, Medicare needs to do a more careful inspection before certifying a hospice provider as eligible to receive government payments. The second encompasses policies that need to be updated to account for the entrance of private equity in hospice, such as an enhanced merger review by the FTC and DOL. The third prong is the development of new policies that close loopholes that unscrupulous hospice agencies, including some owned by private equity firms, are well-positioned to exploit.



Introduction

The mission of hospice care is to ease the physical pain and existential anxiety of patients with terminal illnesses and help family and friends care for patients facing the end of life. Prior to 1983, nonprofit agencies provided nearly all hospice care. Then, in 1982, legislation was passed that required Medicare to provide a hospice benefit; its purpose was to enable terminally ill Medicare beneficiaries to receive needed care and live out their final months and days with dignity. Hospice was a low margin business and there was no expectation that providing the benefit would prove attractive to for-profit providers. But the lure of government-funded hospice care attracted small for-profit hospice providers, followed soon after by publicly-traded corporations and then by private equity firms that saw an opportunity to extract profits from caring for the dying. These organizations, often led by people with no experience in health care but deep expertise in finance, were motivated by the pursuit of profit.

In 1983, the Center for Medicare and Medicaid Services (CMS) – hereafter Medicare – implemented the hospice benefit. Medicare contracts with hospice providers for the management of pain and other symptoms for Medicare beneficiaries expected to live six months or less. As explained in greater detail below, Medicare makes a fixed payment to the hospice provider for every day the patient is enrolled, whether the patient receives care services on that day or not. This payment model has been catnip to for-profit providers, providing an incentive for them to enter the industry. This includes private equity firms that, since 2018, have accounted for a disproportionate share of the increase in the number of hospice deals. The payment system provides opportunities for legally gaming the payment system, and even for fraudulent behavior by unscrupulous hospice providers.

Terminally ill patients have a choice between continuing on Medicare and receiving treatment for their condition, or entering hospice and foregoing further curative medical treatment. Most hospice patients receive care in their homes (GAO 2019). These patients are typically suffering from terminal diseases – heart, kidney, cancer, or from conditions such as dementia or Alzheimer's – with no hope of cure or where the negative effects of treatment on the individual's quality of life outweigh any benefits. Enrollment in hospice requires an assessment by a physician – either the patient's personal physician or a physician employed by the hospice

agency – that the patient has six months or less to live. A patient accepted into hospice care is no longer covered by Medicare and no longer receives emergency or curative care.

Caring for the dying has become a booming \$22.4 billion business as for-profit hospice agencies have entered the industry, consolidating small agencies into large chains, and converting nonprofit providers to for-profit businesses (MedPac 2022). Medicare and Medicaid contract with hospice agencies to provide end-of-life care and pick up 90 percent of the tab for these services (with Medicare paying 85.4 percent and Medicaid 5 percent). These contracts with the government guarantee payment to hospice providers for services billed. However, the deficiencies in hospice care documented in this paper raise the question of whether CMS should be contracting with agencies to provide hospice care or whether, instead, hospice care should be provided by the public sector. It is difficult to specify or measure exactly what constitutes adequate quality hospice care, making it difficult for the government to contract for it. Patients and caregivers are not certain exactly how they value quality care or even what constitutes satisfactory care. Economists have shown that in these circumstances, oversight of patient care can be facilitated by providing these services publicly rather than contracting for them with private entities. While having these services provided publicly may be desirable, it is not always feasible. Regulation provides a method of controlling the quality of services provided that is intermediate between public and private ownership of hospice agencies (Sappington and Stiglitz 1987).

Unfortunately, there is very little oversight of hospice agencies by regulators at either the local, state or federal level. They mostly operate on the honor system when it comes to admitting patients and to providing services intended to enable terminally ill patients to experience a pain-free and dignified end of life. The temptations are great for profit-driven organizations to enroll individuals who are not in imminent danger of dying, enroll patients that require little care, and to reduce the quality and frequency of visits while billing Medicare for services that may not be required or even provided. As a result, opportunities for fraud, abuse, and neglect are rampant in the hospice industry.

Few barriers to entry, lax regulation, and little oversight have made hospice attractive to small investors as well as Wall Street and private equity firms. Hospice care was once provided primarily by nonprofit agencies, but today more than two-thirds of hospices nationwide are operating as



for-profit entities. Private equity is a major contributor to this trend (Hawryluk 2022). The design of the payment model for hospice care enables profit-driven providers to profit at the public's expense. Payments intended for the care of Medicare beneficiaries can be diverted to line the pockets of hospice owners. It is more difficult to document the resulting harm to patients, who do not get the care to which they are entitled. Patients and caregivers may not know what services these patients are entitled to. And, in any case, the patient is dying, so it may not seem worthwhile to file a complaint.

This report examines patient eligibility and the payment model, the current regulatory framework, private equity's entrance into hospice care, and impacts on patients. While many for-profit and private equity-owned hospice providers no doubt enroll only eligible patients and provide quality care, the incentives in the Medicare hospice program point the other way. Unscrupulous agencies, whether for-profit or nonprofit, are able to game the system and enrich themselves at the expense of patients. But the evidence points to the greater prevalence of this behavior among for-profit providers and to worse outcomes along multiple dimensions for their patients. Curo Health Services and some of its agencies illustrate what can happen when profit-driven hospice providers prioritize maximizing financial returns to investors over meeting the needs of patients. The report includes a case study of private equity-owned Curo. Finally, the report provides a road map to policy enforcement, policy expansion, and new policies to close off loopholes in the payment model. These policies can better assure that Medicare funds go to the care of hospice patients and are not siphoned off to pad profits.

Medicare Payment Model for Hospice Care

Passage of the Tax Equity and Fiscal Responsibility Act (TEFRA) in 1982 established the Medicare hospice benefit. In 1983, Medicare began paying hospice providers for care of terminally ill patients with a doctor–documented life expectancy of 6 months or less. Hospice spending has grown substantially in recent years. Between 2010 and 2020, spending grew from \$12.9 billion to \$22.4 billion, an average annual growth rate of 5.7 percent. Medicare is the largest payer of hospice services; together, Medicare and Medicaid pay for 90 percent of all hospice patient days (MedPac 2022).

Hospice providers are paid a daily rate for every day an eligible patient is enrolled for care. Medicare pays hospice providers whether the patient receives services on that day or not. The average lifetime length of hospice care until the patient died was 102 days in 2022; the median was 19. The average lifetime length of stay includes the sum of all days of hospice care. Extremely long lengths of stay influence this average (CMS 2023). If the patient is alive at the end of a six–month period, they will be re–enrolled if a hospice doctor certifies that they are still eligible. Re–enrollment is first for 90 days and subsequently for 60 days, and re–enrollment can occur for as long as the patient’s illness threatens them with death within 6 months. Of course, ineligible patients who are not terminally ill will live longer than the expected 6 months. The hospice that enrolled them will receive payments for care for as long as a hospice doctor certifies that they are terminally ill and expected to live 6 months or less.

Hospice payment rates are updated annually, based on the hospital market basket cost index. Payment rates for 2022, described below in Table 1, increased by 3.8 percent in fiscal year 2023 (the result of a 4.1 percent increase in the market basket cost minus a 0.3 percentage point productivity adjustment) (“Fiscal Year (FY) 2023 Hospice Payment Rate” 2022).

There are four categories of Medicare payments for services: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIP). Nearly all payments fall into the category of routine home care, which accounted for 98.7 percent of hospice payments. As California’s state auditor has noted, this can be quite lucrative for a hospice agency. An agency with 20 patients that bills Medicare at the RHC daily rate can collect payments



of more than \$122,000 a month. Payments are per diem and are made for every day the patient is enrolled with the provider, whether or not the patient receives any care on that day. This makes hospice an attractive target for providers who may find it tempting to cheat patients of required care while billing Medicare for payment of the per diem fee (California Auditors' Report 2022, MedPac 2022).

Table 1

Medicare Hospice Payment Rates Depend on the Category of Care Provided		
Category of Care	Description	Daily Payment Rate
Routine home care	Provided on a routine day when a patient is not receiving continuous care	First 60 days: \$203.40 Day 61+: \$160.74
Continuous home care	Provided during brief periods of crisis, consisting predominantly of nursing care to allow the patient to remain at home.	\$487.52 to \$1,462.52 (\$60.94 per hour)
Inpatient respite care	Provided in an approved facility on a short-term basis to relieve the caregiver.	\$ 473.75
General inpatient care	Provided in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings.	\$ 1,068.28

Note: Payment is generally made to the hospice agency for each day during which the beneficiary is eligible and under the agency's care, regardless of the amount of services furnished on that day.
Source: California State Auditors analysis of Federal law and the Federal Register data.

There is one provision in the 1982 TEFRA legislation that addresses the possibility that agencies may be tempted to admit ineligible patients, which is a limit on the aggregate payments a hospice agency can receive from Medicare in a year. TEFRA established a hospice aggregate cap that increases every year by the rate of inflation. In 1983, the first year the hospice benefit was available, the per patient cap was \$6,500; in 2022, the cap was \$31,297.61. The bill for an



individual patient can exceed the cap. However, if the total Medicare payments to a hospice agency exceeds the total number of hospice patients served by the agency in 2022 multiplied by \$31,297.61, the agency is required to turn the excess back to Medicare (MedPac 2022). For 2023 the cap is \$32,486.92 (CMS.gov 2022).



Regulatory Framework

To be eligible for payment by Medicare, a hospice agency is expected to meet the following conditions. The hospice must inform patients of their rights, including a right to effective pain management and symptom control. It must conduct an initial assessment that establishes that the patient requires hospice care. Based on this assessment, the hospice must designate an interdisciplinary group (doctor, RN, health aides, family members, spiritual advisor) to prepare a care plan that specifies the hospice care services that meet the needs of the individual patient and their family. The hospice must routinely provide patients with physician services, nursing services, medical social services, and counseling services as appropriate. The hospice must have a medical director who is a Doctor of Medicine or Osteopathy employed, or under contract, with the hospice. Each patient must have a clinical record of past and current findings available to hospice staff. The hospice must provide patients with drugs, medical supplies and durable medical equipment related to the management of the patient's condition while they are under the hospice's care. Finally, professionals who provide services to patients must have legal authorization (license, certification, registration) to provide such services. These conditions, which Medicare requires for a hospice agency to be eligible for payment, are widely viewed as minimum standards that relate primarily to services provided and staffing (California Auditor's Report 2022; GAO 2019).

The Government Accountability Office (GAO 2019) reports that Medicare provides oversight through inspections, called surveys, conducted by state agencies or approved accreditation agencies. These surveys (inspections) are used to gauge whether the hospice complies with the conditions Medicare requires for participation in its program. Lack of compliance – for example, nonadherence to the care plan developed by the patient's interdisciplinary group – can affect the quality of care and put patients at risk for poor outcomes. Actual harm to patients or their families, either in the past or currently, is not recorded or investigated in these surveys (inspections). As a result, such harms are not included in CMS reports of hospice deficiencies. Family caregivers receive a survey two months after the patient dies about their satisfaction with the care provided by the hospice agency, but reporting is voluntary. The best measures of whether an agency is providing appropriate care is the proportion of live discharges (above 50



percent suggests the agency is enrolling ineligible patients) and the number of visits by clinical staff in the last week of life. As we discuss below, more than half of all patients admitted to hospice care die within the first three weeks. Having more than half of patients still alive and judged to be no longer terminally ill at the end of 6 months or more is unusual, and suggests the hospice may be enrolling ineligible individuals.

Oversight tends to be lax and enforcement weak in the hospice industry, and both vary widely by state. Deficiencies in patient care are widespread across the U.S. A review of hospice agencies across the country found that eight out of ten had at least one deficiency that affected the care of patients (Health and Human Services Office of the Inspector General 2019). California is an extreme example of weak enforcement. The extreme effects of lax regulation and oversight have been documented for California by the state's auditor (California Auditor's Report 2022). The report found little to no enforcement even when the evidence pointed toward organized fraud that cheats patients of necessary care and costs the government millions of dollars.



Lax Supervision, Generous Medicare Payments Lure For-Profit Hospice Agencies to California

In March 2022, the California Auditor released a damning report, “California Hospice Licensure and Oversight,” detailing the growth of hospice providers in that state (California State Auditor 2022). By January 2022, the state had licensed more than 2,800 hospice providers, 94 percent of which were for-profit agencies. Hospice growth over the 2012–22 decade bore no connection to the size of the state’s elderly population and the need for services. The report concluded that inadequate licensing and investigations by the California Department of Public Health led to “large-scale fraud and abuse of Medicare and MediCal (California’s Medicaid program),” putting patients at risk and costing taxpayers millions of dollars for services provided to ineligible enrollees or never provided at all.

Los Angeles County in particular stood out. There were several red flags, including:

- The growth in hospice providers far exceeded the need for hospice services in the county; in 2019, Los Angeles County had more than six times the national average of hospice agencies in relation to its aged residents; nearly all the growth in hospice providers was in for-profit agencies.
- Dozens of separately licensed agencies were located in the same building; one building in the community of Van Nuys was the address for more than 150 licensed hospice and home health agencies – more than the building could hold.
- The agencies had abnormally high rates of discharge of live patients from hospice, an indicator that the agencies had enrolled ineligible patients.
- And evidence suggested the use of possibly stolen identities of doctors and other medical professionals, raising questions about who is providing care to patients.

The red flags should have alerted the California Department of Public Health to the possibility of fraud. In particular, the high level of live discharges raises the possibility that the hospice has enrolled ineligible patients that are not close to death and is collecting reimbursements from Medicare for services that should not or are not being provided.



The interrelationship between fraud and patient abuse suggests that the quality of patient care has suffered. But oversight by the California Department of Public Health, the agency responsible for granting licenses and overseeing agencies, was exceedingly lax. For example, the state auditor found that the initial licensing process did not provide sufficient screening of hospice employees to determine if they were qualified to care for patients, putting patients at risk of unnecessary suffering and poor quality of life in their final days. The state auditor also found that complaints of patient abuse often did not result in thorough investigations. Moreover, investigations of complaints typically took more than five months, so many patients complaining of abuse died before the investigation was completed.

Hospice licenses must be renewed after 24 months. Unfortunately, the renewal process does not require The California Department of Public Health to inspect the agency, and problems often go unobserved.

The California Department of Public Health is not the only government agency responsible for overseeing hospice providers. To be eligible for payment by Medicare, hospice providers must meet the conditions outlined above. Medicare is required to verify that a hospice continues to meet these requirements. Responsibility for this verification can be delegated to the states – in the case of California, verification can be delegated to the Department of Public Health. The rules allow states to contract with private companies to conduct the certification inspections. In California, hospice providers can choose to have the California Department of Public Health or an accreditation organization contracted by the state conduct the inspection. About half of the hospice agencies in California have taken the latter option. The accreditors carry out the initial site visit to the agency's business offices in order to approve the license. They are supposed to provide the California Department of Public Health with all reports and findings from the initial visit and any subsequent inspections. They are responsible on an ongoing basis for making sure hospice providers comply with Medicare's requirements and are eligible for reimbursement.

This system is ripe for fraud and abuse, and significant and serious problems have been identified in Los Angeles by investigative reporters for the *Los Angeles Times* (Christensen and Posten 2020). They documented the widespread use of paid recruiters to sign up elderly people in no danger of dying in six months by misleading them and lying to them about what they were signing up for (promising housekeeping help, a free hospital bed, 24-hour nursing care). The *LA Times* documented cases of patients who did not know they had signed away their rights to medical care until they showed up in the emergency room requiring life-saving medical treatment. They documented cases of patients that suffered excruciating pain when the hospice agency failed to send a nurse in their final days of life. A review by the *LA Times* of more than 800 licensing reports turned up case after case in which patients suffered from “mismanaged pain medications, neglected infections, missed nursing visits, incompetent or dishonest home health aides” (Christensen and Posten 2020). Hospices were cited for hundreds of violations and were required to develop plans to correct the problems. However, there was little or no disciplinary action taken against them.

The California State Auditor’s report confirmed that deficiencies created serious problems for patient care. The report found that in one instance, the California Department of Public Health substantiated a complaint that a hospice agency was falsifying documents in order to keep patients enrolled. Patients were enrolled that were not eligible for hospice care; as a result, they lost their Medicare insurance and access to care to treat health problems. Nursing staff had not visited these patients for months. That is, the agency was receiving payment but providing no care. In another instance, a patient’s caregiver complained that the hospice provider enrolled ineligible patients, let them believe they could be admitted to a hospital for treatment if necessary, and did not provide the hospital bed a patient had been promised. The complaint was substantiated. In one particularly egregious instance, the California Department of Public Health received a complaint that the hospice agency was failing to manage a patient’s insulin level, and the patient experienced periods of low blood sugar that reduced their quality of life and could be life-threatening. The complaint was classified as ‘immediate jeopardy,’ which required the California Department of Public Health to conduct

a timely onsite investigation. The investigation was carried out, but the results were not provided to the hospice agency for more than a year.

2019 Medicare Hospice Patient Trends Indicate Potential Fraud in Los Angeles County

Location	Live discharge rate	Average duration of services (in days)	Average total amount paid per patient
Los Angeles County, Burbank	31%	104	\$ 17,300
Los Angeles County, Glendale	32%	89	\$ 15,100
Los Angeles County, North Hollywood	45%	110	\$ 19,300
Los Angeles County, Van Nuys	51%	102	\$ 17,000
Los Angeles County Total	26%	89	\$ 15,200
California (excluding Los Angeles County) Total	14%	78	\$ 13,200
National Total	11%	76	\$ 13,200

Note: Original table in California Auditors' Report 2022.
Source: CMS Medicare data for 2019

Largely as a result of the detailed reports of rampant fraud and patient abuse and neglect published in the *LA Times*, a moratorium on licensing new agencies in California was signed into law by Governor Gavin Newsome in October 2021, effective January 1, 2022 (Senate Bill 664). A companion bill (Assembly Bill 1280) prohibits hospice providers or their agents from paying recruiters for patient referrals (Christensen and Poston 2021). In December 2022, legislation (Assembly Bill 2673) was passed in California to tighten regulation of hospices. It extends the moratorium on new hospice licenses until Public Health sets regulations, no later than January 1, 2024. The regulations must do the following (Vossel 2022c):

- Establish standards that put a cap on staff travel time and distance to patients in rural and urban settings

- Set standards for hospice nursing staff patient caseloads
- Limit the number of hospice agencies that management personnel can be involved with concurrently
- Require management personnel to meet minimum standards of hospice-specific training and experience
- Set timelines for reporting changes of name, location or mailing address

The legislation prohibits change of ownership of hospices during the first five years of being licensed. In addition, Public Health is required to perform validation surveys of five percent of hospice providers who choose to have an accreditation agency do the initial inspection and continuing oversight required for a license.

These measures are expected to rein in fraud and mistreatment of patients in California. They may serve as a model for state and national legislation to address widespread fraud, abuse and neglect.



The problems identified in Los Angeles have plagued the Medicare hospice benefit program. On the basis of media and other reports of major opportunities in the Medicare system to cheat hospice patients of needed care and Medicare of millions of dollars, the U.S. Department of Health and Human Services Office of Inspector General (OIG) has investigated Medicare fraud. The published results of this investigation (Health and Human Services Office of the Inspector General 2019) found (1) evidence of billing by agencies for patients who are ineligible for hospice care or for services that were under-provided or not provided at all and (2) that some hospice patients have been seriously harmed by poor care. Recruiting patients who are not terminally ill deprives them of potentially lifesaving treatment. OIG's review of hospice agencies across the U.S. found that more than 80 percent had at least one deficiency that affected the quality of patient care. In addition to enrolling patients that were not terminally ill, agencies altered patient records, provided false documentation, and charged Medicare for services they failed to provide. Inappropriate billing, according to OIG, cost Medicare billions of dollars. OIG also found many instances of inadequate patient care, and noted that complaints were submitted against a third of all hospice providers, many of which were for poor patient care.

In November 2022, as reports of hospice agencies billing Medicare and providing inferior or no services to patients surfaced, industry groups concerned about their reputation called on Medicare to address the problem. Industry leaders – LeadingAge, the National Association for Home Care & Hospice (NAHC), the National Hospice and Palliative Care Organization (NHPCO) and the National Partnership for Healthcare and Hospice Innovation (NPHI) – published a letter calling for a national moratorium on licensing new agencies targeted toward high-risk providers “who engage in improper, unethical, and potentially illegal activities that harm patients and families” (Parker 2022).

Which Medicare Beneficiaries Receive the Medicare Hospice Benefit?

According to MedPac (2022), usage of the Medicare hospice benefit has increased for each demographic group; however, usage of this benefit varies widely across the groups. Between 2010 and 2019, the share of white decedents (Medicare beneficiaries who died) using hospice increased from 45.6 to 53.8 percent. That is, more than half of white Medicare recipients who died in 2019 made use of hospice. For Black decedents, the increase was from 34.2 to 40.8 percent; Hispanic from 36.7 to 42.7; Asian–American 30.0 to 39.8; North American Native from 31.0 to 38.5. Part of these differences could be cultural, but part may reflect differences in access to hospice care in urban and rural areas.



Table 2**Share of Medicare decedents who use hospice by demographic characteristics**

	2010	2018	2019	2020	Average annual percentage point change, 2010–2019
All decedent beneficiaries	43.8	50.6	51.6	47.8	0.9
Age					
< 65	25.7	28.8	29.5	26.5	0.4
65–74	38.0	40.6	41.0	37.2	0.3
75–84	44.8	51.2	52.2	48.3	0.8
85+	50.2	61.1	62.7	59.0	1.4
Race/ethnicity					
White	45.5	52.7	53.8	50.8	0.9
Black	34.2	39.7	40.8	35.5	0.7
Hispanic	36.7	42.5	42.7	33.3	0.7
Asian American	30.0	38.8	39.8	36.1	1.1
North American Native	31.0	37.8	38.5	33.5	0.8
Sex					
Male	40.1	45.9	46.7	42.9	0.7
Female	47.0	55.0	56.3	52.7	1.0

Source: MedPac 2022 Report Table 11–3; MedPAC analysis of data from the Common Medicare Enrollment file and hospice claims data from CMS



Evolution of the Hospice Industry

The hospice industry is highly fragmented. According to CMS, which administers the Medicare and Medicaid programs, the largest providers only have a market share of 5 or 6 percent (Donlan 2021b). This makes hospice an attractive space for private equity funds because of the huge opportunities to buy up small agencies and consolidate them. Private equity (PE) buys up businesses using a lot of debt (a so-called ‘leveraged buyout’) that the acquired company is required to repay. In health care, this often means buying a successful company (the ‘platform’ company) and then building scale and market power by buying up this company’s competitors and adding them onto the platform (Appelbaum and Batt 2020). As with all for-profit enterprises, the goal is to maximize returns for their investors. But the use of high levels of debt which the company must service, as well as the promise to investors of outsized returns, puts pressure on PE-owned hospices to increase revenue, reduce labor costs, and generally cut corners when caring for patients. As PE firms are financial institutions and not health care professionals, they are not obligated to put the interests of patients above profit.

Private equity activity in hospice care was already under way before the pandemic in response to the preference of elderly individuals to remain in their own homes rather than move to congregate living arrangements. Merger and acquisition (M&A) consulting firm The Braff Group tracks overall mergers and acquisitions in hospice. For private equity alone, the group reported that between 2011 and 2020, PE deals in the hospice industry rose nearly 25 percent. In 2020, PE acquisitions of hospices reached their highest level up to that time – the deadly outbreaks in nursing homes and assisted living facilities during the pandemic hastened that process. (Vossel 2021). In the fourth quarter of 2021 private equity was the dominant dealmaker in hospice – closing 18 out of a total of 23 deals involving hospice providers – or more than three-quarters of the total (Vossel 2022a). Changing macroeconomic conditions in 2022 took their toll on the hospice industry. M&A activity slowed across the board as rising interest rates and fear of recession made dealmaking more risky, but PE firms continue to be leading players in this market. PE firms see opportunities to consolidate post-acute care in the home and to move hospice beyond its traditional siloed care to become part of a continuum of home care offerings (assisted living, home health, skilled nursing, and hospice care each with a separate payer and



payout). Private equity firms argue that they can coordinate the care that elderly patients require (interview with M&A consulting group with health care expertise, November 10, 2022).

The first two decades of the 21st century witnessed the transformation of hospice care from mainly non-profit providers to domination of the industry by for-profit chains. Attracted by loose oversight and guaranteed payments by Medicare for hospice services, for-profit chains bought up small nonprofit providers and began consolidating the highly fragmented industry. Private equity firms stepped up their activity in 2018, accounting for a disproportionate number of hospice agencies. Small for-profit hospices also proliferated, drawn by the guarantee of Medicare per diem payments per enrollee. The number of hospice agencies increased from 3,498 in 2010 to 5,058 in 2020^[1]. The net increase in the number of these agencies is accounted for by the growth in for-profit and freestanding hospices. The number of nonprofit hospices declined over the period, as did the number of home health-based hospices. As of 2020, nearly three-quarters of hospices were for-profit and about a quarter were nonprofit. However, the shares of hospice patients cared for by for-profit and nonprofit hospices are about the same, 49 percent and 47 percent respectively, due to the smaller size on average of for-profit providers (MedPac 2022). The decline in home-health based hospices may be something of an optical illusion. Private equity firms typically establish each of their portfolio companies as a separate entity to limit liability in the event there is a serious problem at one company. So, a PE-owned hospice agency and a PE-owned home health business may show up in government data as two separate companies when, for all intents and purposes, they enjoy common ownership and operate as a single company providing hospice and home health services (interview with M&A consulting group with health care expertise, November 10, 2022).

Table 3**Total number of hospices over time by provider type**

Category	2010	2017	2018	2019	2020	Average annual percent change 2010–2019
All hospices	3,498	4,488	4,639	4,840	5,058	3.7%
For profit	1,958	3,101	3,234	3,436	3,680	6.4%
Nonprofit	1,316	1,226	1,245	1,255	1,220	-0.5%
Government	224	161	159	148	147	-4.5%
Freestanding	2,401	3,525	3,701	3,936	4,178	5.6%
Home health based	465	471	463	456	444	-0.2%
Urban	2,485	3,603	3,760	3,976	4,196	5.4%
Rural	950	879	872	859	850	-1.1%

Source: MedPac 2022 Report Table 11-1; MedPAC analysis of Medicare cost reports, Provider of Services file, and Medicare hospice claims data from CMS



The Role of Private Equity in Hospice

In the 2000s, it was mainly publicly traded companies that began consolidating small hospice providers into large chains. In the last decade, however, private equity firms have stepped up their acquisitions of hospice agencies, attracted by the prospect of steady Medicare payments and facilitated by low barriers to entry (Bugbee, O’Grady, and Fenne 2023).

A careful study of this phenomenon by Braun, Stevenson, and Unruh (2021) using data collected by CMS examined both the increase in the number of hospice providers operating in the U.S. and the consolidation of the industry between 2011 and 2019. The use of somewhat different CMS data and methodology leads to estimates that are similar but not precisely the same as the MedPac numbers. Over the eight years covered by the study, the authors found that the number of hospice agencies increased from 3,162 to 5,615. Private equity ownership of hospice agencies increased between 2011 and 2019 from 106 agencies to 303; ownership by publicly traded companies grew from 93 to 151. Almost three-quarters (72 percent) of PE transactions over the period were acquisitions of agencies that were previously nonprofit. The same is true for almost three-fifths (58 percent) of transactions by publicly traded companies. Thus, the majority of transactions by these players were purchases of nonprofit agencies by large, for-profit firms. This is a major driver of consolidation of hospice agencies and of the transformation from nonprofit to for-profit providers in this industry.

In the two decades since the start of the 21st century, there has been a substantial increase in both Medicare spending for hospice services and the number of Medicare beneficiaries using these services. The study’s authors estimate that the number of Medicare hospice beneficiaries nearly tripled, from 513,000 in 2000 to 1.46 million in 2019. Of these, 113,000 were cared for in PE-owned hospices and 125,700 in hospices owned by publicly traded corporations. While just 16 percent of all Medicare beneficiaries in hospice were cared for by large, investor-owned hospice agencies, it is notable that beneficiaries cared for in PE-owned hospices increased 327 percent from 2012 to 2019, and in publicly traded corporations by only 57 percent (GAO 2019; Braun, Stevenson and Unruh 2021). In “Private Equity in Health Care: Profits before Patients and Workers,” Batt and Appelbaum (2021) argue that patient care suffers when profit and the



maximization of returns to company shareholders is introduced into health care. The effects on patient care may be especially pernicious when private equity firms buy up health care providers.

Private Equity in Hospice: Advent International

A nurse with many years of clinical experience in hospice care and as a nurse educator explained their experience with the recruitment of patients when they took a job at Seasons Hospice, a hospice agency owned by PE firm Advent International (interview March 8, 2023).

“I then transitioned to Seasons Hospice as an educator, educating new staff on compliance and working with insurance rules. Private equity firm Advent International bought AccentCare which then acquired Seasons Hospice. Advent bought their way into the top 10 hospice providers. My hire was triggered by this Seasons agency reaching a daily census of 200. The person who was responsible for quality improvement and staff education went full time with quality improvement and I was hired to do the staff education that person had previously done.

“I was employed in an office environment and I got to see how the back office worked. It was very clear the Executive and Clinical and Intake directors were looking at the board of referrals (qualified leads); their job was to convert qualified leads into closed sales (admissions). The focus was on growing the census and referral base.

“I was horrified and uncomfortable with things I saw.

“They plotted and schemed to keep the census up. The Executive Director built an in-patient unit licensed by the Department of Public Health for in-patient care which paid a higher reimbursement. Once she hit that mark, she got her bonus and retired.

“I met with someone who came in later who was responsible for growing the census to the point where they would split into two offices.

“They were just not looking at who are these people and are they eligible patients we are equipped to care for. It was scheming about how to keep this pipeline going and grow it further. As a staffer, I got to sit in on the weekly strategy meeting: made up of the Clinical

Director, Operations Director, Executive Director, intake person, and the sales manager whose job was to go out and generate referrals. The middle part of my nursing career was in technology sales, so I am very clued into the similarities and differences between nursing and sales. Season Hospice's language was the language of sales.

"I witnessed sloppy and unethical clinical practice. I decided I gotta get the heck out of there."

It should not be surprising that a hospice company owned by Advent International would define its purpose in terms of growing sales, meeting benchmarks, and bonuses as incentives. Advent International, established in 1984, is a generalist private equity firm that engages in large deals in a variety of industries. It has made 1,138 acquisitions, exited 542 of them, and has nearly 600 current portfolio companies (Pitchbook Advent International 2023). Nearly three quarters (71 percent) are in IT and business, selling to other businesses or to consumers. Healthcare makes up 14.4 percent of its portfolio, spread mainly over pharmaceutical companies, rehab and physical therapy clinics, and medical supply and distribution businesses. AccentCare, parent company of Seasons Hospice and Fairview Health Services in Minnesota are its main forays into home health and hospice. In this context, growing the patient census may seem no different than growing the sales book. But when one of its portfolio companies increases sales of, say, furniture and home furnishings, the company does not need to consult the furniture about its needs. Increasing the patient census without due regard for the patients' needs and the ability of the hospice to optimally meet those needs is what left the hospice nurse, in their own words, "horrified."

Seasons Hospice is not alone. A similar experience was reported by a former clinical employee after Dorilton Capital-owned Traditions Health acquired a Texas Hospice in 2019. The hospice, which had typically enrolled 1 to 20 patients a month was now expected to enroll 20 to 30. Marketers got a bonus for exceeding their quota. "It turned into a numbers game," the employee reported. Patients were admitted who were a 'stretch' in terms of meeting eligibility criteria (Redden 2021).

PE Business Model

PE promises its investors ‘outsized returns’ that beat the returns earned by owning a portfolio of publicly traded companies. Achieving this result generates strong pressures on PE firms to take actions that increase the enterprise value of companies they own so they can be resold at a profit even if the actions may be harmful to other stakeholders. In health care in particular, this focus on the interests of investors is often in tension with the mission of clinicians to deliver care that is focused on quality outcomes. The drive for high returns for investors leads PE firms to extract wealth from the companies they have acquired, Firms then exit their investment in the company in three to five years, before the sometimes–disastrous effects of their ownership become evident. According to PitchBook, as of March 2023, holding times for hospice companies during the 2016 to 2022 period averaged 4.3 years, with a median hold time of 4.25 years. PE firms lack health care expertise and are not bound by the Hippocratic oath as doctors are. But they have financial expertise and a well–worn playbook for maximizing returns for their investors. Among their tactics is the use of debt to buy up companies – a double–edged sword that boosts private equity returns but may undermine the acquired companies’ financial stability.

While the incentives in hospice – the payment model and lack of oversight and enforcement actions – make hospice care a lucrative business for all for–profit hospice providers, PE firms are uniquely able to take the for–profit hospice model to scale. This creates particularly significant risks that unscrupulous private equity firms will make outsized returns by preying on the dying, a particularly vulnerable patient population. Ongoing M&A activity leads to organizational disruption and ongoing turmoil that often results in higher employee turnover, disrupting patient care. The creation of massive chains of hospice agencies also means that any corporate level financial, human resource, or care management policies affects a much larger population of healthcare workers and hospice patients – far greater than small independently owned mom and pop operations.

The role of large private equity–owned chains of hospice agencies in driving scale and scope is illustrated by the history of Kindred at Home (now rebranded as Gentiva for hospice agencies and CenterWell Home Health for home health care and personal services). It also highlights the complexity of financial dealmaking and the way in which PE owners approach hospice agencies

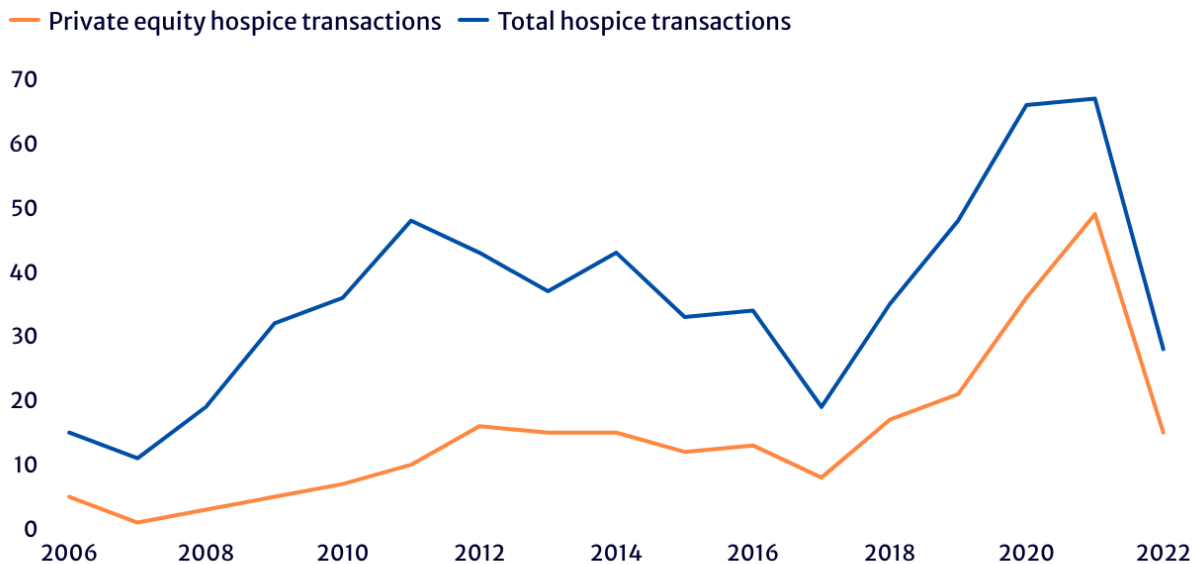


as tradable assets to be bought and sold. Deal making is not driven by a desire to improve patients' final days; rather hospice agencies are abstract assets and deals are undertaken based on their contribution to the PE firm's bottom line. The disruptions and chaos that may follow the merger of a small non-profit with a typically larger for-profit agency as the two cultures clash can spill over and compromise the quality of patient care. At Kindred, the hospice division provides care for more than 50,000 Medicare beneficiaries (See box Untangling Kindred at Home Timeline).

While private equity firms have been engaged in acquiring companies that provide hospice care for nearly two decades, the pace picked up in the years 2018 to 2021 as a group of PE firms created new agencies or acquired smaller providers (see Figure 1 below).

Figure 1

Hospice Deals by Year, 2006 to 2022



Source: The Braff Group



Private equity accounted for five deals for hospice agencies in 2005, rising to a peak of 47 deals in 2021 – nearly three-quarters (73 percent) of the 67 deals that were carried out that year. Note that this is the number of deals, not the number of hospice agency sites. As we note in the box

below, when Humana and private equity firms TPG and Welsh, Carson, Anderson & Stowe (WCA&S) acquired Curo Health Services in July 2018 as an add-on to their platform company Kindred at Home, they added 245 hospice agency sites in that one deal.

Acquisitions by PE firms include Edgewater Funds' financial backing of Family Home Health Services and Waud Capital's acquisition of Concierge Home Care, both providers based in Florida. Two of the largest home health and hospice providers – Elara Caring and AccentCare – are PE-owned (Dayen 2021). Elara Caring, with 32,000 employees, was acquired by Blue Wolf Capital, HarbourVest, Constitution Capital and Leavitt Equity in 2016 with additional capital provided by Athyrium, Kelso, Hancock Capital Management and NexPoint Capital in subsequent years (PitchBook Blue Wolf Profile 2022).

Untangling the Kindred at Home Acquisitions

Timeline

In December 2017, insurance company Humana and private equity firms TPG and Welsh, Carson, Anderson & Stowe (WCA&S) acquired Kindred at Home, the largest provider of home care and hospice services in the U.S. Humana held a minority stake in the acquired company (Pifer 2021). At the time of sale, Kindred Healthcare – the parent company of Kindred at Home – was one of the largest providers of post-acute and senior care in the U.S. Its Kindred at Home division was the single largest U.S. home health company and second largest hospice provider in the country, with more than 600 home health and hospice sites and about 40,000 caregivers, generating annual revenue of approximately \$2.5 billion (Mullaney 2018; Donlan 2021a). In 2017, a year before being purchased by Humana and the two private equity firms, Kindred at Home reported more than \$740 million in revenue for its hospice business alone, and operated at 178 hospice sites nationwide, admitting nearly 51,000 patients who stayed an average of 96 days for a total of 4.9 million hospice patient days (Kindred Healthcare 2017).

Kindred Healthcare was seeking a buyer because it faced a huge debt load generated by its buying spree of long-term care facilities and home health and hospice providers. Its debt was becoming unmanageable and the company faced challenging industry conditions, as well as uncertainty regarding Medicare and Medicaid funding. Kindred Healthcare had already sold off its nursing homes and used the proceeds to pay down some of the debt (Li 2018). On Humana's side, controlling more of the care continuum offered an opportunity to better manage costs and outcomes for its large Medicare Advantage beneficiary population. The fixed payments from Medicare for patients enrolled in hospice, and the lower costs associated with home care, as compared with hospital care, for the patients it insures, made the deal attractive to Humana (Li 2018; Mullaney 2018a). Prior to the acquisition of Kindred

Healthcare, Humana had experience with home health and hospice via joint ventures with other providers. Humana applied its expertise from the insurance side of the industry to the providers' operations to improve patient experience and control care costs (Larson 2018).

Under stipulations included in the deal, Kindred Healthcare was split into two businesses: Kindred at Home (home health, hospice, personal services/care) and Kindred Healthcare (acute care, long-term care and rehabilitation hospitals). TPG Capital and WCA&S attained 100 percent ownership of Kindred Healthcare's hospitals and clinics, which they sold in June 2021 to Apollo-owned LifePoint.

PE firms TPG and WCA&S held a 60 percent stake in Kindred at Home; Humana held the remaining 40 percent. Just a few months after the acquisition of Kindred at Home, in July 2018, Humana and its private equity partners TPG and WCA&S acquired Curo Health Services, a provider of hospice services based in Mooresville, North Carolina, from PE firm Thomas H. Lee Partners through a \$1.4 million leveraged buyout. Curo, with 245 locations in 22 states, was merged with Kindred at Home, further enlarging the latter's foot print in home health and hospice (Japsen 2018). Three years later, in June 2021, Humana acquired home-based services provider One Homecare Solutions from WayPoint Capital Partners, the private equity arm of a family office (Pifer 2021).

In April 2021 Humana agreed to acquire the remaining 60 percent of Kindred at Home from TPG Capital and WCA&S for \$5.7 billion, valuing the company at \$8.1 billion, including Humana's \$2.4 billion equity value in the company (Parker 2021a). In March 2022, Humana rebranded Kindred at Home as CenterWell Home Health – a company it launched with the goal of uniting most of its healthcare service businesses under one brand (Lagasse 2022). Just a few months later, however, in August 2022, Humana split CenterWell into two companies, a home health company and a hospice and personal care business. Humana then divested a majority stake in CenterWell's hospice and personal care business to PE firm Clayton, Dubilier & Rice (CD&R), retaining a minority interest in the company (Business Wire 2022; Humana 2022). The deal did not include the Curo Health Services hospice agencies, which Humana continued to own. The newly standalone hospice and personal care company,

owned by CDR and Humana, took the name of one of its subsidiaries and was rebranded as Gentiva. All subsidiaries that had been acquired by Humana, including Curo, were also rebranded as Gentiva.

The Gentiva chain owned by Humana and its PE partner CD&R further expanded its network on February 27, 2023 when it announced plans to acquire nonprofit ProMedica's Heartland home health and hospice assets for \$710 million. The deal will increase Gentiva's number of locations from 380 to 500 and its patient census from about 25,000 to 34,000 across 36 states (Donlan 2023; Parker 2023). This does not include the more than 200 Curo locations now also branded as Gentiva and wholly owned by Humana.

Some of the subsidiaries acquired by Humana and its PE partners had a history of bad behavior that defrauded Medicare and put patients at risk. We document this in our case study of Curo Health Services. The bad behavior of some Curo hospice agencies did not disappear after Curo was acquired by Humana and its PE partners; rather, the bad behavior became more sophisticated and difficult to detect. In June 2021, a whistleblower suit alleged that Curo Health Services, among other hospice providers in Tennessee, helped themselves to a portion of the money available from government programs for hospice care by falsely certifying that patients' illnesses had reached a terminal stage, when, in fact, they had not. These allegations fell under violations of the False Claims Act, as well as Tennessee state laws. That year, Kindred at Home's relationship with PE firms TPG and WCA&S came under scrutiny by the U.S. Senate Finance Committee, which was concerned about the quality of hospice care provided by the company as well as by the surge in private equity investments in health services since 2010 (United States Senate Committee on Finance 2021; Parker 2021b). Senators Wyden, Brown, and Warren, who sit on the Committee, sent a letter requesting information about their operations to Humana, TPG and WCA&S ("Letter to President and Chief Executive Officer of Kindred at Home" 2021).

Strategic acquirers have also been active over the past decade. Advocate Aurora Enterprises, a subsidiary of Advocate Aurora Health, recently acquired one of the biggest home care companies in the country, Senior Helpers (Holly 2021b). Other major publicly traded corporations that own hospices include Amedisys, Chemed (the Roto-Rooter company), Encompass Health, LHC Group (MedPac2022). But during this time period, acquisition of home health and hospice providers has tilted toward PE firms.

Intrepid is a private equity-owned health care company that has been marketing itself to other PE firms since October 2021 as a platform for PE acquisition of hospice providers (Parker 2021c). The company operates 64 locations in 17 states, seventeen of which are hospice operations. Its hospice strategy is to co-locate hospice services where it already has home health operations. With additional private equity financial backing, Intrepid plans to buy up smaller providers. Its home health operations are mainly in rural areas, and it expects to consolidate hospice services and dominate its target areas. It is not unusual for PE buyers to invest in hospice companies with the vision of adding on other companies and growing via acquisition. For example, Bain Capital has followed this path, steadily acquiring smaller hospice providers to add onto the platform it created in 2018 by merging Arosa and LivHome (Holly 2021a). It is common for PE-owned hospice chains to concentrate acquisitions in a target area in order to be the locally dominant provider of these services. Vistria Group adopted this strategy and established a dominant position for its Agape Care hospice chain in South Carolina and Georgia. It followed the same playbook with Mission Hospice, centered in the western U.S. and St Croix hospice in the Midwest (Pringle 2021).

Large, franchise full-service home health providers have been an important target of PE takeovers. A recent example is PE firm RiverGlade's acquisition of Home Helpers, a company with 322 individual franchise units across North America operating in more than 1,000 U.S. communities. Home Helpers was acquired in April 2021 from PE firm Linsalata Capital Partners which had owned it since 2016. As the company approached 5 years in Linsalata's hands, the PE firm began looking for a buyer. It settled on RiverGlade. At least nine large, multi-state franchise home health and hospice companies have been acquired since 2015. In view of private equity's preferred three to five year holding period, more deals like Linsalata to RiverGlade can be expected (Holly 2021c).

This sale of home health and hospice agencies from one PE company to another is fairly common. Horse trading of agencies by PE firms too often has nothing to do with improving care operations and everything to do with the financial needs of the PE firms that must find a way to deliver returns and exit on the one hand, and PE firms that have to find a place for newly committed funds on the other. In November 2021 Centerbridge Partners and The Vistria Group teamed up to purchase Help at Home (Famakinwa 2020). This is a large, Chicago-based home- and community-based services provider that operates across 13 states. It had formerly been owned by Wellspring Capital Management. Vistria also invested in the San Diego-based Mission Healthcare, a home health, hospice and palliative care provider, in December 2021. Mission had previously been backed by HCAP Partners (Holly 2021a).

Implications of For-Profit and PE Ownership for Patients and Families

Licensing and oversight by Medicare and state agencies is lax. Asymmetric information about what constitutes good patient care is an issue in hospice care. Patients and their families may not be able to evaluate the quality of care that is provided. Families are in the midst of a significant life event, the imminent passing of a loved one. They often have no prior experience with hospice and no point of comparison for the services their family member receives. Even if the family is concerned about the quality of hospice care and has complaints, the length of hospice stay may be too short. As we noted earlier, the median number of days from entering hospice care to death is 19, meaning half of all patients die in less than three weeks, so it may not seem worthwhile to report quality concerns to Medicare once the patient has died. This makes it difficult to hold a hospice provider accountable for a misalignment between the services a patient requires and the services the hospice provides (Teno et al. 2016). Problems measuring the quality of care and holding hospice providers accountable for meeting adequate standards of care suggest that it may be desirable for Medicare to provide these services publicly, rather than contract with private hospice agencies (Sappington and Stiglitz 1987), especially those that are for-profit.

The overall number of complaints is relatively low in any year, due in part to the inability of many caregivers to evaluate and report poor care. But complaints that are made do offer insights into the care provided by nonprofit and for-profit hospice agencies. A study of patient complaints in the United States (Stevenson and Sinclair 2018) examined 12,931 allegations of poor quality or deficiencies in care provided over the period 2005 to 2015. Investigations of varying quality by state agencies or private accredited organizations resulted in 6,710 confirmed allegations of poor patient outcomes and deficiencies in the care that was provided. Complaints centered on concerns about quality of care (45 percent), patients' rights (20 percent) and administrative/personnel concerns (14 percent). For-profit agencies were more likely than nonprofits to have complaint allegations and confirmed deficiencies. An analysis of the odds of a complaint or confirmed deficiency found that for-profit agencies were 1.33 more likely to face allegations and 1.52 more likely to have a deficiency. That is, controlling for other relevant



factors, for-profit agencies were 33 percent more likely to face allegations of poor care and 52 percent more likely to have those allegations confirmed than were nonprofits.

For hospice providers that put profits over patients, there are five main ways that they can meet their financial goals. They can reduce the number of visits to patients by health care professionals, use less-skilled staff to visit patients, shift the cost of expensive medications that they are supposed to provide to the patient's Medicare pharmacy benefit (Medicare Part D), knowingly recruit ineligible patients with more than 6 months to live, and enroll patients that require less intensive care (Teno 2021).

A growing body of empirical research confirms these negative effects of for-profit ownership on hospice quality. The Government Accountability Office (GAO 2019), in a major study of the industry, compared the performance of nonprofit and for-profit hospices. The study used CMS data on Medicare hospice beneficiaries, hospice providers, and hospice services covering the calendar years 2014 through 2017. GAO found that nonprofit and for-profit hospices served similar shares of Medicare beneficiaries, and that the beneficiary populations had similar demographic characteristics. However, for-profit providers received 58 percent of the \$17.9 billion in Medicare hospice payments in 2017, which amounts to \$10.4 billion compared to \$7.5 billion for nonprofit providers. The difference is due to the longer stays by patients in for-profit than nonprofit hospices, which is itself due in part to the higher enrollment of dementia patients with a longer progression, as well as a lower enrollment of cancer patients that require more intensive services but have shorter life expectancy.

The quality of care hospice patients receive is difficult to measure. The Hospice Item Set (HIS), a survey of hospice providers, measures processes including pain screening and assessment, dyspnea screening and treatment, bowel regimen of patients on opioids, and discussion with patients and their caregivers of treatment preferences and beliefs. The scores on the items in the HIS and a composite based on it are one type of quality measurement (Price et al. 2020). For-profits and nonprofits had similar average scores in 2017 on this composite measure of quality. However, looking at the 329 providers with the lowest scores – at or below the tenth percentile – GAO (2019) found that 261 were for-profits and 68 were nonprofits.

CMS also uses a survey of caregiver experiences, the Consumer Assessment of Healthcare Providers and Systems (CAHPS), to evaluate quality of care. Two months after the death of the

hospice patient, caregivers are invited to fill out a survey of their experiences with the hospice that cared for their loved one. There are 47 total questions in the caregiver survey. One single question measures how willing the caregiver is, on a scale of 1 to 10, to recommend the hospice. Other questions fall into six categories: hospice team communication; getting timely care; treating the family member with respect; getting emotional and religious support; getting help for pain and other symptoms; and getting hospice care training. Answers to these questions are scored as the percent of caregivers who responded with the most positive response – for example, answered ‘always’ to the question, “How often did the hospice team listen carefully to you when you talked with them about problems with your family member’s hospice care?” The range of responses is from 0 to 100 percent. Scores for questions in each of the six categories can be averaged to provide an overall score for the category. One final question asks about the overall rating of care, measured on a 0 to 10 scale (Price et al. 2017). GAO (2019) reported that caregivers’ experiences were generally similar on average in for-profit and nonprofit hospices. But here again, the lowest performing providers were overwhelmingly for-profit. Of the 290 providers in the tenth percentile or lower, 248 were for-profit providers and 42 were nonprofit.

For-profit and nonprofit hospice providers differed on two other measures – the number of patients discharged prior to death and provider visits in patients’ last days before death. Live discharges can reflect patients’ dissatisfaction with their care or, alternatively, providers’ enrolling ineligible Medicare beneficiaries and fraudulently collecting the Medicare reimbursement for patients that did not require care. While it is difficult to predict the life span of individual hospice patients, hospices in which half or more of patients are live discharges raises questions about whether the hospice agency is enrolling ineligible patients. For-profits have higher rates of live discharge than nonprofits; 462 for-profits discharged half or more of their Medicare beneficiaries alive, compared to just 10 nonprofits with this high rate of live discharges. For-profit hospices were also more likely than nonprofit providers to fail to visit patients in the last 3 days or last 7 days of life. 290 providers (248 for-profit providers and 42 non-profits) had scores on this measure at the 10th percentile or lower (GAO 2019).

An analysis using data from CAHPS hospice surveys between April 2017 and March 2019 (Price et al. 2023) examined whether differences in profit status (for-profit, nonprofit) is associated with reports of poor patient care experienced by family caregivers. Data came from more than

653,000 caregivers whose loved ones had received care from about 3,100 hospices. Caregivers reported worse experiences at for-profit than at nonprofit hospices for all measures. Significant differences remained after controlling for hospice characteristics. Nearly a third (31.6 percent) of for-profit hospices scored 3 or more points below the national average of overall performance compared with 12.5 percent of nonprofits. Just 21.5 percent of for-profit hospices scored 3 or more points above the national average of overall performance compared with 33.7 percent of nonprofits.

New quality measures for hospice care are under development. A patient assessment instrument, the Hospice Outcomes and Patient Evaluation (HOPE) is in beta testing (CMS.gov 2022).

A 2019 study examining different outcomes, commissioned by the National Partnership for Healthcare and Hospice Innovation found important differences between nonprofit and for-profit hospices (Bazell et al. 2019). The study found that nonprofit hospices provide patients with 10 percent more nursing visits, 35 percent more social worker visits and twice as many therapy visits as do for-profit hospices. Nonprofit hospices enroll more patients immediately upon release from a hospital who may require more intensive services. Spending on bereavement services for families by for-profit hospices is less than half the amount spent by nonprofit hospices. Not surprisingly then, as we see in Table 4, for-profit hospices are more profitable with an aggregate net margin averaged over 2016–2019 of 19 percent compared with an average of 3.75 percent for nonprofit hospices. Meanwhile, for-profit hospices spent more than triple the amount on advertising as nonprofit hospices.

MedPac (2022) confirms that hospice margins vary by provider characteristics.

Table 4

Total number of hospices over time by provider type						
Category	Share of hospices 2019	2015	2016	2017	2018	2019
All	100%	9.9%	10.9%	12.5%	12.4%	13.4%
Freestanding	81	13.8	14.0	15.3	15.1	16.2
Home health based	9	3.3	6.2	8.1	8.4	9.6
Hospital based	9	-23.8	-16.7	-13.8	-16.5	-18.4
For profit	71	17.7	17.9	20.0	19.0	19.2
Nonprofit	26	0.1	2.2	2.5	3.8	6.0
Urban	82	10.4	11.4	12.9	12.6	13.6
Rural	18	4.8	6.3	8.9	10.3	11.5

Source: Hospice Medicare aggregate margins by selected characteristics, 2015 to 2019; MedPAC 2022 Table 11-16

Hospice margins are calculated from Medicare cost reports, submitted to Medicare by hospices. Medicare calculates the payments it has made to the hospice and then subtracts the costs to the hospice of Medicare approved costs such as the cost of labor, necessary medications to relieve pain and anxiety, and so on. The difference is the hospice's margin. If there are no other costs, this will be its profit in the case of for-profit agencies and its surplus in the case of nonprofits. Other expenditures may reduce hospice profit or surplus, but in general higher margins lead to larger profits or surpluses. As Table 4 shows, hospice margins in 2019 were higher in freestanding hospice agencies than in those that are part of a home health agency, 16.2 compared to 9.6 percent; in for-profit hospices than in nonprofit, 19.0 compared to 6.0 percent; and in urban than in rural hospices, 13.6 compared to 11.5 percent. The increase in margins of rural hospices, from 4.8 percent in 2015 to nearly 12 percent in 2019, likely reflects the acquisition and consolidation of rural hospice agencies by private equity firms. The very large difference in margins between for-profit and nonprofit hospices – margins in for-profit are triple those in nonprofit – is a cause for concern and suggests that these hospices have found ways to game the system to increase their margins and their profits.



Medicare beneficiaries enrolled in for-profit hospice agencies are likely to receive a narrower range of services than those cared for by nonprofits. Researchers analyzed the 1998 National Home and Hospice Care Survey to examine services used by patients. The survey covered 2080 patients cared for by 422 hospice agencies and found patients accessed fewer services in for-profit agencies. The difference is most pronounced in discretionary services, rather than in the core services Medicare requires that hospice agencies provide (Carlson, Gallo and Bradley 2004).

An analysis of the 2006 Medicare Provider of Services survey found that staffing patterns differed significantly by ownership type (Cherlin et al. 2010). The researchers found that “for-profit hospices had significantly fewer registered nurse FTEs as a proportion of nursing staff, fewer medical social worker FTEs as a proportion of psychosocial staff, and fewer clinician FTEs as a proportion of total staff.” (Cherlin et al. 2010, Abstract). That is, compared to nonprofit hospice agencies, for-profit hospices utilize lower staffing levels of skilled nurses and provide a narrower range of specialist services. Finally, Aldridge and colleagues (Aldridge et al. 2018) examined the relationship between spending on direct patient care and rates of hospital use by hospice patients. They found that patients cared for by hospices that spent the most on patient care had “5.2% fewer hospital admissions, 6.3% fewer emergency department visits, 1.6% fewer intensive care unit stays, and \$1,700 less in nonhospice Medicare expenditures per patient compared with hospices spending the least on direct patient care. Ninety percent of hospices with the lowest spending on direct patient care and highest rates of hospital use were for-profit hospices” (Aldridge et al. 2018, Abstract).

Gaming the System Has Potentially Serious Implications for Patient Outcomes

Dishonest practices by hospice agencies cause serious harm to patients. Patients admitted to hospice who are not close to death lose access to potentially lifesaving curative treatments that could extend their lives or improve their quality of life. In a 2022 New Yorker article, Ava Kofman (2022) found evidence that unwitting recruits who weren’t offered sufficient information before enrollment were denied kidney dialysis, mammograms, coverage for life-saving medications, or



a place on the waiting list for a liver transplant. One patient even lost access to chemotherapy treatment. These aren't isolated instances. In a 2018 report, the U.S. Department of Health and Human Services' Office of Inspector General found that hospice beneficiaries and their families and caregivers are not receiving crucial information to make informed decisions about their care (OIG 2018).

To justify receiving higher hospice payments from Medicare, there are instances of staff being directed to give excessive dosages of medications. At one Dallas-based hospice agency owned by Novus Health Services, providers have kicked patients out of their programs, including some who required end of life services, to avoid paying a fine to Medicare for having more than half their patients exceed the 6-month life expectancy. The Novus Hospice CEO was sentenced to jail for defrauding Medicare and overdosing and mistreating patients (United States Attorney's Office, Northern District of Texas 2022).

While there are notable exceptions, publicly-traded corporations acquiring smaller hospice providers have less incentive to cut corners and endanger patients. These so-called strategic acquirers often have health care experience and a longer time horizon for the hospice agencies they control. Their obligations to their public shareholders and their interest in retaining them means that they often – though not always – have an interest in the long-term performance of their agencies. Private equity firms, by contrast, may have little experience running a multi-agency hospice chain, typically load the chain with debt, and generally focus on selling the chain at a substantial profit in 3 to 5 years. The short time horizon and emphasis on a profitable sale may leave hospice agencies in a PE-owned chain starved for resources, including staff and supplies.

Curo Health Services: A Case Study of Private Equity in Hospice

Curo Health Services provides a good illustration of the PE business model in hospice and the problems that can arise for hospice agency patients and employees.

Since its establishment in 2010, Curo – a large hospice and home health provider and operator of hospice chains – has passed through the hands of five different private equity companies in three separate deals, from GTCR to Thomas H. Lee Partners and HealthView Capital Partners and then to TPG and Welsh, Carson, Anderson, & Stowe. Under PE ownership, and driven by PE’s need to increase scale and price at exit rather than the needs of hospice patient operations, Curo grew from a small agency to one of the largest hospice providers in the country by acquiring other, mainly smaller, hospice agencies (Donlan 2021a). However, during its immense and rapid growth, the hospice companies and non-profits it acquired were left unmonitored and unregulated by the government agencies charged with oversight of hospice providers. As we document in this case study, this left room for some Curo-owned agencies to deliver a series of bad outcomes and practices including fraudulent billing, admission of ineligible patients, and retaliation against workers who spoke out about Curo’s illegal actions.

Curo Health Services is more focused on hospice care, but has also been involved in the home health market. According to Pitchbook, the company’s services “include an individualized course of treatment based on the patient’s wishes, the family’s needs and the complex array of medical, emotional and social issues which accompany a terminal diagnosis, enabling its patients with access to a network of community resources specifically arranged to provide comfort and reduce anxiety” (Pitchbook Curo Health Services 2023). Like other hospice companies in the industry, ninety-five percent of Curo revenue is generated by Medicare (*United States v. Curo Health Services*, Case No. 3:13-cv-00672, slip op. at page 4, M.D. Tenn. May 21, 2022). Since its buyout by Humana and two PE firms in 2018, Curo has been rebranded as Gentiva Hospice, along with other hospices owned by the Humana PE partners.

Curo Ownership History

Curo has been private equity owned and operated for the entirety of its life. The company was created as a platform in April 2010 by GTCR Private Equity. Within four years, Curo had completed half a billion dollars in acquisitions. Sometimes, Curo acquired agencies that were passed from one PE company to another; in other cases, it acquired non-profit agencies and brought them under PE control for the first time. These hospices were acquired by Curo but became part of the Gentiva network of care in 2018 when Curo itself was acquired by PE firms TPG and Welsh, Carson, Anderson, & Stowe and by insurance company Humana. Today it is wholly owned by Humana (“Fiscal Year (FY) 2023 Hospice Payment Rate” 2022).

In September 2010 when the platform was established, Curo completed its first transactions by acquiring three hospice providers across Texas and Utah, including Hospice Plus, Goodwin and Phoenix hospices, which were all non-profits prior to PE involvement (Pitchbook Curo Health Services 2023). A year later, in November 2011, Curo acquired Regency Healthcare Group and its subsidiary Avalon Hospice. At that point, the combined Curo business was operating 45 locations across 8 states, serving almost 2,100 patients (Mihos and Kos 2011). In May 2012, Curo went on to acquire Family Care in Arizona and Community Home Care and Hospice in North Carolina (Olson 2022, footnote 53). In June 2014, Curo acquired SouthernCare Hospice Services from another private equity owner. All these acquisitions expanded Curo’s market and geographic reach, although it continued to predominantly operate in the South and Southwest United States.

In August 2014, Curo was purchased by two other private equity firms, Thomas H. Lee Partners and HealthView Capital Partners. At the time, Curo was operating locations across 19 states and had over 7,200 patients (Reuters News 2014). The company continued its consolidation of hospice centers but remained at this relatively small-scale size. Between 2014 and 2018, many private equity firms and banks loaned money to Curo to finance the company’s expansion. PE firms providing finance included AlInvest Partners, Blackstone Group, Blackrock, and Goldman Sachs Group. Banks included SunTrust, Nomura Bank, CIT Group, and Credit Suisse (Pitchbook Gentiva Health Services 2022).

Curo experienced another change in ownership in July 2018 when it was acquired by PE firms TPG and Welsh, Carson, Anderson, & Stowe and insurance company Humana. At the time of the deal,

Curo had 245 hospice locations in 22 states (Olson 2021, footnote 52). The acquisition of Curo took place less than two weeks after Humana completed its acquisition of Kindred at Home division of Kindred Healthcare. Humana subsequently merged Curo with Kindred Healthcare with the goal of creating the country's largest hospice operator (WCAS 2018). They succeeded: the merger led to the biggest hospice company in the U.S. (O'Grady 2021; WCAS 2018).

In August 2021, Humana acquired the remaining 60 percent stake in Kindred at Home from TPG Capital and Welsh, Carson, Anderson & Stowe. A year later, in August 2022, Humana divested its majority interest in Kindred at Home's hospice and personal care divisions to PE firm, Clayton, Dubilier & Rice (Humana 2022). A new standalone company was formed following the divestiture for the hospice and personal care services division of Kindred at Home and was rebranded to 'Gentiva' (Donlan 2022).

Humana retained a minority stake in Gentiva. Curo was not part of this divestiture to CD&R but was also rebranded under Gentiva while remaining under the majority ownership of Humana.

Curo's Business Model

Much like other private equity-owned health care companies, Curo is under pressure to create outsized profits for its private equity owners and to service the debt loaded on it as it passes from PE firm to PE firm. To quickly increase company revenues, Curo acquired smaller hospice agencies, expanded the number of their locations, and diversified their services. Financial pressures and the demand for outsized profits from PE-owned Curo has led agencies to game the Medicare payments system by admitting patients before they require care or by billing/overbilling CMS for patient care services that were not required and, in some cases, not provided. The impact of this push for profits has negatively affected outcomes for hospice workers and for patients and their families.

How Curo Agencies Gamed the System

There are key parts of the hospice process and current regulatory environment which draw private equity in. It is hard to predict how long someone will need hospice care or how long they have left to live. Medicare and Medicaid reimbursement systems account for this and will allow patients to extend their stay beyond six months. Physicians are in charge of determining whether a patient's prognosis meets the definition of a terminal illness (U.S. v. Curo, 3). Medicare pays for hospice services on a per diem basis and the very hospice agencies that certify hospice eligibility are the ones receiving the payments. This payment system leaves room for abuse by private equity companies like Curo; the longer a patient stays, the more money the provider makes. Instead of adding days to the end of a patient's period of care, these providers often add days to the beginning by certifying the patient as terminally ill earlier than is needed. Curo was guided by these incentives and multiple Curo agencies engaged in fraudulent behavior, both before and after it was acquired by the Humana/PE group. This behavior led to a series of bad outcomes described below.

Multiple hospice agencies owned by Curo Health Services implemented financial incentives to employees administering patient admission processes which led to billing fraud, False Claims Act Violations, and illegal kickbacks to help line the company's own pockets. These agencies then ignored employee complaints and audits that found wrongdoing, and instead disciplined and retaliated against employees who spoke out, and even fired employees who brought formal legal complaints surrounding the fraud.

On April 18, 2017, the U.S. Attorney's Office, Northern District of Texas announced that Curo subsidiary, Hospice Plus, would be required to pay a \$12.2 million settlement for illegally paying kickbacks in exchange for patient referrals (US Attorney's Office, North District of Texas 2017). Curo had acquired Hospice Plus, Goodwin Hospice, and Phoenix Hospice in 2010, and consolidated the three companies under the Hospice Plus brand, which primarily does business around Dallas, Texas.

The allegations were originally brought by several whistleblower employees who claimed that their employers submitted claims to Medicare and Texas Medicaid that "were rendered false as a result of the payment of kickbacks by the hospices, its owners and employees, and others" (DOJ

2017). In the first kickback scheme (2007–2012), Curo paid American Physician House Calls and other healthcare companies that Curo’s CEOs owned in exchange for patient referrals. Curo offered them sham loans, a free equity interest in another entity, stock dividends, and free rental space. In the second scheme (2007–2014), Curo paid kickbacks to medical providers (doctors, nurses, hospitals, and long-term care facilities) in the form of cash, gifts cards, and other valuables. These actions violate the False Claims Act, a federal statute that imposes liability on persons and companies who defraud governmental programs, as well as the Federal Anti-Kickback Statute and the Stark Law.

In a press release at the time that a \$12.2 million settlement was reached with Curo, U.S. Attorney Parker of the Northern District of Texas said, “We will not tolerate the payment of illegal kickbacks, which unjustly drive up the cost of health care.” (DOJ 2017). The plaintiff also requested that the Court permit them to intervene and prosecute fraud claims against two former Curo executives, Dr. Bryan White and Suresh Kumar (DOJ 2017). Despite the success of a settlement, Curo Health Services was not required to admit any wrongdoing or liability.

In a second case in June of 2021, further bad practices came to the surface about Curo. The U.S. Department of Justice and the State of Tennessee filed a consolidated complaint against Curo Health Services Holdings and its subsidiary, Avalon Hospice (also known as TNMO Healthcare), for knowingly submitting false claims for hospice ineligible patients and then concealing the obligation to repay overpayments for those services (O’Grady 2021; U.S. v. Curo). In other words, they “helped themselves to a portion of public money available from those programs for hospice care by falsely certifying that patients’ illnesses had reached a terminal stage, when, in fact, they had not” (U.S. v. Curo, 1). This was a violation of the False Claims Act (FCA), as well as Tennessee state laws.

Avalon is the patient-facing hospice operator that owns and controls at least 27 agencies in Tennessee. Curo Health Services Holdings purchased Avalon’s then parent company, Regency Healthcare Group in 2011. The 2021 case was about multiple Avalon locations/facilities spanning a period from January 1, 2010 through February 20, 2020 during which Avalon was owned by Regency and then Curo (U.S. v. Curo, 7). Curo maintained the bad practices that were used under Regency ownership, while introducing more sophisticated and less easily identifiable ways of carrying them out.

Corporate policies at Avalon enabled and encouraged aggressive, financially motivated admissions with unsupported eligibility criteria. The Directors of Operations (DOO) at multiple Avalon locations intervened in staff procedures and reclassified patients as hospice-eligible and exaggerated patient diagnoses in insurance documentation, overruling nurses' existing decisions. Avalon let financial incentives determine care protocols. One patient was admitted to hospice at the Avalon Jackson location in June of 2010 under the diagnosis of "end stage" heart failure. The DOO, Barbara Gordon, was known for taking regular steps to "circumvent clinicians' concerns about hospice eligibility that led to the admission and retention of ineligible patients" (U.S. v. Curo, 4). For this patient, Gordon instructed a nurse to document they had shortness of breath even though the nurse had not observed such a symptom. Plaintiffs also allege that Gordon told clinicians to deduct five pounds from patients' weight and exaggerate the extent of their illnesses. Primary care physicians who did not consider patients terminally ill were replaced by the DOOs with others who would comply (U.S. v. Curo, 4).

In addition to giving directions on how to document patients' health, nurses at Avalon Jackson who were responsible for assessing patients prior to admission were told that increasing much needed staff capacity was contingent upon increased patient census. DOO Gordon dangled these staffing reinforcements as nurses were being required, "to work substantial amounts of overtime without additional pay" (*United States v. Curo Health Services*, Case No. 3:13-cv-00672, Consolidated Compl. at page 38, M.D. Tenn. June 6, 2021).

The plaintiffs allege that patterns of admitting ineligible patients to Avalon facilities were not only the result of scattershot errors or a few bad actors like the Director of Operations at Avalon Jackson. Instead, "Regency and Curo pressured Avalon staff to maximize census through aggressive targets, financial incentives, and restrictions on discharging patients" (U.S. v. Curo, 5). At Avalon Nashville, the Director of Operations was offered a "monetized event bonus" equal to 20 percent of her base salary if the census "exceeded 250 patients within 90 days before a 100% cash sale of the company" (U.S. v. Curo, Consolidated Compl., 24).

In the company-wide Regency Hospice Care Coordinator ("marketer") Incentive Plan for 2010, coordinators were required to get twelve referrals per month. If they attained 12-18 referrals for the month, the coordinator received a \$40 bonus (U.S. v. Curo, Consolidated Compl., 22). The bonuses increased as coordinators met higher benchmarks. A year later, when Avalon was

bought by Curo Health Services, Curo changed the policy to base targets on admissions instead of referrals. Hospice care coordinators were also encouraged to reach high admission and referral numbers because Curo would regularly give out awards to the coordinator that brought in the most business (U.S. v. Curo, Consolidated Compl., 25).

As the parent company, Curo kept a monthly “scorecard” of each hospice agency's average daily census, referrals, admissions, referral conversion rate, revenues, and profits. If an agency failed to meet the targets, the DOO was required to submit a 30-day action plan (U.S. v. Curo, 5, ¶ 90). In staff trainings, Avalon coached personnel not to use words or phrases that could undermine a terminal prognosis, such as “stable,” “no change,” “feels good,” or “looks good.” (U.S. v. Curo, Consolidated Compl., 28). Not only did Regency and Curo direct Avalon physicians to make profit-driven diagnoses, but they also failed to properly train certifying physicians on how to correctly determine eligibility. The physicians did not receive “complete and accurate clinical information from Avalon staff” (U.S. v. Curo, 1).

When Avalon transitioned to Curo ownership in 2011, Curo maintained the bad practices that were used under Regency ownership and introduced more sophisticated and less easily identifiable ways of carrying them out. For instance, Curo removed the DOO bonuses, yet continued to overlook broader issues which fueled their profit model. The 2021 case documentation says Curo continued “to reward admissions and/or patient census numbers in such a way that particular agency personnel stood to benefit financially from admitting more patients, while effectively punishing the management of facilities that admitted fewer patients. (U.S. v. Curo, 5).

Ultimately, the court displayed how Curo – as a parent company – willingly overlooked the fact that Avalon – its subsidiary provider – was admitting and retaining ineligible patients across various Mississippi hospice agencies. Federal and state prosecutors describe in the court documentation how there were numerous internal complaints, audits, and investigations that were reported to regional and national managers and executives through the years but were dismissed (Parker 2021a; U.S. v. Curo, Consolidated Compl., 36). Individual employees *were* submitting complaints and pushing for change and transparency. Even in situations where Regency and Curo discharged ineligible patients, the parent companies rarely took the step to return overpayments (U.S. v. Curo, 6).

The four employees that came forth to officially file complaints that the company was submitting false claims and concealing evidence were terminated by Avalon (Farmer 2021).^[2]

A third series of cases involves Curo subsidiary, Southerncare. Prior to being bought by Curo, Southerncare was involved in two different fraud cases. In 2009, the company paid \$24.7 million for False Claims Act violations (Parker 2021b). At the time, Alice H. Martin, U.S. Attorney for the Northern District of Alabama, said: “Our investigation showed a pattern and practice to falsely admit patients to hospice care who did not qualify and to bill Medicare for that care [which] resulted in taxpayers bearing inappropriate costs” (Parker 2021b).

In December 2018, similar allegations were brought against Southerncare for its actions between 2009 and 2014 in Pennsylvania hospices. Two employees brought forth whistleblower complaints alleging their employer was submitting false claims to Medicare. Southerncare ultimately agreed to pay roughly \$6 million to the federal government (U.S. Attorney's Office, Eastern District of Pennsylvania 2018).

Despite Southerncare's record of bad practices, Curo bought the company in June 2014 via its financial sponsor GTCR (Parker 2021b). The bad practices continued. In June 2021, a federal False Claims Act case was filed against SouthernCare in the Southern District Court of Mississippi in *McClinton et al v. Southerncare, Inc.* Whistleblowers from the company alleged that, “Southerncare submitted hospice claims to Medicare for patients who were not eligible, billed for services it did not provide and terminated an employee who raised concerns about these practices” (Parker 2021b). Former nurse, Rhonda McClinton, alleges she was fired after confronting her superiors in the organization about the accusations. The complaints were dismissed in May 2022 on a technicality due to the “first to file”^[3] rule (Vossel 2022b).

Overall, the three cases show how PE-owned Curo Health Services systemically introduced practices at its subsidiaries that put profit over quality care for patients and quality working conditions for employees. Under the direction of Curo, subsidiaries Hospice Plus, Avalon Hospice, and Southerncare took steps to break Medicare eligibility rules by reclassifying patients, exaggerating patient diagnoses for insurance documentation, and dismissing the concerns of employees who spoke up.

In the current regulatory environment for the hospice industry, employee whistleblowers seem to be the government's main defense against hospice wrongdoings in the pervasive absence of guardrails, oversight, and regulation from government agencies (Kofman 2022; GAO 2019). In fact, seven out of ten of the largest hospice providers in the U.S. have been sued at least once by their former employees under the federal False Claims Act (Kofman 2022). At the same time, only nineteen of the more than four thousand U.S. hospices were cut off from Medicare funding between 2014 and 2017 (GAO 2019).

Curo (now rebranded Gentiva) is representative of a pattern found in other private equity owned healthcare providers – that of acquiring smaller agencies with troubled pasts. Curo has a track record of ignoring internal complaints, not acting upon audits and investigations, implementing policies like 20 percent of salary bonuses for Operations Directors who increase the patient census, and engaging in fraudulent billing. When subsidiaries of Curo were acquired, the company did not eliminate these practices but altered them to make it more difficult to identify them. They introduced more sophisticated ways of continuing the bad behavior. In numerous cases, when employees tried to do the right thing to bring light to these practices, they were either harassed or fired. The Curo case demonstrates how a hospice company can grow under private equity ownership, and how profit-oriented incentive systems can lead to a reduction in the quality of care.

Policies to Rein in For-Profit and PE Excesses in Hospice Care

The concerns raised in this report – fraud that drives up costs for Medicare and cost cutting that harms patient care – are well known to CMS. In response to these challenges, Medicare has begun a federal pilot project it believes can rein in soaring costs by turning hospice agencies in the pilot over to insurance companies. In the pilot, Medicare pays insurance companies a lump sum to manage each patient in traditional Medicare fee-for-service enrolled in the hospice care pilot. The argument is that this payment system provides an incentive for insurance companies to keep costs down and save money for the Medicare program. The pilot, which was originally slated to end in 2024, has been extended to 2030. Health insurer Humana, part owner along with a private equity firm of the large hospice chain Gentiva discussed earlier in this report, is an enthusiastic supporter of, and participant in, the pilot program (Walker and Gorenstein 2023).

The pilot, which is modeled on insurer-run Medicare Advantage programs, is seriously flawed and very much misguided. The Health and Human Services Office of the Inspector General (OIG) recently investigated concerns that the lump sum payment model used in Medicare Advantage (so-called capitated payments) might provide an incentive for these organizations to deny beneficiaries access to expensive specialists and other services in order to increase profits. They found 13 percent of requests for prior authorization for services that traditional Medicare would have approved were inappropriately denied by Medicare Advantage organizations. These denials prevented, or at a minimum delayed, beneficiaries from receiving medically necessary care (Health and Human Services Office of the Inspector General 2022). In addition to denying beneficiaries needed care, Medicare Advantage has increased costs for the Medicare program. Medicare pays more per beneficiary enrolled in Medicare Advantage than it does for those in traditional Medicare (Biniek, Cubanski and Neuman 2021).

This approach, which many fear may be the wave of the future, is a serious step backward. It avoids addressing the fundamental question of how Medicare, which contracts with others to provide hospice services it pays for, can control the provision of hospice services to reduce fraud and improve care. A payment model that pays a lump sum for each patient enrolled in hospice is



an open invitation to enroll ineligible hospice beneficiaries. It is also an incentive to deny patients expensive care covered by traditional Medicare, such as expensive medications to control pain or other symptoms, and care by specialists who are expert at mitigating the disease's worst effects on the patient. The clear winner is not the patient or the Medicare program and its finances; instead, it is the insurance companies looking for a way to collect lump sum payments from Medicare for the half of the elderly still enrolled in traditional Medicare and not in Medicare Advantage which is neither Medicare nor, for those requiring expensive medical care, an advantage. Rather, it is a highly profitable insurance program paid for by Medicare that offers health care for the elderly. Wall Street recognizes this, and investors have been buying shares in the largest Medicare Advantage providers – health insurance companies like United Health, Humana, CVS Health, Elevance Health and Centene (Herman 2023).

In what follows, we briefly review Medicare's challenges in contracting for hospice services, and then present a three-pronged approach to addressing them.

Medicare Needs New Policies to Address Bad Behavior by Hospice Agencies

Private equity is not unique in its ability to exploit weaknesses in the Medicare payment system or to take advantage of weak requirements when establishing a hospice agency. Nor is it alone in exploiting lax oversight to game the system by billing for ineligible patients, while at the same time delivering inadequate services to patients requiring end-of-life care. These practices are widespread among for-profit hospice providers. But private equity's debt-financed acquisition of agencies, its prioritization of profits, and the short time frame before it plans to sell them for much more than it paid to acquire them creates unique pressures to quickly increase revenue and operating profits.

Private equity firms are able to take the for-profit hospice business to scale by acquiring smaller hospice chains, consolidating local health care markets, and reducing competition. It can do this because each individual acquisition falls below the price threshold set by the Hart-Scott-Rodino Act that triggers an antitrust review. Regulators are largely blind to the scale at which the PE-

owned hospice chains are growing. The Federal Trade Commission (FTC) is only now beginning to assess the effects on competition as health care companies grow via add-on acquisitions. To date, it has not raised objections to the growth by acquisition exemplified by Curo and Kindred at Home, both now rebranded as Gentiva.

PE firms have adopted two strategies to quickly increase profits. The first is to take advantage of the Medicare fixed payment for every day the patient is enrolled by enrolling patients that require less care. This includes enrolling ineligible patients who are more than six months from death and require little or no care services or by enrolling individuals whose terminal illness requires less intensive care – e.g., more patients with dementia and fewer with cancer. The second strategy is to reduce the quality of care provided to patients facing the end of life. This can take the form of using less skilled workers to provide care, providing patients with fewer days of care, reducing the hours of physical therapy the patient receives, and using the patients' Medicare Part D to pay for expensive medicines that the hospice agency is supposed to pay for. Lax oversight of hospice providers means that neglect and abuse of patients that put them at risk of serious health consequences go unreported. When problems are uncovered, agencies are required to do little more than develop a plan to correct deficiencies. Notably, the agencies are not booted from the Medicare program and continue to collect generous payments while providing substandard care.

The Curo case raises questions about whether this type of tax-payer financed capitalism has a place in the hospice industry or in health care more generally. Economists have long been concerned about which services are better to produce privately and which should be produced publicly. In hospice, the nature of incentives in private production and asymmetric information between producers and consumers about adequate standards of service quality are reasons to favor public over private provision of the service. Incentives in the hospice payment systematically attract private, for-profit agencies that routinely game the system to line the pockets of private owners. This is possible because most patients and caregivers have not had prior experience with hospice care, and are not able to judge the adequacy of the end-of-life care that is provided.

A Three-Pronged Approach to Improving Regulation of Hospice Agencies

When it is not feasible to provide such services publicly, economists argue that strong regulations are called for that would allow government agencies to oversee private firms supplying these services. The government, as the Curo case makes clear, has failed to do this in hospice. We identify a three-pronged policy agenda to reduce fraud, reduce opportunities to game the system, and assure that more of Medicare payments are directed to patient care. The first prong consists of strengthening and enforcing policies that are already on the books and can immediately improve the care of patients; the second encompasses policies that need to be updated to account for the entrance of private equity into the industry; and the third prong is the development of new policies that close loopholes that dishonest hospice agencies are well-positioned to exploit.

In the first category, clearer requirements and strict enforcement of existing laws and penalties for engaging in fraudulent practices would go a long way toward assuring the safety and wellbeing of hospice patients. As the California auditor's report makes clear, Medicare needs to do a more careful inspection before certifying a hospice provider as eligible to receive government payments. For example, hospice licenses must be renewed after 24 months. Unfortunately, the renewal process does not require regulators to inspect the agency, allowing problems to go unresolved.

One result of lax licensing requirements is a proliferation of hospice agencies, many of them motivated only by the promise of Medicare payments. As we saw in Los Angeles, the concentration of hospice organizations far outweighed the size of the elderly population and the need for hospice care. The state of California eventually responded to this by imposing a moratorium to limit new hospices from entering the market. CMS should use its existing moratorium authority to do the same where the growth of hospice agencies far exceeds the need for hospice services.

The current hospice certification process is also not sufficient to weed out poor performing and non-operational hospices. More frequent and more rigorous site visits by CMS can identify such

hospices and revoke their enrollment in the Medicare system. This further prevents the hospice organizations from being sold to inexperienced providers for a profit (NHPCO 2023).

State public health agencies need to quickly and thoroughly investigate complaints, shutting down repeat offenders. They need to proactively examine hospice providers to determine whether they are illegally enrolling ineligible patients, understaffing facilities, and otherwise cutting corners in ways that endanger patients. Regulators must be willing to use the main tool they have – closing an agency that engages in fraud or fails to adequately serve patients.

California, which had the worst record in terms of oversight of hospice providers, has now passed legislation that, among other provisions, tightens standards for licensing agencies, sets caseload standards for nurses, and makes management of hospice agencies more accountable (Assembly Bill 2673). Furthermore, the bill prohibits the state's health department from approving a change of ownership of a licensed hospice agency for 5 years from the date of initial licensure. State and federal authorities must have sufficient funding to carry out this oversight function in a rigorous manner.

The information about the growth of hospices in California and the red flags suggesting widespread fraud and unethical behavior documented in this report, as well as similar concerns about a proliferation of agencies in Texas, Nevada and Arizona, has spurred CMS to action. On April 4, the agency issued proposed changes to hospice conditions of participation and hospice quality reporting intended to tighten the integrity of the hospice program and weed out inappropriate and potentially unethical and illegal behavior by hospice agencies (CMS 2023). Fraudulent behavior by hospice agencies steals Medicare dollars and deprives patients of necessary care. The proposed rules, according to CMS, are an initial step towards protecting the program from fraud and abuse. The changes are welcome and long overdue.

CMS proposes to do a deep dive into hospice utilization, patient diagnoses, live discharges and other data that can signal potential fraud. These data can also point to unequal access to hospice care for disabled and nonwhite terminally ill individuals in violation of national statutes. Another proposed safeguard would require that all physicians who order or certify hospice services for Medicare beneficiaries be enrolled in Medicare as a condition of Medicare payment for the services. This would replace the current requirement that hospice services can be authorized by the hospice agency's Medical Director, an MD or DO on the staff of the hospice agency who may

not be accountable to Medicare. CMS also proposes examining barriers to hospice care for patients whose health conditions are more acute, suggesting that they will represent a higher expense to the hospice agency than other patients. These agencies may falsely inform these dying individuals that the health care services they need to keep them comfortable in their final days are not covered by the Medicare hospice benefit. CMS also proposes to improve its collection of quality of care data, and to make the results of its quality assessments more easily available to patients, their families and their caregivers. This is a promising start for Medicare, in contrast to the pilot program to turn the hospice benefit in traditional Medicare over to insurance companies.

The second prong of the policy agenda, developing policy reforms that recognize the increased role of Wall Street and private equity firms in hospice, should focus on antitrust regulations. New merger guidelines are needed to address the effects on consolidation and monopolization via serial acquisitions of add-on companies that fall below the Hart-Scott-Rodino (HSR) price threshold for review by the FTC. The buy and build strategy of PE firms in health care allows hospice agencies to grow to a size that enables them to accrue market power in local health markets. Checks and balances are needed to stop the consolidation of hospice agencies into huge chains when this is not in the public interest. Consolidation may limit competition and consumer choice. The FTC and DOJ need enhanced merger review authorization, as well as increased enforcement ability to meet this challenge. The FTC, for example, should be empowered to carry out enforcement actions in the case of anti-competitive mergers of nonprofit organizations, something it currently is not empowered to do. Both agencies would be better able to monitor mergers and acquisitions if they had clearer authority to take a backward look at serial acquisitions by a company that escaped review because its acquisitions fell under the HSR threshold.

State officials also have a role to play in health care mergers and acquisitions. The state attorney general is already able to set conditions when a nonprofit health provider is acquired by a for-profit company and becomes a for-profit entity. This should be expanded to enable state AGs to review M&A activity in health care, and to impose conditions to assure that the community continues to have local access to the health services formerly provided by the nonprofit provider. State AGs should be required to coordinate with other state agencies – state Departments of

Health and Human Services, public health agencies, and organizations representing stakeholders such as consumers, patients, and workers. All of these need to play a role in the approval of M&A activity. This is especially important when mergers may lead to the shuttering of a hospice provider or when providers serving rural areas close the only agency serving that area.

The third policy prong, development of new policies that close loopholes, focuses on reforming the payment system. CMS needs to move away from the flat fee model that is easily gamed and towards one that is based on individual patient needs assessment, with reimbursements varying according to the number and intensity of services needed (NHPCO 2023). This payment model would reduce opportunities and incentives to overbill for services or under serve patients. There is a need for new regulations that link payment for hospice services to the patient's diagnosis, to the frequency of care services, and to the skills of the individuals providing these services. In addition, hospices caring for patients newly released from a hospital or the emergency room experience higher costs, as these patients initially require more intensive care and services, and they should receive payment commensurate with the care provided. CMS, which pays for care of Medicare and Medicaid beneficiaries, may already be empowered to make these changes to the payment system; if not, new legislation should require these changes. Such a payment system would provide incentives to provide more and higher quality care to patients. This would close a loophole that some PE firms have been only too happy to take advantage of, and would improve end-of-life care of hospice patients.



Conclusion

Hospice care provides services to patients in the final months of life that are intended to anticipate and relieve the physical pain and emotional stress of a terminal illness. CMS introduced the hospice benefit to guarantee that dying beneficiaries would be well taken care of and could face their final days with dignity. Unfortunately, loopholes in the structure of the hospice benefit created opportunities for providers to game the system and profit at the expense of patients. Patients and their caregivers generally have little to no prior experience with hospice and the care of a person approaching death, and may not be aware of what constitutes good care or whether it is being provided.

The hospice benefit pays a fixed amount to the hospice agency for each day an eligible Medicare beneficiary within six months of death is enrolled in its hospice program, whether or not the patient receives services on that day. This sets the stage for unscrupulous providers to game the system and increase their profits. They can focus on enrolling patients suffering from dementia, for whom it is more difficult to predict the length of time to death. These patients are more likely than those suffering from cancer to live six months or more. They are even likely to be eligible for extensions beyond the initial six-month enrollment period. As hospice agency profits are tied to the length of stay of enrolled patients, this is a straightforward and legal means to increase profits.

Nonprofit hospice providers typically have a larger share of cancer patients, as well as patients recently released from acute care hospitals, compared to for-profit agencies and a smaller share of patients with dementia. Cancer patients typically have a shorter life expectancy and require more intensive and higher skilled nursing care, making them more expensive to care for. Medicare makes a flat per diem payment to providers that does not take the condition of the patient or the skill required of the nursing staff into consideration. Medicare also does not set a standard for the number of visits to a patient in the last week or even the last three days before death when the patient's need for pain relief and treatment to improve their comfort are most acute. Neglect of patients at the very end of life increases profitability while denying patients badly-needed care; it occurs more often in for-profit settings.



While providers are able to increase profits legally by focusing on a patient mix that is likely to live longer and to require less care or less-skilled care, for some for-profit providers this has not been enough. They have committed Medicare fraud by recruiting people who are not terminally ill and are ineligible for hospice care, and enrolled them and collected the per diem payment while providing little or no services to them. Recruiters paid on the basis of the number of people they enroll target poor people with little access to medical care. They promise the recruited patients housekeeping help, a free hospital bed, 24-hour nursing care, and other hospice benefits. As these ineligible patients are not close to death, they will generally live six months and the hospice provider will often be able to renew their eligibility for subsequent periods of care with the help of a corrupt doctor or by forging the identity of an unknowing doctor.

Regulators – both state public health boards and Medicare – carry out few rigorous inspections of hospice agencies and their practices. The public currently relies on whistleblower complaints and investigative reporters to learn about illegal practices, which is not a very effective check on organizations committing fraud. Even when fraudulent practices are identified, regulators rarely pull the license of a hospice agency. Instead, the agency is typically required to develop a plan for eliminating the fraud going forward, and is allowed to continue enrolling patients and billing Medicare for their care.

To curb these practices and improve the quality of patient care, Medicare payments need to be calibrated to the seriousness of the illness of enrolled patients and the skills of the nurses and others providing hospice care. Standards of care, including number of visits and access to services such as physical therapy, need to be established and disseminated to patients and caregivers. Regulators need to carry out inspections (called surveys in this industry) on a regular basis, and to impose steeper penalties for failure to adhere to standards, including the loss of their hospice license.

Patients at the end of life are entitled to have their pain and other symptoms alleviated and to live out their last days with dignity. That is the promise of the Medicare hospice benefit. Opportunities to game the system and failure to provide adequate care to hospice patients should be eliminated; illegal behavior should be dealt with harshly. No one should be able to profit by preying on the dying.

^[1] The number of hospice locations is much larger than the number of hospice agencies, as an agency may have multiple locations.

^[2] When proceedings center around qui tam complaint, a whistleblower -- called a "relator" by the courts -- files a False Claims Act suit in concert with the government and possibly receives a portion of any funds recovered by the government via the lawsuit, typically ranging from 15% to 25% (Parker 2021b).

^[3] A relator cannot file suit to resolve allegations that have already been made in a separate complaint. At the time, Southerncare was already involved in a pending suit in Pennsylvania, *McClinton et al v. Southerncare, Inc.*, which is described just before this case (Vossel 2022b).

References

- Assembly Bill–1280 California Hospice Licensure Act of 1990*. 2021. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1280
- Aldridge, Melissa D., Andrew J. Epstein, Abraham A. Brody, Eric J. Lee, R. Sean Morrison, and Elizabeth H. Bradley. 2018. “Association between Hospice Spending on Patient Care and Rates of Hospitalization and Medicare Expenditures of Hospice Enrollees.” *Journal of Palliative Medicine* 21 (1): 55–61. <https://doi.org/10.1089/jpm.2017.0101>
- Appelbaum, Eileen, and Rosemary Batt. 2020. “Private Equity Buyouts in Healthcare: Who Wins, Who Loses?” <https://cepr.net/report/private-equity-buyouts-in-healthcare-who-wins-who-loses/>
- . 2021. “Private Equity in Healthcare: Profits before Patients and Workers.” <https://cepr.net/private-equity-in-healthcare-profits-before-patients-and-workers/>
- Bazell, Carol, Melissa Caplen, William Coates, Pamela Pelizzari, and Bruce Pyenson. 2019. “Hospice Medicare Margins: Analysis of Patient and Hospice Characteristics, Utilization, and Cost.” National Partnership for Hospice Innovation. https://www.hospiceinnovations.org/wp-content/uploads/2020/05/Hospice_Medicare_Margins_NPHI_7-2019-1.pdf
- Binieck, Jeannie Fuglesten, Juliette Cubanski, and Tricia Neuman. 2021. “Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare’s Solvency and Affordability Challenges.” KFF. <https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/>
- Braun, Robert Tyler, David G. Stevenson, and Mark Aaron Unruh. 2021. “Acquisitions of Hospice Agencies by Private Equity Firms and Publicly Traded Corporations.” *JAMA Internal Medicine* 181 (8): 1113–14. <https://doi.org/10.1001/jamainternmed.2020.6262>
- Bugbee, Mary, Eileen O’Grady, and Michael Fenne. 2023. “Recent Trends in Private Equity Healthcare Acquisitions.” Private Equity Stakeholder Project. https://pestakeholder.org/wp-content/uploads/2023/02/PESP_Report_HC_Acquisitions_Feb2023_FINAL.pdf
- Business Wire. 2022. “Humana Announces Agreement to Divest Majority Interest in Kindred at Home Hospice and Personal Care Divisions to Clayton, Dubilier & Rice.” April 21. <https://www.businesswire.com/news/home/20220421005421/en/Humana-Announces-Agreement-to-Divest-Majority-Interest-in-Kindred-at-Home-Hospice-and-Personal-Care-Divisions-to-Clayton-Dubilier-Rice>
- California State Auditor. 2022. “California Hospice Licensure and Oversight: The State’s Weak Oversight of Hospice Agencies Has Created Opportunities for Large-Scale Fraud and Abuse.” 2021–123. <https://www.auditor.ca.gov/pdfs/reports/2021-123.pdf>
- Carlson, Melissa D. A., William T. Gallo, and Elizabeth H. Bradley. 2004. “Ownership Status and Patterns of Care in Hospice: Results From the National Home and Hospice Care Survey.” *Medical Care* 42 (5): 432–38. <https://doi.org/10.1097/01.mlr.0000124246.86156.54>
- Cherlin, Emily J., Melissa D.A. Carlson, Jeph Herrin, Dena Schulman–Green, Colleen L. Barry, Ruth McCorkle, Rosemary Johnson–Hurzeler, and Elizabeth H. Bradley. 2010. “Interdisciplinary Staffing Patterns:

- Do For-Profit and Nonprofit Hospices Differ?" *Journal of Palliative Medicine* 13 (4): 389–94. <https://doi.org/10.1089/jpm.2009.0306>
- Christensen, Kim, and Ben Poston. 2020. "End-of-Life Care Has Boomed in California. So Has Fraud Targeting Older Americans." *LA Times*, December 9, 2020. <https://www.latimes.com/california/story/2020-12-09/hospice-industry-growth-marked-fraud-deficient-care>
- . 2021. "Hospice Reforms to Become Law after Times Investigation Reveals Widespread Fraud, Abuse." *LA Times*, October 4, 2021. <https://www.latimes.com/california/story/2021-10-04/hospice-reforms-law-fraud-abuse-times-investigation>
- CMS.gov. n.d. "Hospice Quality Reporting Program | CMS." Centers for Medicare & Medicaid Services. Accessed February 7, 2023. <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospice-quality-reporting>
- CMS, Centers for Medicare & Medicaid Services. 2023. Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements, Table 4. April 4. Available online at [federalregister.gov/d/2023-06769](https://www.federalregister.gov/d/2023-06769) and on [govinfo.gov](https://www.govinfo.gov)
- David E. M. Sappington, and Joseph E. Stiglitz. 1987. "Privatization, Information and Incentives." *Journal of Policy Analysis and Management* 6 (4): 567–82. <https://doi.org/10.2307/3323510>
- Dayen, David. 2021. "Private Equity's Potential Payday From Build Back Better." *The American Prospect*. August 31, 2021. <https://prospect.org/api/content/00018b1e-09e5-11ec-95d7-1244d5f7c7c6/>
- Department of Justice. 2017. "Hospice Companies To Pay \$12.2 Million To Settle Kickback Claims." <https://www.justice.gov/usao-ndtx/pr/hospice-companies-pay-122-million-settle-kickback-claims>
- . 2022. "13 Novus Healthcare Fraud Defendants Sentenced to Combined 84 Years in Prison | United States Department of Justice." <https://www.justice.gov/usao-ndtx/pr/13-novus-healthcare-fraud-defendants-sentenced-combined-84-years-prison>
- Donlan, Andrew. 2021a. "[Updated] The Top 10 Largest Home Health, Hospice Providers in 2020." *Home Health Care News*. February 9. <https://homehealthcarenews.com/2021/02/the-top-10-largest-home-health-hospice-providers-in-2020/>
- . 2021b. "'Better Systems, Better Controls and a Digitized Industry': Analyzing PE's Impact on Home-Based Care." *Home Health Care News*. April 12. <https://homehealthcarenews.com/2021/04/better-systems-better-controls-and-a-digitized-industry-analyzing-pes-impact-on-home-based-care/>
- . 2022. "'Gentiva' Formed As Humana Closes Personal Care Divestiture." *Home Health Care News*. August 11. <https://homehealthcarenews.com/2022/08/humanas-divestiture-of-kindreds-personal-care-and-hospice-assets-closes-forms-gentiva/>
- . 2023. "[Updated] CD&R-Backed Gentiva Agrees To Acquire ProMedica's Home Care, Hospice Assets For \$710M." *Home Health Care News*. February 27. <https://homehealthcarenews.com/2023/02/cdr-backed-gentiva-agrees-to-acquire-promedicas-home-care-hospice-assets-for-710m/>
- Famakinwa, Joyce. 2020. "Centerbridge Partners, The Vistria Group Acquire Wellspring's Help at Home." *Home Health Care News*. November 2. <https://homehealthcarenews.com/2020/11/centerbridge-partners-the-vistria-group-acquire-wellspring-help-at-home/>



- Farmer, Blake. 2021. "Feds Accuse Tennessee's Largest Hospice Agency Of Enrolling Patients Who Aren't Dying." *WPLN News*. June 2. <https://wpln.org/post/feds-accuse-tennessees-largest-hospice-agency-of-enrolling-patients-who-arent-dying/>
- "Fiscal Year (FY) 2023 Hospice Payment Rate Update Final Rule (CMS-1773-F) | CMS." n.d. Accessed March 23, 2023. <https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2023-hospice-payment-rate-update-final-rule-cms-1773-f>
- Gentiva Hospice. 2023. Gentiva Hospice Homepage. Accessed April 23, 2023. <https://www.gentivahs.com/>
- Hawryluk, Markian. 2022. "Hospices Have Become Big Business for Private Equity Firms, Raising Concerns About End-of-Life Care." *Kaiser Health News* (blog). July 29. <https://kffhealthnews.org/news/article/hospices-private-equity-firms-end-of-life-care/>
- Health and Human Services Office of the Inspector General. 2019. "2019: Vulnerabilities in Hospice Care." <https://oig.hhs.gov/newsroom/media-materials/media-materials-2019-hospice/>
- Health and Human Services Office of the Inspector General. 2022. "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care." April 27. <https://oig.hhs.gov/oei/reports/oei-09-18-00260.asp>
- Herman, Bob. 2023. "Wall Street Embraces Health Insurers after Scoring Medicare Advantage Payment Win." *STAT News*, April 7. <https://www.statnews.com/2023/04/07/wall-street-medicare-advantage/>
- Holly, Robert. 2021a. "House Hearing Slams Private Equity's 'Troubling' Expansion into Health Care." *Home Health Care News*. March 25. <https://homehealthcarenews.com/2021/03/house-hearing-slams-private-equitys-troubling-expansion-into-health-care/>
- . 2021b. "[Updated] 'We Own the Full Health Care Continuum': Advocate Aurora Enterprises Acquires Senior Helpers." *Home Health Care News*. April 1, 2021. <https://homehealthcarenews.com/2021/04/we-own-the-full-health-care-continuum-advocate-aurora-enterprises-acquires-senior-helpers/>
- . 2021c. "[Updated] Health Care-Focused PE Firm RiverGlade Capital Acquires Home Helpers." *Home Health Care News*. April 8. <https://homehealthcarenews.com/2021/04/health-care-focused-pe-firm-riverglade-capital-acquires-home-helpers/>
- Humana. 2022. "Press Release: Humana Completes Divestiture of Majority Interest in Kindred at Home Hospice and Personal Care Divisions to CD&R." <https://press.humana.com/news/news-details/2022/Humana-Completes-Divestiture-of-Majority-Interest-in-Kindred-at-Home-Hospice-and-Personal-Care-Divisions-to-CDR/default.aspx>
- Japsen, Bruce. 2018. "Humana And Private Equity Finalize \$1.4 Billion Curo Health Hospice Deal." *Forbes*. July 11. <https://www.forbes.com/sites/brucejapsen/2018/07/11/humana-and-private-equity-finalize-1-4-billion-curo-health-hospice-deal/>
- "Kindred Healthcare, Inc. Form 10-K for the Fiscal Year Ended December 31, 2017." 2018. United States Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/1060009/000156459018003936/knd-10k_20171231.htm
- Kofman, Ava. 2022. "How Hospice Became a For-Profit Hustle." *The New Yorker*, November 28, 2022. <https://www.newyorker.com/magazine/2022/12/05/how-hospice-became-a-for-profit-hustle>

- Lagasse, Jeff. 2022. "Humana Finalizing Launch, Branding of CenterWell Home Health." *Healthcare Finance News*. September 6. <https://www.healthcarefinancenews.com/news/humana-finalizing-launch-branding-centerwell-home-health>
- "Letter to President and Chief Executive Officer of Kindred at Home, David Causby." 2021. <https://www.warren.senate.gov/imo/media/doc/080621%20Wyden%20Brown%20Warren%20Kindred%20Hospice%20Private%20Equity%20Letter.pdf>
- McClinton et al v. Southerncare, Inc., Case No. 3:2016-cv-00128, Document 51 (S.D. Miss. 2021). <https://law.justia.com/cases/federal/district-courts/mississippi/mssdce/3:2016cv00128/91455/51/>
- Medicare Payment Advisory Commission. 2022. "March 2022 Report to the Congress: Medicare Payment Policy – MedPAC." <https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/>
- Mihas, Dean, and John Kos. Newsletter. 2011. "GTCR Leadership Newsletter: Healthcare," Winter 2011.
- Minemyer, Paige. 2022. "Humana Kicks off Transition of Kindred at Home to CenterWell Brand." *Fierce Healthcare*. March 1. <https://www.fiercehealthcare.com/payers/humana-kicks-transition-kindred-home-centerwell-brand>
- Mullaney, Tim. 2018. "Humana, Private Equity Firms Complete Kindred Acquisition." *Home Health Care News*. July 2. <https://homehealthcarenews.com/2018/07/humana-private-equity-firms-complete-kindred-acquisition/>
- NHPCO, National Hospice and Palliative Care Organization. 2023. "National Hospice Leaders Urge CMS and Congress to Advance Program Integrity in Hospice Care through Effective Oversight." *NHPCO* (blog). January 19. <https://www.nhpco.org/national-hospice-leaders-urge-cms-and-congress-to-advance-program-integrity-in-hospice-care-through-effective-oversight/>
- O'Grady, Eileen. 2021. "US Government Joins Fraud Case Against PE-Owned Hospice Giant Curo Health Services." Private Equity Stakeholder Project PESP. June 10. <https://pestakeholder.org/news/us-government-joins-fraud-case-against-pe-owned-hospice-giant-curo-health-services/>
- Olson, Laura Katz. 2022. *Ethically Challenged: Private Equity Storms US Health Care*. 1 online resource (x, 425 pages) vols. Baltimore: Johns Hopkins University Press. <https://search.ebscohost.com/login.aspx?direct=true&scope=site&db=nlebk&db=nlabk&AN=3121954>
- Parker, Jim. 2021a. "Justice Department, Tennessee File False Hospice Claims Suit Against Curo Health Services." *Hospice News*. June 7. <https://hospicenews.com/2021/06/07/justice-department-tennessee-file-false-hospice-claims-suit-against-curo-health-services/>
- . 2021b. "False Claims Case to Proceed Against Hospice Provider Southerncare." *Hospice News*. June 25. <https://hospicenews.com/2021/06/25/false-claims-case-to-proceed-against-hospice-provider-southerncare/>
- . 2021c. "Intrepid USA Poised for Growth with New Private Equity Backers." *Hospice News*. October 1. <https://hospicenews.com/2021/10/01/intrepid-usa-poised-for-growth-with-new-private-equity-backers/>
- . 2022. "Senators Ask CMS for Briefing on Hospice Fraud." *Hospice News*. December 20. <https://hospicenews.com/2022/12/20/senators-ask-cms-for-briefing-on-hospice-fraud/>



- . 2023. “Gentiva Inks Deal to Acquire Heartland Hospice from ProMedica for \$710 Million.” *Hospice News*. February 27. <https://hospicenews.com/2023/02/27/gentiva-inks-deal-to-acquire-heartland-hospice-from-promedica/>
- Pifer, Rebecca. 2021. “Humana Snaps up Remaining Stake in Home Health Giant Kindred for \$5.7B.” *Healthcare Dive*. April 28. <https://www.healthcaredive.com/news/humana-snaps-up-remaining-stake-in-home-health-giant-kindred-for-57b/599158/>
- Pitchbook Advent International. 2023. Pitchbook Advent International Company Profile, as of April 3, 2023. Downloaded April 3, 2023.
- Pitchbook Blue Wolf Capital Partners. 2023. Pitchbook Blue Wolf Capital Partners Company Profile, as of March 23, 2023. Downloaded April 3, 2023.
- Pitchbook Gentiva Health Services. 2023. Pitchbook Gentiva Health Services Company Profile, as of March 23, 2023. Downloaded April 3, 2023.
- Pitchbook Gentiva Hospice (Curo). 2023. Pitchbook Gentiva Hospice (Curo) Company Profile, as of February 23, 2023. Downloaded April 3, 2023.
- Price, Rebecca Anhang, Layla Parast, Marc N. Elliott, Anagha A. Tolpadi, Melissa A. Bradley, Danielle Schlang, and Joan M. Teno. 2023. “Association of Hospice Profit Status With Family Caregivers’ Reported Care Experiences.” *JAMA Internal Medicine*, February. <https://doi.org/10.1001/jamainternmed.2022.7076>
- Price, Rebecca Anhang, Layla Parast, Ann Haas, Joan M. Teno, and Marc N. Elliott. 2017. “Black And Hispanic Patients Receive Hospice Care Similar To That Of White Patients When In The Same Hospices.” *Health Affairs* 36 (7): 1283–90. <https://doi.org/10.1377/hlthaff.2017.0151>
- Price, Rebecca Anhang, Anagha Tolpadi, Danielle Schlang, Melissa A. Bradley, Layla Parast, Joan M. Teno, and Marc N. Elliott. 2020. “Characteristics of Hospices Providing High-Quality Care.” *Journal of Palliative Medicine* 23 (12): 1639–43. <https://doi.org/10.1089/jpm.2019.0505>
- Pringle, Sarah. 2021. “Levine Leichtman Taps Bank for 2022 Sale of Eating Disorder Platform, Vistria Reaps More than 4x Return on Agape Care, Genstar and GI Recap Daxko.” *PE Hub*(blog). October 20, 2021. <https://www.pehub.com/levine-leichtman-taps-bank-for-2022-sale-of-eating-disorder-platform-vistria-reaps-more-than-4x-return-on-agape-care-genstar-and-gi-recap-daxko/>
- Redden, Molly. 2021. “Private Equity Is Gobbling Up Hospice Chains And Capturing The Business Of Dying.” *HuffPost*. December 21. https://www.huffpost.com/entry/hospice-private-equity_n_61c0f858e4b061afe39659ea
- Reuters News. 2014. “Thomas H. Lee Partners in Talks to Acquire Curo Health – Reuters.” Content. *PE Hub* (blog). December 12. <https://www.pehub.com/thomas-h-lee-partners-in-talks-to-acquire-curo-health-reuters/>
- Stevenson, David, and Nicholas Sinclair. 2018. “Complaints About Hospice Care in the United States, 2005–2015.” *Journal of Palliative Medicine* 21 (11): 1580–87. <https://doi.org/10.1089/jpm.2018.0125>
- Teno, Joan M. 2021. “Hospice Acquisitions by Profit-Driven Private Equity Firms.” *JAMA Health Forum* 2 (9): e213745–e213745. <https://doi.org/10.1001/jamahealthforum.2021.3745>

- Teno, Joan M., Mike Plotzke, Thomas Christian, and Pedro Gozalo. 2016. “Examining Variation in Hospice Visits by Professional Staff in the Last 2 Days of Life.” *JAMA Internal Medicine* 176 (3): 364–70. <https://doi.org/10.1001/jamainternmed.2015.7479>
- United States v. Curo Health Services, Case No. 3:13-cv-00672, slip op. at page 4, M.D. Tenn. May 21, 2022.
- United States v. Curo Health Services, Case No. 3:13-cv-00672, Consolidated Compl. at page 38, M.D. Tenn. June 6, 2021).
- United States Senate Committee on Finance. 2021. “Press Release: Wyden, Brown, Warren Probe Private Equity Ownership of Kindred at Home | The United States Senate Committee on Finance.” <https://www.finance.senate.gov/chairmans-news/wyden-brown-warren-probe-private-equity-ownership-of-kindred-at-home>
- U.S. Attorney’s Office, Eastern District of Pennsylvania. 2018. “Hospice Care Provider Pays Nearly \$6 Million to Resolve False Claims Act Allegations.” <https://www.justice.gov/usao-edpa/pr/hospice-care-provider-pays-nearly-6-million-resolve-false-claims-act-allegations>
- United States Attorney’s Office, Northern District of Texas. 2022. “Novus Hospice CEO Sentenced to 13+ Years for Healthcare Fraud.” United States Department of Justice. January 25. <https://www.justice.gov/usao-ndtx/pr/novus-hospice-ceo-sentenced-13-years-healthcare-fraud>
- U.S. Government Accountability Office. 2019. “Medicare Hospice Care: Opportunities Exist to Strengthen CMS Oversight of Hospice Providers.” GAO–20–10. <https://www.gao.gov/products/gao-20-10>
- Vossel, Holly. 2021. “Private Equity Investment in Hospice Hits All-Time High, Valuations Rising.” *Hospice News*. March 26, 2021. <https://hospicenews.com/2021/03/26/private-equity-investment-in-hospice-hits-all-time-high-valuations-rising/>
- . 2022a. “Hospices, Investors Navigate Deal-Threatening Regulatory Hurdles.” *Hospice News*. February 3, 2022. <https://hospicenews.com/2022/02/03/hospices-investors-navigate-regulatory-hurdles-that-could-threaten-deals/>
- . 2022b. “Court Dismisses SouthernCare Fraud Allegations, Proceeds with Whistleblower Retaliation Complaint.” *Hospice News*. May 4. <https://hospicenews.com/2022/05/04/court-dismisses-southern-care-fraud-allegations-proceeds-with-whistleblower-retaliation-complaint/>
- . 2022c. “New California Law Further Tightens Hospice License Oversight.” *Hospice News*. December 1. <https://hospicenews.com/2022/12/01/new-california-law-further-tightens-hospice-license-oversight/>
- Walker, Leslie, and Dan Gorenstein. 2023. “Medicare Tests a Solution to Soaring Hospice Costs: Let Private Insurers Run It.” *NPR*, April 13, 2023, sec. Shots – Health News. <https://www.npr.org/sections/health-shots/2023/04/13/1169602873/medicare-tests-a-solution-to-soaring-hospice-costs-let-private-insurers-run-it>
- WCAS Press Release. 2018. “Humana, Together With TPG Capital And Welsh, Carson, Anderson & Stowe, Announce Agreement To Acquire Curo Health Services.” Press Release. WCAS. April 23. <https://www.wcas.com/firm/news/humana-together-with-tpg-capital-and-welsh-carson-anderson-stowe-announce-agreement-to-acquire-curo-health-services>

