Americans for Financial Reform Education Fund

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Wall Street on Your Doorstep: Protecting Home Care from Private Equity Abuses

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I. Executive Summary

The care economy is at a critical turning point. Home and community based services (HCBS) have steadily become a viable choice for aging and disability care after decades of campaigning to make care available in responsive environments that are grounded in peoples' support systems. At the same time, the private equity industry, which has left a wake of destabilization in facility based healthcare like nursing homes and hospitals, has been turning its attention to additional sectors across the care economy including HCBS. If left unchecked, private equity's extractive business model may damage HCBS infrastructure at a moment when its stability and expansion are of the utmost importance. To make HCBS a social good that provides sustainable livelihoods and is accessible, affordable, and responsive to client and family needs, advocates and policymakers need to design programs that aim to keep care investments focused on serving community needs, not lining Wall Street executives' pockets. This paper investigates private equity's presence in the HCBS sector and identifies the key players and their financial strategies. The goal is to spur more detailed conversation about what actions can be taken to curb the negative outcomes associated with private equity ownership with client advocates, community-based providers, and policy makers who are setting care policy.

Key Findings

Private Equity's Major Imprint on HCBS

- Private equity firms have taken over hundreds of small home health and home care chains and consolidated them into three dozen flagship brands
- Of these, five large brands are among the largest chains in the country: Help at Home, Accentcare, Aveanna Healthcare, Interim Healthcare, and Elara Caring
- Private equity has also helped insurance companies, like UnitedHealthcare and Humana, assemble the two biggest chains through repeat purchases and resales
- Private equity-owned chains have different levels of dominance in different subparts of the industry. For example, they are the largest national providers of specialized disability and pediatric care in home and community settings

A threat to clients, families, workers, and other care providers

- Private equity firms are taking millions of dollars out of the HCBS system through financial engineering tactics and excessive cost cutting, leaving less money for those who need care and the workers who provide it
- Private equity-owned chains have a record of particularly egregious client neglect in pediatric and disability care, where they also are particularly dominant
- Private equity firms are eroding family and client self-determination by taking over family caregiving, self-directed programs, and needs assessment

- Private equity-owned chains degrade job standards: they continue to pay direct care workers poverty wages, fail to prioritize worker safety, and have lobbied hard against government rules that require 80 percent of government spending goes to workers

Federal and State Policy Tools Can Create Community Based Solutions

- Health planning, procurement, and anti-monopoly policies can check private equity's takeover
- Wage floors, collective bargaining rights, and pass-through requirements, which specify how much money goes to workers, coupled with increased Medicaid funding, can raise standards for workers and make HCBS less attractive to predatory financial actors
- Quality controls and co-governance models bringing together clients, workers, and health administrators that can improve client care and direct money where it is needed
- Anti-looting rules that curtail practices like dividend recapitalizations, excessive fees, and asset-stripping that threaten the stability of the HCBS system
- Financial regulation that levels the playing field between private equity and other types of ownership models will reduce the likelihood that providers will be taken over by the industry
- Tax policies like closing the carried interest loophole and eliminating the tax preference for debt would also help protect the HCBS sector

II. Introduction

This report surveys the private equity footprint in home and community based services (HCBS), with a focus on multi-service chains, disability care specialists, adult day care, self-determined care, pediatric home-based care, and needs and risk assessment. Private equity firms have increasingly established platforms to create large chains that offer a wide range of these diversified services. The paper identifies key players and trends at the national level and explains why private equity is interested in the HCBS sector and these areas in particular. It next examines the private equity model and how the industry's extractive business practices have played out in the HCBS sector, putting clients, workers, and smaller providers at risk. It concludes with a list of tools and approaches at the federal and state level that can be used to protect these much-needed services. Together, this information and analysis can provide a framework for clients, workers, providers historically grounded in community-based models, and policymakers to understand how private equity is showing up in their own geographies and spur a discussion about how to protect HCBS in this critical time for the sector.

Private equity leveraged buyouts occur when a private equity firm uses significant amounts of debt—up to 80 percent of the sale price—[1] to finance a takeover of a company or a nonprofit.[2] The debt becomes the responsibility of the bought company to pay off. As a result, high levels of private equity transactions are alarming for the HCBS sector, as this debt can undermine the financial stability of providers and leave far fewer resources for care for clients and their families. (The full details of this model are discussed in Section V.)

Millions of older people and people with disabilities receive integrated support services and health care that are critical to their well-being and independence in home and community based settings. Over the past two decades, successful campaigns have increased funding streams for these services, dubbed home and community based services, which now make up nearly two-thirds of long term services and support ("LTSS") spending under the Medicaid program, up from just over one tenth in 1988.[3] This complements the other significant share of LTSS spending, in nursing homes and other institutional care settings.

In the same period, the private equity (PE) industry has amassed substantial influence across the full range of aging and disability care – from nursing homes[4] and home health agencies[5] to hospice,[6] behavioral health,[7] durable medical equipment,[8] and autism services.[9] In home health and home care, private equity accounts for roughly 10 percent of the sector, as PE firms have bought up hundreds of previously independent providers to create some of the largest home- and community- based services chains in the country. This mirrors a peak of four in 10 of the largest for-profit chains owned by private equity in the nursing home industry[10] and in childcare, where eight of the top 10 chains have

had private equity involvement.[11] In this way, private equity has inserted itself into the fabric of how services are provided and resources allocated in these areas of critical care infrastructure.

Private equity's growing control threatens the future of HCBS in four ways:

> A speculative business model and direct control of several of the largest providers, many of which are now debt-laden, undermines the stability of the care economy at a critical time for these services;
>
> Financially extractive practices leave less money for care, and workers and clients pay the price;
>
> Takeovers of self-directed care and larger agencies undermine family and client autonomy and crowd out community-based providers; and
>
> The private equity industry's role in HCBS advocacy could steer any *new* resources into windfall corporate profits instead of client care.

Private equity is endangering the home health ecosystem at a time where there is a clear shortage and need for increased supply, with 825,000 people on the waitlist for these services.[12] Its extractive model is a threat to the gains families have made to be able to care for their loved ones across a range of appropriate and accessible settings. A model that focuses on care as a public good, responsiveness, on-the-ground relationships, existing support systems, and keeping decision making with clients and their families should not be hijacked by corporate interests with a buy-to-sell approach that seizes control of the care apparatus, saddles it with unsustainable debt, and puts profits over care.

III. Where private equity is shaping Home and Community Based Services

Since 2010, private equity has been extremely active in home and community based acquisitions,[13] consolidating hundreds of for- and non-profit entities into three dozen flagship brands.[14] A number of studies have demonstrated private equity's sizeable presence in specific subsectors of the HCBS continuum such as hospice[15] and durable medical equipment.[16] This report explores elder and disability care with a focus on long term care, in particular home care and home health agencies, self-directed care and family caregiving, and select community based facilities, because increasingly, private equity firms are bringing all of these services under one umbrella. Several of the chains covered in this report are also active in the other related HCBS specialties, such as hospice or durable medical equipment. This diversified service model makes it difficult to ascertain specific market share, but points to one of the key strategies private equity firms pursue in their takeovers of the industry: amassing the largest possible client base and a multiplicity of revenue streams.

Large multi-service chains owned by private equity shape the broader national landscape

Today, a number of private equity-owned firms are among the largest HCBS chains in the US (Table 1). These chains usually combine both home health and home care activities in one business.

Table 1. Private Equity Owns Several of the Largest HCBS Chains

Brand	Services	Private Equity Involvement	Size*	Geography
Help at Home	Home care Home health	**Wellspring Capital Management** 2010- present (now minority share) **The Vistria Group, Centerbridge Partners** 2020 - present	57,000 workers, 70,000 clients	180 locations in 11 states
Accentcare	Home care Home health	**Oak Hill Capital Partners** 2010 - 2019 **Advent International Corp.** 2019 - present **Ares Capital Management** Unknown - present	30,000 workers, 200,000 clients	250 locations in 31 states, DC
Aveanna Healthcare	Home care Home health Hospice	**Bain Capital** and **J. H. Whitney Capital Partners** 2017 - present	30,000 workers 40,000 clients	265 locations in 33 states

Brand	Services	Private Equity Involvement	Size*	Geography
	Medical supplies	*Controlled publicly-traded: - these PE firms own nearly 70% of all shares*		
Interim Healthcare	Home care Home health	Franchise Five separate private equity leveraged buyouts since 1997; the most recent by **Wellspring Capital Management** 2021 - present	43,000 workers, 190,000 clients	300 franchises in 44 states
Elara Caring, Inc.	Home care Home health Hospice Behavioral health	**Angelo, Gordon & Co.** and Eureka Capital Partners 2007 - 2016 **Blue Wolf Capital Partners and Kelso & Company** 2016 - present	26,000 workers, 60,000 clients	200+ locations in 18 states
Senior Helpers	Home care Home health			320 locations (company-owned and franchised) in 43 states, Canada, and Australia
Comfort Keepers	Home care			45 states

Note: Grey text indicates prior ownership.

**It can be difficult to compare different firms in the home health and home care sectors, since they cover a wide range of services and have multiple revenue streams. Brands that have a greater share of short-term post-acute home health may see more clients per year than those companies that have a greater percentage of their work in home care.*

The combined footprint of the private equity-owned HCBS companies' is second only to the consolidated chains owned by large private Medicare ("Medicare Advantage") insurers like Humana (with the brand Centerwell Home Health) and Optum/UnitedHealth (with its takeover of LHC Group).[17] To give a sense of comparative size of these insurance-owned entities, Optum-owned LHC group has 527 locations and 500,000 clients in its predominantly home health business, while Centerwell, owned by Humana, serves 350,000 clients per year through 360 locations. For some large buyouts, private equity and these publicly traded corporations have worked together in these multi-billion-dollar purchases in the industry, driving the resulting market consolidation.

For example, in 2018, Humana and private equity firms Welsh, Carson, Anderson and Stowe (WCAS) and TPG Capital (TPG) together purchased the hospital and healthcare chain Kindred Healthcare.[18] They rebranded the home health, hospice, and community portions of the company Kindred at Home, with WCAS and TPG controlling 60 percent and Humana 40 percent. The physical facilities (long term acute care hospitals and rehab sites) were entirely bought by the two private equity firms. Then, in 2021, Humana bought out TPG and WCAS to wholly own Kindred at Home,[19] incorporating it into its Centerwell brand. It spun off the home care and hospice portions of Kindred at Home to yet another private equity firm, Clayton, Dubilier & Rice (CD&R), in a 2022 leveraged buyout.[20] In that transaction, Humana kept a 40 percent minority share in the newly resurrected Gentiva Health Services while CD&R[21] took majority control (Kindred had previously retired the brand after a 2015 acquisition).

The level of private equity driven industry consolidation has been of such concern that the Department of Justice has sued to block several of them. The concern is that a handful of private equity-owned chains will exert concentrated or monopoly control in the industry and have the ability to raise prices or cut off services. For example, private equity was poised to play a critical role as a ready buyer in another giant, pending transaction which the Department of Justice (DOJ) sued to block in November 2024.[22] VitalCaring (owned by private equity firms Vistria Group and Nautic Partners)[23] proposed to buy some home health locations that the prospective merging firms Amedisys and Optum are divesting in an attempt to complete one of the largest ever contemplated home-based care mergers more palatable to antitrust regulators.[24,25] The DOJ complaint asserts that VitalCaring is not a viable buyer, explicitly noting its private equity control and calling it an "unproven company with only three years of operational experience, poor financial performance, and potentially catastrophic legal exposure."[26] The complaint goes on to stress that Vistria Group and Nautic Partners have written down their valuations of the firm because of negative financial performance, and that locations taken over by VitalCaring have "seen their quality decrease post-acquisition" by the private equity backers.[27] Earlier, the Federal Trade Commission's scrutiny of private-equity-controlled Aveanna Healthcare's proposed $1.25 billion purchase of Maxim Healthcare scuttled the transaction when both parties walked away.[28] Had the FTC approved the merger, it would have made Aveanna one of the largest home health providers in the country.

For clients and families, the dizzying changes characteristic of private equity ownership can make navigating the system to find quality and responsive care difficult, especially while handling the financial and emotional stress of caring for a loved one with an illness or disability. Private equity firms have adopted a range of strategies in how they organize care chains: formally merge the new business into an existing brand; keep the two related (and competing) businesses separate; rebrand a whole range of smaller entities into a new, larger name, either keeping some reference to the older entities or

subsuming them altogether; or some combination of all of the above. For example, the LinkedIn profile for Sonas Home Health Care, which specializes in pediatric in-home nursing, reads: "Sonas is now a part of the Care Options for Kids network! This partnership will allow our passion and dedication to providing the highest quality nursing."[29] The Sonas website, sonashomehealth.com redirects to careoptionsforkids.com. Meanwhile, Solace Pediatric Healthcare, another brand bought up by Care Options for Kids, has retained its brand and website, but notes in its website header that it is a "Care Options for Kids" company. This allows Solace to continue to advertise that it was founded by an occupational therapist in 2005, giving prospective clients a sense of homegrown commitment, even while it has been agglomerated into a private equity home care chain.

Disability and pediatric care HCBS chains are the site of repeat private equity transactions

Some private equity-owned chains specialize in services for those with physical and/or intellectual and developmental disabilities (I/DD), which can span home and community settings. The true size of this sector, which was traditionally composed of faith-based or non-profit providers and is "one of the most complex and fragmented…of the behavioral health industry" can be hard to measure, but some estimates are that 20 percent of providers are part of larger non-profit or for-profit chains.[30]

The largest of these specialized private equity-owned firms is BrightSpring Health Services, a publicly-traded firm controlled by private equity behemoth Kohlberg, Kravis, and Roberts (KKR) that serves over 35,000 clients per year through its home care segment.[31] Sevita Health (previously the MENTOR group) is another large scale for-profit HCBS provider, with foster care, behavioral health and I/DD services as well as an arm for adult day and in-home health care,[32] with approximately $3 billion in annual revenue.[33]

Some private equity firms are repeat HCBS players across subsectors. The same duo behind home care giant Help at Home - Centerbridge Partners[34] and the Vistria Group - bought Sevita in March 2019[35] for $1.4 billion.[36] Vistria appears to have sold its stake, leaving Centerbridge and Madison Dearborn Capital Partners as investors.[37] Madison Dearborn was actually the company's first private equity buyer back in 2001, when it took over The MENTOR Network in a leveraged buyout,[38] before offloading to another private equity firm, Vestar Capital Partners, in 2006 for $800 million. Vestar took the company public through an IPO in 2014,[39] but retained a majority stake until it sold the company to the current owners, who took it private again.[40] As discussed in Section X, these repeat transactions create additional debt burdens that can threaten the stability of these providers.

Both of the large private equity-owned disability care chains have deeply troubling records, as discussed below in Section IV. In addition to these specialized businesses, three of the large private

equity-owned home care/home health chains, Aveanna,[41] Elara Caring,[42] and Help at Home,[43] also provide services in I/DD home care.

Private equity firms have also invested in smaller, regional outfits, with the hopes of turning them into larger players. Repeat buyer Webster Equity Partners formed the Redwood Family Care Network, now one of California's largest HCBS I/DD providers, by merging People's Care and the SAILSgroup in 2021.[4445] Pharos Capital Group bought The Baroco Corporation, with five community-based day habilitation programs in Massachusetts and three day support programs in Connecticut in 2023.[46] Support, Inc., a small Colorado-based day and residential HCBS provider specializing in I/DD populations,[47] was bought by private equity firm Petra Capital in 2021.[48] These investments demonstrate that middle-market private equity firms are interested in even highly localized disability care providers and continued activity in this subsector is likely. Ultimately, these chains may be swallowed up by still larger providers. Consolidation is usually a one-way street: firms rarely divide back up into smaller entities.

Similar to its role in disability care, private equity has a significant presence in the specialized pediatric home care chains for children with disabilities and complex medical needs. These include Care Options for Kids, Pediatric Home Service, At Home Healthcare, Angels of Care and Team Select Home Care.[49] In addition, VitalCaring, Aveanna, and Interim all have a pediatric home care segment within their larger business, with VitalCaring's operating under its previous name, "At Home Healthcare." According to analyst reports, Aveanna holds a "leading niche position in the otherwise fragmented market of pediatric home health services."[50]

Community based elder care: another frontier

Another smaller portion of the community-based service sector, adult day centers, remains primarily non-profit,[51] although the largest adult day center chain, Active Day, with 100 locations in 10 states, is owned by Audax Private Equity (Table 2). Similar to the disability care sector, smaller regional chains of adult day centers assembled by private equity abound. Edgewood Healthcare, which includes a range of residential and day elder care services and is owned by private equity firm Badlands Capital,[52] operates 24 adult day/memory care centers in the Dakotas, Nebraska, Montana, Idaho, and Minnesota.[53]

Private equity has also taken a significant interest in Medicare's Program of All-inclusive Care for the Elderly ("PACE"). The largest PACE provider, InnovAge, converted from a non-profit to private equity control under four separate buyers through a leveraged buyout in 2016. Under private equity firm Welsh, Carson, Anderson & Stowe's (WCAS) control, InnovAge sought to boost patient enrollment at its facilities, which generated more revenue as a result of increased PACE funding for

these patients.[54] Ballooned enrollment soon outpaced staffing capacity, leading to a subsequent decline in care quality, evident in the multiple false claims lawsuits, negligence-related investigations, and various state government sanctions against the home health company. While these patient care problems proliferated, in May 2019, WCAS paid out $66 million in dividends to its shareholders.[55] In 2023, the remaining private equity firms Apax Partners and WCAS conducted an initial public offering, but still control over 85 percent of the stock.[56]

The assisted living model is still largely paid for out-of-pocket by clients, but 43 percent of facilities are certified for Medicaid[57] and approximately 20 percent of residents have their assisted living covered by Medicaid HCBS funding.[58] Two of the top ten assisted living chains are owned by private equity: LCS and Pacifica Senior Living, with 6,300 and 5,300 units respectively.[59] As is characteristic of private equity involvement in HCBS, changes in ownership are paired with a troubling record for residents.[60]

Conducting assessments and determining what care clients can receive

Private equity-owned HCBS providers often also take on public contracts to serve as independent assessor entities that review individual clients' needs to determine the amount of HCBS they can receive under Medicaid.[61] Many firms then also control agencies that provide the services. Other private equity firms have purchased backend healthcare support services that specialize in needs assessments, such as private equity firm The Carlyle Group's Acentra Health,[62] which administers needs assessments in several states, including Virginia, Wyoming, and Pennsylvania, as well as for the US Department of Labor.[63] In addition, Acentra provides claims and payment processing as well as utilization management. In all, the company has contracts with 45 out of 50 state Medicaid agencies and 25 different federal agencies.[64] Private equity firms control both national case review contractors for Medicare's Quality Improvement Organizations program:[65] Acentra, and Livanta, which is held by The Acacia Group, Petra Capital Partners, Five Points Capital, and Concentric Investment Partners. These two companies are in charge of reviewing all Medicare quality of care complaints as well as general quality review processes for Medicare providers. In this way, private equity has inserted itself into the entire workflow of HCBS, shaping care through a myriad of decisions that remain hidden from clients and their families, as well as community-based and other independent providers.

Private equity has inserted itself into self-directed care - included paid family caregiving

Private equity firms have won lucrative state contracts to facilitate HCBS services, and end up taking control of significant parts of self-directed care programs. As families have won increased funding to self-determine care for older adults or disabled family members by managing an allocated Medicaid

budget themselves, states have sought to streamline the systems and supports they rely on. Private equity has seen this as yet another market opportunity. For example, state Medicaid programs typically contract with community-based non-profit organizations to conduct the assessments to determine their members' level of need for HCBS. Employees of these organizations, such as Independent Living Centers and Aging Services Access Points, know their communities, the programs and services that are available, and often have personal experience with the programs themselves. Recently, some states have moved toward contracting with a single Independent Assessor Entity (IAE) to perform this function. Many of these states have engaged large, national or multinational for-profit organizations as their IAE. An example is Acentra Health, which was formed in 2023 by the merger of CNSI and Kepro, and is backed by the Carlyle Group.[66] North Carolina recently awarded a $56.9 million contract to Acentra to be its "Comprehensive Independent Assessment Entity." Under this contract, Acentra will implement and operate the state's new delivery model that creates a single point of access for multiple LTSS programs.[67]

Private equity firms also act as employers and fiscal agents for family caregivers. Aveanna Healthcare is one of the eligible Financial Management Service providers in California's Self-Determination Program (SDP),[68] meaning families contract with Aveanna to serve as the employer of record of the caregivers and handle payment for the services chosen by the family. Aveanna helps find, vet, and pay these caregivers as well as handle the overall budget and payment for other providers,[69] in exchange for a monthly fee paid by the families.[70] One commenter in a support group for families enrolled in the program observed in a now removed post that:

> Now an equine therapy/PT/OT program (NCEFT) would like to participate in the SDP program but they've had so much trouble getting payment over the past two years they've had to put a total moratorium on accepting third party payment, so SDP families are losing this resource. (Aveanna got really behind and little companies don't have time/staff to chase down payments)...SDP individuals simply **won't be able to access needed services from small organizations** who need payment within 10 days.[71] (emphasis added)

Aveanna essentially acts as a gatekeeper that can exert concentrated market pressure on other service providers within the state because of its role as a payment facilitator as well as because of its size. This especially damages smaller organizations that cannot handle the cash flow interruptions and delays caused by these larger third-party payment organizations.

In New York, private equity-owned Public Partnerships LLC was just awarded the contract to become the *sole* fiscal intermediary for the state's nine billion dollar self-directed Consumer Directed Personal Assistance Program, or CDPAP.[72] The contract was granted over the objections of disability rights and provider advocates,[73] with significant procurement irregularities, and despite pending litigation against Public Partnerships by home care workers

alleging wage theft related to overtime pay in another state.[74] Ironically, Governor Hochul claims to have made the changes to address evidence of waste in the program. Weaving private equity further into the system is unlikely to root out these problems and has turned a client and family self-determination approach into yet another site of corporate control and widespread worker abuse.[75]

In Colorado and Arizona, Aveanna serves as the employer of record for the caregivers families work with. Team Select Home care offers family caregiver programs in six states.[76] Team Services Group—not related to Team Select—supports over 100 different HCBS programs in 29 states through software for both providers and clients. It has also acquired 12 different home care agencies,[77] including Circle of Life and Soaring Eagle,[78] which serves the Indigenous community in six states, and Hmong Home Health Care, which focuses on the Hmong community in Minnesota.[79] In total, Team Services has over 80,000 caregivers and services 60,000 clients, making it one of the larger private equity-owned HCBS providers, though its footprint is even more opaque than several of its private equity counterparts since so much of this reach is through their self-directed services business. In this way, private equity has inserted itself into the entire workflow of HCBS, shaping care through a myriad of decisions that remain hidden from clients and their families, direct care workers, and community-based and other independent providers.

IV. Why private equity has a growing interest in care

Seismic shifts, fragmentation, and racially structured labor markets

Until 1980, only non-profit home health agencies were eligible for payment through Medicare.[80] Once this restriction was lifted, the industry rapidly shifted, and by 2020, 83.5 percent of home health agencies were for-profit.[81] This major change in for-profit eligibility helped set the stage for the rapid influx of private equity into what appeared to be a lucrative market. Home care is attractive to private equity buyout funds because it is complex and fragmented, offering numerous inefficiencies and inconsistencies for private equity companies to exploit for financial gain. It also offers steady demand and revenue streams, a large share of which are public dollars, which is especially attractive during economic downturns.[82] This is similar to many other segments of healthcare.

Private equity firms began rapidly consolidating the fragmented landscape of over 11,000 home health providers, many of which also provide home care, starting 15 years ago.[83] The industry has been pursuing serial merger and acquisition strategies to roll-up smaller firms into larger companies that can build market power to generate higher revenues and eventually be resold at much higher prices.[84] Firms pay a high price for a first "platform" company in a sector, then "bolt-on" many subsequent purchases

of smaller firms, "rolling up" these acquisitions into a larger company that can then be sold at a substantial premium even if there were no operational improvements (the whole becomes worth more than the sum of the parts). Emphasizing this strategy, the website for Help at Home, a home-based care company offering services in a dozen states, includes a "Partnerships" page, soliciting other companies for acquisition. The page boasts of Help at Home's in-house mergers and acquisitions team. Private equity firms also make their pitch to small HCBS providers directly instead of through their existing portfolio companies. Dallas-based private equity firm Actinium Holdings encourages small providers to sell by playing on concerns about changes in the sector and owners' retirement goals, asking "Are you a home health, hospice or provider services owner worried about how to keep your business thriving in constantly changing and tightening regulatory and payer environments?" and encouraging them to "[l]earn how Actinium Holdings can ease your stress and get you back to the things that you enjoy to do!"[85]

No single firm has significant national market share even after all this merger and acquisition activity. However, at the level that clients and families obtain care, more than half of local markets have become highly concentrated, as defined by the Herfindahl-Hirschman Index (HHI), a measure used by the US Department of Justice and Federal Trade Commission to evaluate market concentration and competitiveness,[86,a] or dominated by a small number of providers, due in no small part to private equity-driven consolidation. For example, BrightSpring Health Services owned locations across NC, TN, and MS in five cities (Burlington, NC; Manteo, NC; Brownsville, TN; Martin, TN; Indianola, MS) where they were the *only* CMS-registered home health provider and captured 100 percent of the Medicare payments to registered home health agencies in those cities in 2022.[87,88,b]

Larger HCBS providers can harm workers by keeping wages and benefits low and only offering precarious schedules that keep workers from earning living wages or having stability. Private equity has often focused on sectors where occupational segregation has pushed women of color into low-wage jobs with low unionization rates,[89] such as retail.[90, 91] Care work is even more precarious, as women of color and especially Black and undocumented women often work in homes under informal arrangements that are not well regulated – often resulting in denial of basic worker rights.[92] Eight-six percent of direct care workers are women, 53 percent are women of color, and 40 percent are immigrants.[93] The average wage for direct care workers is $15.60 per hour, the fifth lowest among all occupational groups.[94] Private equity roll-ups and interrelated home health conglomerates that

[a] The HHI is calculated by summing the squares of the market share of each company in a given geography. An HHI of greater than 1,800 is considered highly concentrated.

[b] BrightSpring Health Services had changed private equity owners since 2010, most recently acquired by a consortium of firms led by KKR in 2019. The private owners took it public in 2024, but KKR remained invested with a major stake in the company.

heighten local market concentration worsen conditions for workers, because the private equity care networks can become a dominant local sectoral employer that suppresses wages and hinders switching jobs to find better pay through networks and blacklists. These kinds of labor market conditions can make it easier for firms to keep their operational costs low as they seek to extract as much profit as possible from their acquisitions, but harm the workers who are the care providers.

Growing demand for HCBS

One reason for the heightened private equity activity in HCBS is the surging demand from demographic and policy changes. In 2022, 57.8 million people were aged 65 or older, making up 17 percent of the population.[95] By 2040, this will grow to 78.3 million, or 22 percent of the population. Fifty-six percent of people turning 65 between 2021 and 2025 will have a significant need for long term services and supports in their lifetime.[96] Demand for direct care workers is projected to grow 41 percent from 2021 to 2036.[97]

At the same time the public — led by disability advocates — has increasingly demanded more home and community-based services that has led to major policy shifts to provide more services in these settings. Starting in 1981, after a hard-fought victory by disability justice advocates to move individuals out of institutional facilities, the Medicaid Home and Community-Based Services Waiver Program created the first public funding stream for such services.[98] The Supreme Court's 1999 *Olmsted* decision established that under the Americans with Disabilities Act, people with disabilities have the right to receive services in the least restrictive setting that the individual desires (and treatment professionals agree is appropriate).[99] Home-based care can also cost less than providing care in institutions, at $5,000 per month (for a 40+ hour week) compared to $8,000 to $9,000 per month for nursing home care.[100]

Reflecting these realities, the Affordable Care Act and the American Rescue Plan Act included incentives for "rebalancing" long-term supports and services (LTSS) towards HCBS, along with new Medicaid state plan options for HCBS. As part of such rebalancing, most states have shifted the focus of their Medicaid programs from facility-based care to HCBS. Nearly all states have at least one section 1915(c) Home- and Community-Based waiver in their Medicaid program, which allows the appropriate provision of HCBS services for certain people that are determined to be at a nursing facility level of care. States can also provide HCBS without a waiver under the authority of sections 1915(i) and (j) of the federal Medicaid law (Medicaid state plan option and self-directed personal care services, respectively). Today, all states deliver LTSS to more than half of eligible recipients in a home or community-based setting; one-quarter of states provide at least 90 percent of the care in these settings. Nationally, 86.2 percent of LTSS users received HCBS in 2021.[101]

In 2020, 4.2 million people used paid home and community based services.[102] Another 825,000 were on waitlists. At least 53 million family caregivers, most of whom were unpaid, provide part-time care to loved ones, often supplementing the work of other, formal paid caregivers.[103] The trend of increased in-home care was accelerated by the COVID-19 pandemic, when nursing homes had a high mortality rate; the virus killed over 170,000 residents.[104] The total number of US nursing home residents dropped 12 percent between 2015 and 2023.[105]

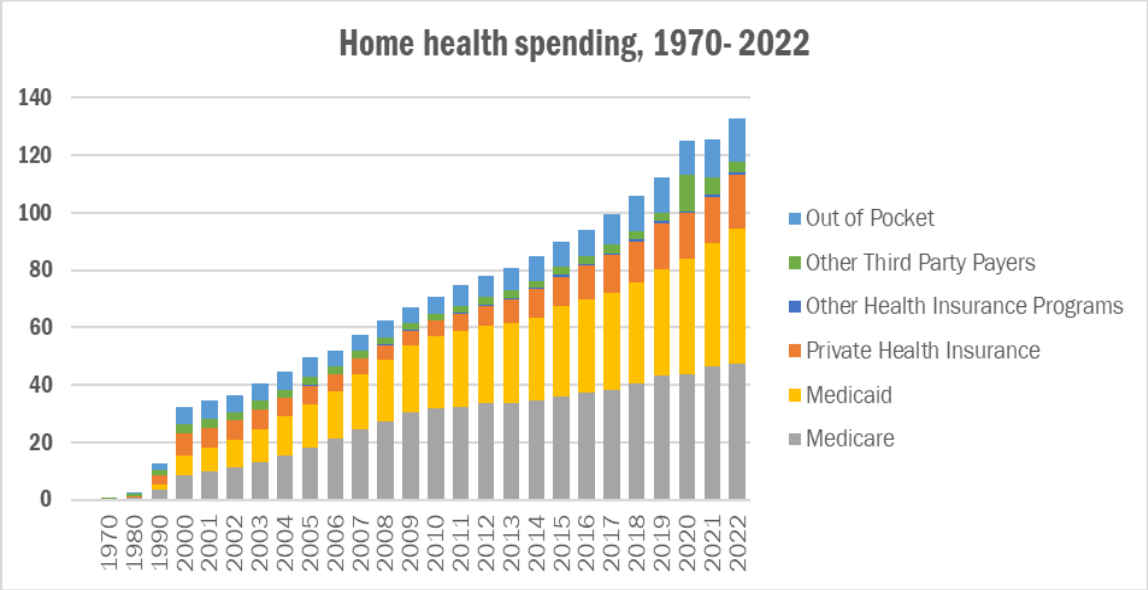
These policy shifts shape and are in turn shaped by individual preferences: as HCBS have become more available, people are taking advantage of the options if they prefer to remain in their home or community.

Guaranteed revenue stream of public dollars

Along with these demographic and policy shifts, private equity is drawn to home and community based care because it has seen a steadily growing stream of spending. Home based health spending totaled $147.8 billion in 2023, with 70 percent from public programs (half of that from Medicare and half from Medicaid), and the rest from private health insurance or clients paying out of pocket (Figure X).[106] Home health expenditures are expected to double in the next 10 years to $282.7 billion in 2032.[107]

Medicare covers home health for post-acute services for those returning from hospital or nursing home treatment and Medicaid covers long-term non-medical care services in home settings through state benefit options and HCBS waivers. Clients for these services are usually older adults and people with disabilities of all ages. Community based care providers manage group homes, day habilitation, intermediate care facilities, and supported employment. These serve people with disabilities as well as older adults.

Figure X. Public home health spending increase, 1970- 2022



Over the past two decades, advocates have succeeded in increasing government funding streams for home and community based settings, which now makes up nearly two-thirds of long term services and supports spending under the Medicaid program, up from just over one tenth in 1988.[108]

Private equity firms like steady and guaranteed payments from Medicare and Medicaid, which can help them pay down interest on their debt-financed takeovers. Often, in larger private equity owned chains, the same home care agency or company provides both types of services, in order to secure access to multiple revenue streams. This is part of a larger trend of private equity firms availing themselves of public revenue streams and funds. During the COVID-19 pandemic, 611 portfolio companies owned by the largest private equity firms received a total of $5.3 billion in CARES Act relief, with six percent of that, or $231 million, going to home health companies.[109]

Exhausting other options

The private equity buyout model runs on short-term horizons and a large volume of transactions, which means it needs to regularly move into new sectors. Private equity has already torn through the adjacent nursing home sector, which featured many of the same characteristics as the HCBS sector where big chains bought local non-profits that had provided these much needed services.[110] Much of this shift was driven by private equity takeovers, and the sector has gone through many bankruptcies, leaving investment firms to look elsewhere for their next opportunities.[111] As researcher David Hoffman observes, "The data has shown that private equity has in some ways finished exploiting the nursing home industry and moved onto other health care segments that impact the elderly."[112]

V. How the private equity model is a threat to clients, families, workers, and other care providers

Private equity's HCBS footprint is of particular concern due to the risks created by its business model, which is, as one study put it, "fundamentally incompatible with sound healthcare that services patients."[113] Private equity firms' debt-driven acquisition model and use of extractive tactics like dividend recapitalizations, fees, sale lease-backs, and rapacious cost cutting leaves less money for care recipients' needs and workers' livelihoods, and causes instability in the HCBS sector, often leading to bankruptcy and closures. This has harmful consequences for those needing care, for workers, and for the care system at large. As private equity owned chains grow larger, they exercise greater control over the HCBS system, exerting monopoly power over clients and workers and translating it into political power to win more revenue—which is diverted into the pockets of private equity executives.

Private equity's use of debt and financial engineering leaves less money for care

The private equity acquisition model is fundamentally harmful

Private equity takeovers of companies are usually financed by a high degree of debt—between 60 and 80 percent of the purchase price—which becomes the responsibility of the purchased company (in this case, the home care or home health agency), not the private equity firm, to pay back through high monthly interest payments.[114] This is where the term "leveraged buyout" comes from. Often, this debt is also issued by a private equity firm—at one point in 2023, 94 percent of leveraged buyouts were financed through private credit from either hedge funds or private equity firms.[115]

The private equity firm usually puts a vanishingly small amount of its own capital—as little as one to two percent—into the fund used to complete the purchase; the balance comes from very wealthy individuals and institutional investors like endowments and pensions).[116] Private equity firms typically charge two percent in management fees each year to these investors, and take 20 percent of the profits (above a six to eight percent threshold) from managing and re-selling the companies they take over (known as the two-and-twenty model).[117] These factors create incentives for exaggerated risk-taking, as private equity firms benefit from an all-upside, no-downside model, reaping benefits from high returns while facing no losses beyond their miniscule equity contribution.

Dividend recapitalizations, prevalent within HCBS, further increase indebtedness

In addition to the heavy debt burden and fees tied to the initial private equity takeover, the dangers to the finances of the HCBS provider can be further compounded when private equity firms take out more loans to fund further acquisitions or to pay themselves dividends. In a "dividend recapitalization," the parent private equity firm takes out additional debt on the books of the portfolio company for the express purpose of giving owners—including the private equity general partners

themselves—a one-time dividend, or cash payout.[118] The amount, timing, and frequency are entirely up to the private equity firm, while the portfolio company is saddled with huge interest payments over years. The story of Help at Home provides a good example. Private equity firm Wellspring Capital Management took over home care agency Help at Home in a 2015 leveraged buyout. Wellspring held onto Help at Home for five years before selling most of its stake to two new private equity firms, the Vistria Group and Centerbridge Partners, in yet another leveraged buyout for a reported $1.4 billion,[119] with much of the purchase covered by debt (the firms put in $685 million of the total in equity). By 2021, Help at Home was approximately $760 million in debt.[120] But Vistria and Centerbridge did not stop there. The two firms took out three more loans totaling over $460 million in the next two years before borrowing another $1.5 billion to both refinance the previous debt and pay themselves and the other private equity owners a $262.6 million dividend in 2024.[121] Analysts estimated that this last move would add an *extra* $25 to $30 million per year to Help at Home's interest payments and noted key features of the private equity playbook:

> Our assessment of the company's financial risk profile as highly leveraged reflects corporate decision-making that prioritizes the interests of controlling owners, in line with our view of most rated entities owned by private-equity sponsors. Our assessment also reflects the generally finite holding periods and a focus on maximizing shareholder returns.[122]

For now, despite its indebtedness, Help at Home continues to expand rapidly. Between September 2024 and April 2025, it announced it had acquired nine separate home care businesses – three in Georgia,[123] two in Indiana,[124] two in Pennsylvania, one in Delaware, [125] and one in Florida.[126]

There have been several other instances of dividend recapitalizations in HCBS in the past few years. Giving Home Health Care is a home health provider specializing in care for employees who contracted chronic conditions through their work on the Department of Energy's nuclear energy programs. It has 4,500 caregivers and is concentrated in southwestern states.[127] In August 2022, FS Investments, a Philadelphia-based alternative investment firm, took over Giving Home,[128] and added $300 million in debt.[129] Then, in 2024, FS Investments took out *another* $650 million loan for a dividend payout.[130] In 2021, Sevita's private equity owners paid themselves a $375 million dividend—the third significant payout in 18 months.[131] It is notable that eighty-five to 90 percent of the company's revenue comes from Medicaid.[132] In this way, private equity owners siphon hundreds of millions of dollars of government funding earmarked for the HCBS system on these dividends, all while harming providers and workers. A 2024 study found that private equity dividend recapitalizations increased the likelihood of bankruptcy almost twenty-fold after six years and suppressed wage growth by 53 percent in a four-year period after the payout.[133]

Extractive fees leave less money going towards care

Private equity-owned HCBS providers typically have to pay annual monitoring or management fees back to the parent private equity firm in addition to increased interest payments after a private equity

takeover. These fees — like debt payments and dividend payments — constrain the private equity-owned provider's ability to pay for care and wages. Under Bain Capital and J.H. Whitney's control of Aveanna Healthcare for example, annual retainer fees came to $3 million dollars per year, which would increase when subsequent acquisitions increased Aveanna's valuation.[134] On top of the periodic fee, the private equity firms also charged an episodic fee for every subsequent merger transaction amounting to one percent of the purchase price, and they were also entitled to an additional lump sum fee of five times the standing annual retainer fee in the event of an initial public offering (IPO). In the case of BrightSpring's 2024 IPO, the company had to pay owners KKR and Walgreens a termination fee of $27 million as the monitoring agreement came to an end,[135] even though they remained controlling owners after the firm went public. AccentCare's local subsidiaries pay up to 12 percent of revenues to AccentCare in aggregate management fees per year.[136,137] BrightSpring disclosed in its prospectus that it pays a fee of one percent of earnings quarterly to KKR and Walgreens under its monitoring agreement,[138] and that it had previously paid $4.9 million per year in management fees. These monitoring fees can have a long reach — in BrightSpring's case, monitoring fees *that would have been* paid all the way through either three and a half years since the IPO, which was in January 2024, or December 31st, 2028 have to be paid in a lump sum back to the sponsors. These fees add up quickly.

Enlivant, which used to be the third largest assisted living chain nationally, went out of business in the fall of 2023 after private equity company TPG and real estate investment trust Sabra ran it for ten years. When TPG and Sabra took over the company in 2013, it was known as Assisted Living Concepts, and already had a troubled past: a union pension fund had sued the former CEO accusing him of providing misleading information regarding finances and regulatory violations, and the company settled the claim for $12 million.[139] In the intervening years, TPG and Sabra pursued the typical extractive tactics, leaving little money for improving quality of care.[140] An audit noted that the company paid its private equity owners $3.7 million in management fees and $4.48 million in overhead costs (both about triple the charges in 2021) as well as a new $1.6 million in incentive fees that kicked in after three years of current ownership. On top of this, Enlivant paid Sabra and TPG a total of $45 million in "support fees" over two years "acknowledging the unprecedented challenges and significant economic stress caused by the COVID-19 pandemic."[141]

The financing process can also introduce significant self-dealing and fees. BrightSpring noted in its prospectus that KKR Capital Markets, LLC, an affiliate of KKR, was one of the main underwriters for BrightSpring's initial public offering.[142] Underwriters conduct due diligence so that they can stand behind what they report to investors before offering up shares for sale. An underwriter is supposed to include all the potential risks a company may face but having one arm of KKR playing a key role as an underwriter raises questions about how thorough it is in raising the potential risks of a company owned by another arm of KKR. KKR Capital Markets also "acted as an arranger and bookrunner" for

different debt transactions under two of BrightSpring's loans, and took a total of approximately $8.3 million from BrightSpring in underwriter and transaction fees between 2020 and 2021.[143]

Asset stripping is common in community based settings

One of private equity's preferred methods for quick cash extraction is the sale-leaseback,[144] where the owner separates out any real estate held by the HCBS entity and sells it off, forcing the provider to lease back the property and pay rent on properties it previously owned (an extraction that only applies to facility-based care). While home based services are protected from this particular maneuver, private equity firms have forced sale-leasebacks on community-based HCBS providers. Audax Private Equity placed three New Jersey facilities of Active Day, which has over 100 adult day care sites across the United States, up for sale after emerging from the pandemic, advertising that they had a steady stream of Medicaid supported clients and netting $5.4 million for their sale.[145] In exchange, each location will have to pay rent—one of the three adult day cares will now have an additional $133,700 in rent payments each year.[146]

Significant rental costs can compromise the finances of HCBS companies. BrightSpring owns 77 facilities but leases nearly 2,000 properties (overwhelmingly provider locations)[147] and its annual rental payments exceed $58 million.[148] BrightSpring's auditor noted the lease burdens were being underrepresented on its balance sheet, demonstrating the importance of rental payments. KKR or a prior private equity owner may have sold these properties out from under BrightSpring, but the rental expenditures are funds that cannot go toward providing care or paying workers.

Cutting corners leaves care on the chopping block

Private equity firms differ from other types of private capital, such as hedge funds or venture capital, in that they usually but not always take full control or a majority stake and operational control of portfolio companies. This allows private equity firms to enact swift changes in the day-to-day operation of the business. The debt burden, coupled with the relatively short time horizon for most private equity investment—on average three to seven years—creates a powerful incentive to make as much profit as quickly as possible.[149] Cost-cutting measures are a much faster way to increase profits than the more steady work of increasing revenues through investment and improving services, and are a favored strategy for private equity firms. In a healthcare setting, especially for older adults or clients with complicated cases, a propensity for speedy cost cutting measures can mean the difference between life and death.[150] In health care, this can come through tactics like using lower quality supplies,[151] understaffing, or increasing the use of antipsychotic medications to further reduce the amount of staffing needed.[152] Workers and patients bear the costs. One study found that patients at private equity-owned hospitals had a 25 percent increase in hospital-acquired conditions, due to a 27 percent increase in falls and a 38 percent increase in center-line related infections than at other

hospitals.[153] Both falls and infections are important considerations in a home or community based care setting as well —one study found that among home health providers, larger, for-profit companies and those with more patients of color were most likely to underreport falls to CMS , with for-profit companies failing to report falls 56 percent of the time.[154] In nursing homes, private equity ownership led to a 10 percent increase in mortality rates, causing 20,000 excess deaths.[155]

There is particularly disturbing data about the impacts of private equity ownership in community-based disability care. Sevita Health (formerly The MENTOR Network, or "MENTOR") owned by private equity firms Centerbridge Partners and the Vistria Group, is large scale for-profit specialized HCBS provider, with foster care, behavioral health and I/DD services as well as an arm for adult day and in-home health care. A 2015 *Buzzfeed News* investigation of Mentor found instances of murder, sexual abuse, and neglect in the company's operations,[156] and spurred the US Senate to launch an investigation into private foster care providers.[157] In response to a Senate Finance Committee's information request, MENTOR announced in 2015 that it would cease operations in five states (Florida, Louisiana, Indiana, North Carolina, and Texas)[158] while maintaining its operations in seven other states.[159] Further press investigations found additional instances of neglect, abuse and death in Iowa[160] and Oregon,[161] in both at home and residential settings, prompting the Senate Finance committee to again request information from the company in 2018.[162] But the practices continued, as documented by a second Senate report.

The first Senate investigation found that between 2005 and 2014, 86 children enrolled in MENTOR's programs died, which made its "death rate among foster children… 42 percent higher than the national average."[163] The later investigation, released in December 2020, found "a consistent pattern of substandard care persist[ed]"[164] in MENTOR/Sevita's Oregon practice, even after a settlement with the Oregon Department of Human Services that required the hiring of a new executive director in Oregon, adding new training, conducting a full evaluation, and improving recordkeeping. In Iowa, the MENTOR/Sevita subsidiary failed to report instances of abuse and neglect, including sexual abuse, and ignored client medication and care schedules.[165] A former Sevita disability group home director described conditions at a California facility as some of the worst she had ever seen, alleging chronic understaffing and overuse of medication. Company records show routine lack of compliance with training requirements and neglectful treatment of clients, including leaving one resident on the toilet for hours at a time.[166] In 2021, Centerbridge and Vistria extracted $375 million to fund a dividend recapitalization payout to investors,[167] all while Sevita "was forced to increase use of expensive overtime and contract labor to meet required staffing levels in its facilities."[168]

The swift transactions and quick name changes characteristic of private equity involvement can serve as a way to evade the notoriety that comes from cutting corners in client care. It is no surprise

Centerbridge and Vistria decided to change MENTOR's name[169] while buying up 27 smaller providers in 15 months.[170] Through the rebrand and aggressive mergers and acquisitions strategy, Sevita now operates in more states than ever (41), and has returned to all of the states the MENTOR Group had previously exited.

This pattern, down to the name change, is not unique to Sevita. The other large disability care provider, BrightSpring, along with its private equity owner, KKR, were also the subject of a Senate inquiry[171] when a *Buzzfeed News* investigation documented multiple instances of abuse and neglect of clients with disabilities in BrightSpring's residential group homes after KKR's takeover.[172] (BrightSpring was previously named ResCare, and rebranded in 2018,[173] shortly before KKR took it over.[174]) The state of West Virginia had to enact a statewide admissions ban for BrightSpring facilities in 2020 after KKR and BrightSpring ignored multiple warnings of immediate jeopardy from state inspectors over conditions that resulted in at least one preventable death.[175] The ban was subsequently lifted as the result of a settlement agreement.[176] BrightSpring disclosed further serious violations, including instances in which clients had to be removed from its care, in its prospectus, including:

> regulatory inquiries and matters, such as recoupments as a result of alleged insufficient documentation, overpayments, audits, removals of clients as a result of staffing and incidents identified during a monitoring visit, contract terminations, suspensions or revocations of licenses, home closures, vendor holds, which may occur as a result of our failure to submit an acceptable report under state law, and administrative penalties issued as a result of staffing issues and incidents found during monitoring visits.[177]

Aveanna Healthcare has a similarly grievous record in pediatric home care. A *Bloomberg News* investigation found that the company "has left a trail of injury and death in some of the biggest states where it does business,"[178] with seven children dying under its watch in one year alone after staff did not check vital signs, give the right medicine, or even show up.[179] In Texas, the company received a disproportionate percentage of violations (85 percent) and an outsize number of complaints out of the ten largest pediatric home health agencies, despite serving only 23 percent of the clients. Former employees pointed to private equity owner Bain Capital's emphasis on profit. Bonuses were tied to earnings, collections, and hours of client care, and workers alleged the company would skimp on needed care in order to save on overtime. Aveanna did not fill its shifts or adequately train workers. Other private equity-owned chains face allegations about similar devastating behavior. Help at Home did not supervise or check in on a family caregiver in Indiana whom it had cleared even though he failed a caregiver competency test. The caregiver allegedly neglected and mistreated his brother, the client, who eventually died.[180]

Private equity perpetuates unsafe and unfair working conditions for care workers

Harmful conditions for clients are deeply connected to practices that hurt care workers as well. Private equity firms' emphasis on fast profits and taking money out of the system instead of investing it in care has created dangerous working environments and extremely low-wage jobs with high turnover, and private equity-owned brands face numerous allegations of wage theft.

Private equity chains fail to create safe working environments

Content warning: the following section contains descriptions of sexual and physical violence.

In a 2021 lawsuit, a care worker alleged that Aveanna failed to ensure a safe work environment, demonstrated indifference to acting on this lack of safety, and wrongfully denied benefits. The complaint states that the worker was providing at-home care for a child client in the summer of 2019, and she had safety concerns about the general conditions in the home, such as constant use of abusive language, daily police calls, and threats of violence. She allegedly communicated these concerns to Aveanna supervisors, but the concerns were ignored. Subsequently, the worker was allegedly sexually assaulted at the home by a member of the child client's family. The employee asserted that she was then terminated because Aveanna denied the fact that the plaintiff was sexually assaulted. The lawsuit was dismissed following a settlement agreement.[181]

In April 2024, the Occupational Safety and Health Administration (OSHA) fined Elara Caring a proposed $163,627 in penalties after a client killed a licensed nurse practitioner during a home care visit at a transitional housing site in Connecticut in October 2023. OSHA found that management had not adequately assessed and prevented hazards from workplace violence despite repeat instances where clients threatened and actually physically assaulted workers, ultimately resulting in this worker's death.[182] OSHA noted in its announcement that "Elara Caring failed its legal duty to protect employees from workplace injury by not having effective measures in place to protect employees against a known hazard and it cost a worker her life."[183]

Elara failed to pay for basic safety measures despite having significant resources at its disposal. As of September 2023, Elara Caring generated $985 million in annual revenue with $92 million in cash on hand, though $43 million of that was held in escrow for acquisitions, which meant it could not go to safety upgrades, additional staffing, or any other workplace improvements. Between October 2023 and June 2024, Elara's private equity owners bought up two new home care firms: Illinois' American Family Home Health[184] and Caregivers Home Health, which expanded the chain into Kansas and Iowa.[185] At the same time, Elara's response to the Connecticut incident was to suggest that it could not afford to meet basic worker safety standards as required under the law without more public funding. When testifying in front of a Connecticut Senate committee on a bill related to workplace violence in March 2024 in light of the October 2023 death, Elara connected paying for basic safety provisions to a lack of Medicaid funding.[186]

Analysts have repeatedly assessed that Elara Caring has been poorly managed through its aggressive expansion strategy, noting in 2022 that "Elara continues to face challenges controlling costs and improving referrals nearly four years after the merger of Jordan Health and Great Lakes"[187] and in 2024 that "the company has had a poor track record of integration, execution and cash flow management since the merger."[188] This mismanagement and lack of focus on the fundamentals of providing care harms workers and clients alike.

Giant, highly resourced firms paying poverty wages and committing rampant wage theft

Home care and home health agencies owned by private equity firms repeatedly claim they cannot afford to pay higher wages unless and until they receive increased government payments, all while extracting huge sums of money from the home care providers. Such recitations appear repeatedly in company comments about the CMS Medicaid Access Rule,[189] finalized in 2024, that mandates that 80 percent of Medicaid payments go to worker compensation in order to raise standards in the care economy, grow the care workforce, and ensure more clients have what they need.[190]Aveanna, which pays direct care workers as little as $10 per hour,[191,c] the lowest among its private equity peers, asserted that "[w]e can **only** increase wages, however, **if** reimbursement rates support those increases" (*emphasis added*). [192] At the same time, its annual report filed with the Securities and Exchange Commission, only a requirement for publicly traded firms, noted that "while our non-medical caregivers generally earn at or above the minimum wage, this has not historically been a source of risk to our margins…"[193] Help at Home, which pays its direct care workers $13 per hour,[194] averred in its CMS comments that it

> share[s] the desire to increase pay for [its] workers but can **only** do that when we receive Medicaid rates that are set at a level that permits us to also meet state-level operational requirements and the expenses necessary to ensure the delivery of high-quality services (separate and distinct from routine overhead costs) (*emphasis added*).[195]

Help at Home's comment did not discuss whether it considers the debt service for an unsustainable ninefold debt-to-earnings ratio or its private equity owners paying themselves out over $260 million in dividends within these "routine overhead costs."[196] AccentCare, which pays direct care workers $15 per hour[197] argued that the Access Rule should be withdrawn in its entirety and threatened that the "proposed rule will result in individuals going without essential community-based LTSS and eventually being forced into facilities, resulting in the institutionalization of such individuals."[198] Its comment emphasized all the other costs, in addition to worker compensation, that a home care agency must handle. Many of them, like worker benefits, are actually covered by the Access Rule, though the

[c] All wages in PA unless otherwise noted.

hundreds of thousands in management fees that each Accentcare location pays back to headquarters and the private equity owners are not. The other large chains also opposed the rule, and pay direct care workers very little: Interim pays $13 per hour[199] while Elara can pay as little as $11.15 per hour.[200]

Advocating for increased HCBS funding is beneficial for all providers, large and small, and for clients and families. Several of the private equity-owned chains pursue aggressive lobbying strategies to secure increased state Medicaid funding. For example, Aveanna Healthcare has pushed for rate increases in dozens of states for home health care for children with complex medical needs for a few years, and it touts its success on quarterly earnings calls.[d,201] The other large chains also pursue similar strategies.[202] But an elision lies at the heart of this advocacy approach, where these large, highly capitalized Wall Street entities hide their true financial circumstances to suggest that they are in the same financial boat as non-profit and small-scale HCBS providers, or even paid family caregivers.

These essentially billion-dollar firms plead poverty while baldly causing it for their workers. Most offer only part-time or irregular hours[203]—the average workweek for a direct care worker is 31 hours[204]—and the median annual salary for workers under $24,000.[205] Forty-seven percent of direct care workers receive public assistance;[206] the number that qualify for benefits is likely larger, as undocumented care workers can only access certain state benefits.[207] On top of this, the home care industry has long been a site of widespread wage theft. A 2009 study found that 12 percent of home care workers earned less than minimum wage.[208] Prior to 2015, many home care workers were not covered by overtime protections. The Department of Labor extended these protections through the Home Care Rule that year.[209]

Despite their larger size and access to hundreds of millions, or in some cases billions, of dollars of federal and state revenue, several of the private equity-owned chains have a record of repeated wage and hour violations. Because of their size, their practices have an outsized impact on workers across the industry. Two different lawsuits from Accentcare workers alleged unpaid overtime hours and either being directed to misrepresent hours worked on timesheets because the facility could not afford overtime or having hours edited to under-report overtime hours.[210,211] Both cases, filed eight years apart in 2014 and 2022, were settled. Three other lawsuits against Accentcare featuring similar allegations related to unpaid overtime between 2012 and 2018 were also settled. Another lawsuit, this time a class action against Guardian Home Care, which merged with Accentcare in 2010,[212] alleged that the

[d] "...We have secured double-digit rate improvements in both Georgia and Massachusetts effective the second half of 2024. These states demonstrate our government affairs strategy to partner with state legislatures and governors to identify shortfalls in private duty nursing wages and to align reimbursement rates to improve access to care for patients with complex medical conditions. I applaud the leadership in Georgia and Massachusetts for their partnership and investing in high-quality nursing care in the home setting. Year-to-date, we have secured 12 state rate increases with a few states still finalizing their legislative process. While we are pleased that our PDS legislative messaging has been well received by state legislatures, there is still work to do." (See note 201).

company illegally withheld overtime pay from nurses because part of their pay was structured as a fee-per-visit. The case settled for $3 million.[213] A lawsuit alleging that Compassus systemically denied California care workers pay for overtime, meal, and rest breaks was settled by the individual worker who sued; others may still bring suit.[214] BrightSpring and Sevita are also subject to ongoing litigation concerning alleged wage theft in California.[215]

Instead of improving wages, hours, and working conditions, or actually paying workers what they are owed, several of the private equity chains have started to offer paycheck advance products to workers. These products can have high fees on small dollar amounts, which can amount to a very high Annual Percentage Rate (APR),[216] in essence an employer linked payday loan. Aveanna advertises on its website that workers can "get a portion of [their] pay instantly" for a $2.99 fee using venture capital-backed DailyPay;[217] Interim Healthcare, using the same vendor, does the same.[218] DailyPay advertises that it has been working with BrightSpring since 2018.[219]

Private equity owned firms' low wage approach can have impacts beyond each individual company's employees. Private equity firms can exercise monopsony buyer power over workers at the local level, where the private equity chains become some of the only employers for home care work in local markets.[220] The private equity-owned companies' decision to keep wages low acts as a center of gravity that depresses wages across local markets beyond the companies themselves. In 2021, the Department of Justice's antitrust division issued a grand jury subpoena to Aveanna examining "nurse wages and hiring activities in certain of [its] markets, in connection with a terminated transaction" —likely its failed bid for Maxim Healthcare.[221]

Increased financial pressure and instability for the HCBS sector

Private equity's reliance on debt, short-term outlook, and growing presence in the HCBS sector all combine to expose more clients and workers to the risk of bankruptcy, closure, and loss of care. Several of the largest home care chains are at or near risk of default, even while pursuing a rapid acquisition strategy. As a result, if left unchecked, private equity's practices threaten the long-term stability of the care sector and the ability to maintain and meet growing demand for these essential services. Hamstringing larger home health agencies, especially those with increasing concentration in local level markets, with unsustainable debt burdens damages HCBS supply.

Private equity's complex financial engineering and extraction activities and lack of checks and balances can lead to one simple result: bankruptcy. One study found that private equity-owned portfolio companies are ten times more likely to go bankrupt than other companies (a 20 percent versus two percent likelihood, respectively).[222] The private equity firm Pharos Capital Group bought the home health and hospice chain Charter Home Health in 2018, and when it filed for bankruptcy in March

2024 it declared that it had $37.7 million in liabilities — seven times its 2023 revenue of $5.3 million.[223] Clients and families faced sudden closures and loss of services.[224] Both Elara Caring and Aveanna are at risk of default, with analysts rating Elara at CCC in January 2024 with a "realistic default scenario occurring"[225] and Aveanna at a "very high default risk" on one of its loans as of April 2024.[226]In particular Elara's debts were 16 times its earnings and it has several loans due between October 2024 and January 2025. While the analysts cheerfully assume Elara's businesses would be reorganized (sold off) rather than liquidated (closed) in the event of a bankruptcy,[227] the changes would still likely cause upheaval for clients and families. The risk of this type of financial meltdown increases as a growing share of critical HCBS infrastructure comes into contact with private equity's signature financial extraction.

Private equity's growing control in HCBS may lead to monopolistic practices

Private equity's growing HCBS footprint not only has ramifications for service supply and access in the event of bankruptcy, it can also impede needed growth in the system by blurring the lines between acquisition growth and the expansion of services. Consolidation reconfigures but does not add new supply. The growth of home health chains appears to have come almost entirely from merger and acquisition activity, not the opening of new ("de novo") locations, though without adequately transparent disclosure, it is difficult to be sure.[e] When larger firms do report on their new branches, as in the rare instance of a home care agency like BrightSpring having to follow public disclosure rules for its stock market listing, they can still obfuscate matters. BrightSpring's prospectus reports "the number of de novos opened since 2018, such number includes de novos opened by each business we acquired prior to our acquisition of such business if opened since 2018."[228] This doublespeak means that if one of its acquisitions had opened new locations before BrightSpring purchased it, BrightSpring might still count these locations in its own tally of new supply. This makes it exceedingly difficult to ascertain where, if at all, HCBS supply is increasing due to the influx of private equity capital.

Private equity's large presence in the industry also shapes how and where care is delivered through the political process. When larger chains expend time and money on advocacy and lobbying, they are able to use their size and clout to potentially win higher reimbursement rates for all providers, which is positive for the HCBS system *if* the increased funding is spent on care and worker wages. However, this political and market power can also easily be used in ways that benefits the private equity model and leaves clients, families, workers, and smaller for-profit and non-profit providers behind, particularly when private equity firms work against raising industry standards. Private equity-owned

[e] While the Biden administration did release ownership information about home health care agencies for the first time, it is not user friendly for families and clients to understand where there is shared ownership and/or where the ultimate owner is a private equity firm, health insurer, or other large corporation.

providers are often members of advisory committees at the state level that can set standards that affect clients and workers. Providers can also participate through industry associations like the Home Care Association of America, the National Association for Home Care and Hospice, and the Partnership for Medicaid Home Based Care. While the two former associations have representatives from private equity-owned chains on their boards along with other types of providers, the latter is composed almost entirely of the largest HCBS chains in the country, allowing private equity-owned chains to coordinate directly and frame private equity-driven recommendations as suggestions for the whole industry. Five out of the 12 provider members are currently owned by private equity firms and two more were previously private equity-owned. Additionally, private equity-owned medical supply and health tech firms are also among the 23 total members.

As private equity-owned chains grow larger, they can threaten to abandon geographies that they find less profitable, or frequently just do so, leaving clients, their families, and workers stranded. Hospitals in big cities, mid-sized cities, and rural areas have long been subject to private equity closures.[229] Now private equity-owned home care agencies are starting to follow a similar pattern of market abandonment. Help at Home elected to close its operations in Alabama in 2024, citing the state's failure to raise reimbursement rates.[230] In 2021, Interim Healthcare closed its San Antonio home health agency due to "continued financial loss"[231] and laid off 366 workers.[232]

Larger private equity-owned chains can use their scale and market power to secure deals on more favorable terms with larger payors or hospital systems, disadvantaging independent HCBS providers. Several of the chains have an explicit strategy to secure more contracts with these buyers or sources of referrals in order to have more guaranteed clients.[233] One private equity-owned chain, Compassus, formed a joint venture with non-profit health system Ascension and now owns 50 percent of Ascension at Home, the Catholic system's home health and hospice division.[234] The firms can also use their larger size to negotiate higher reimbursement rates from private payers, to the disadvantage of smaller providers, both for- and non-profit. At the same time, it does not appear that the larger chains are translating these increased revenues into higher wages for their workers or increased care for clients.

For all the churn and dealmaking within the HCBS sector, the management in these private equity-owned firms are often a familiar cast of characters. VitalCaring, a new home care and home health outfit created in 2021, was actually born out of competitor Encompass's now home care segment Enhabit.[235] Enhabit has sued private equity firms Vistria Group and Nautic Partners for allegedly conspiring with its former CEO, April Anthony, after Enhabit rejected a $3.6 billion buyout offer.[236]Anthony is now the CEO of Vistria and Nautic's newly formed VitalCaring home care business. Court proceedings revealed that in the run up to the creation of VitalCaring, Anthony projected to Vistria and Nautic that the new company would generate $780 million in profit in five

years.[237] The musical chairs in the largest home health chains—which extends beyond private equity firms to the insurance owned companies and large public corporations, is yet another way that the larger companies coordinate and even allegedly conspire across a few players.[238]

Vertical integration and related businesses can also extend private equity's control

Just as private equity's control over the HCBS system is advanced through ownership of both direct care providers and backend program administration, private equity firms also strategically pick portfolio companies that allow them to straddle multiple, related lines of business. Varsity Investment Group, a small private equity firm, makes its approach very explicit. The firm promotes its three, interrelated business lines: "strategically acquiring existing adult daycare facilities to develop a network of wholly owned centers," "building a fleet of non-emergency medical vehicles to aid seniors in their transportation needs," and "prepared meal delivery service…" all designed to "address the three prevailing challenges our aging population regularly struggles with, including isolation, transportation, and nutrition."[239] BrightSpring combines a HCBS pharmacy, Pharmerica, which generates almost 70 percent of its revenue, with its home care segment. As it notes in its prospectus to be listed as a public company, most of its clients "require pharmacy and provider services…the Company's capability to provide these multiple required services to Senior and Specialty populations increases our overall total addressable market size, revenue potential, M&A opportunity set, and de novo possibilities…" While Pharmerica makes up most of BrightSpring's revenue, the care services are a major profit center for KKR, with profit margins of seven percent and 13 percent, respectively.

Waud Capital Partners owns Senior Helpers, a national home care chain, as well as Concierge Home Care, a home health chain in Florida (it has chosen to keep these separate).[240] Also currently in Waud's portfolio: PromptCare, which provides specialty infusion and complex respiratory services in home settings[241] and IvyRehab, which provides physical therapy.[242] If a client at Senior Helpers or Concierge Services is referred to PromptCare or IvyRehab, it would likely be without knowing about their shared ownership. Waud's previous home care investments, now sold, include another home infusion business, CarePoint Partners, and DS Medical, which specializes in home medical supplies.[243] In a similar vein, Vistria Group has among its 20 current healthcare holdings on top of its home care giants Help at Home and Mission Healthcare and smaller VitalCaring: HomeFree, an HCBS pharmacy; alacura, which manages client transportation; AIS Healthcare, which focuses on targeted drug delivery, compounding pharmacies, and infusion services; BioCare, which focuses on drug distribution for people with complex medical needs; MedaLogix, a software platform for home health and hospice entities; Angel MedFlight, an air ambulance company; Supplemental Health Care, a staffing service for skilled medical clinicians; Tango, home-health value based care; Beacon Specialized Living, which provides care, including HCBS, to people with I/DD or mental health conditions; as

well as Sevita and Behavioral Health Group.[244] As the head of healthcare at Vistria observes, this range of related businesses allows it to make deals with insurers, as it "collaborate[s] towards a common solution where we can also leverage or capitalize on our relationships with…risk-bearing entities, whether those be health plans, A[ccountable]C[are]O[rganizations] or enablers."[245]

The private equity industry has also purchased directories for elder care providers including HCBS, such as Caring.com (not to be confused with care.com), which has been owned by private equity since 2018.[246] Beyond healthcare data, private equity firms like Ares Capital own companies that provide financial and workflow platforms that automate and handle some business operations.[247] These platforms are used for claims processing and payment and managing health plans and providers.[248]

Backend data and software is another growing area of private equity investment, and this holds true in HCBS as well as healthcare more broadly. HHAExchange, which specializes in HCBS and connects clients, providers, state Medicaid agencies, and Managed Care Organizations (MCOs) in an online platform, has been backed by private equity since 2014, and is currently owned by private equity firm Cressey and Company.[249] Other larger, more general healthcare data companies are also controlled by private equity, most notably Athenahealth, which just changed hands between two private equity consortiums for $17 billion.[250]

Because private equity firms often own businesses in related or adjacent sectors, the incidence of self-dealing can be quite high, and clients, families, and program administrators may have no inkling of these connections.[251] Self-referrals can violate the Stark Law's anti-kickback provisions. KKR was forced to identify in its prospectus for BrightSpring that "KKR has ownership interests in a broad range of portfolio companies and we may enter into commercial transactions for goods or services in the ordinary course of business with these companies;" it goes on to state that "We do not believe such transactions are material to our business."[252] Vertical arrangements like this can violate antitrust laws if any party receives favorable terms, if these relationships foreclose access to rivals, or if the connections are used to box out new entrants.[253]

VI. Federal and State Approaches for Community Based Services

Advocates for older adults and people with disabilities have fought long and hard for a set of care services that genuinely meet people's needs while allowing them to continue living independently. Private equity companies are purchasing home-based care companies because the steady revenues create the opportunity to make large profits in a short time. Clients, families and caregivers, advocates

and organizers, Medicaid and Medicare administrators, and policymakers—armed with an understanding of the current landscape and the dangers the private equity model poses to the HCBS sector—can come together to identify and pursue changes that will advance the goals of good care.

Here, we lay out a set of varied policy levers that can be used to prevent abuses, close loopholes and protect people needing care, their families and communities, and caregivers. These can check the damaging impacts of private equity ownership and make HCBS less attractive for predatory takeovers by changing the incentives and providing enhanced oversight of market transactions, business practices, job quality, and the quality of the services that companies provide. The tools we describe include health policy measures to set standards and check the damaging impacts of private equity ownership, steps to address corporate concentration that threatens quality care, and better regulation of finance to reduce subsidies and advantages for speculation and extraction.

A combination of these measures can help dramatically increase the likelihood that when advocates secure much needed additional resources for HCBS, those resources—mostly public dollars—stay within communities instead of evaporating into extraordinary profits for a tiny handful of Wall Street executives.

Table 3 summarizes the range of state and federal policy tools that are described in detail below.

INSERT: Table 3. State and Federal HCBS Policy Tools

Creating a sustainable HCBS provider mix and system

Health policy tools can be used to prevent profiteering and extraction in the HCBS sector. We discuss categories of such tools below — specific opportunities will vary considerably depending on individual states' statutory frameworks.

*Licensing and certification - **State, Federal/ Regulatory***

Thirty-four states require licensing for home care providers,[254] while all but four license home health providers, which covers the largest diversified private equity-owned HCBS chains. However, specific requirements vary greatly across states.[255] Medicare requires home health providers to meet its "conditions of participation" to be eligible to deliver care to Medicare beneficiaries. Among these conditions is that the agency is licensed, certified, or registered, in accordance with state licensing authorities.[256] Most state licensing applications will request an organizational chart,[257] but these requirements are rarely specific enough to include beneficial owners like private equity firms. By failing to identify corporate owners, the ultimate corporate parent companies, or review their history, licensing may still fail to prevent bad actors from entering the market. State rules that require beneficial owner information, a license review whenever there is a change in ownership or control, and

consideration of a parent company's performance in other markets, would enhance regulators' opportunity and ability to scrutinize private equity companies as they attempt to enter or increase their presence in a market.

*Using improved ownership transparency information — **State** and **Federal/ Regulatory** and **Legislative***

Regulators and stakeholders can use publicly available information about the ownership HCBS providers to understand patterns of ownership, control, and performance across agencies owned by private equity and other corporate actors. At the federal level, the Centers for Medicare and Medicaid Services (CMS) began in 2023 to release quarterly data on the ownership of the 11,000 Medicare-certified home health agencies, as well as any changes in ownership, under new rules that resulted from the federal government recognizing problems with Wall Street ownership of agencies.[258] States can adopt similar requirements for their licensed home care agencies to capture any home care providers funded solely through Medicaid. States with material transaction laws covering home-based care providers (discussed in a separate recommendation) often collect ownership information from providers in reviewing transactions. The National Academy of State Health Policy's (NASHP) model legislation addressing corporatization and consolidation, described below, includes as one of its three main sections language "creating transparency in ownership and control of health care entities" and specifies that required ownership information be made public.[259]

The federal data could be particularly helpful in performing searches of ownership across multiple states, which HHS states would allow "researchers and enforcement … to identify common owners that have had histories of poor performance, analyze data and trends on how market consolidation impacts consumers with increased costs without necessarily improving quality of care, and evaluate the relationships between ownership and changes in health care costs and outcomes."[260] One challenge, however, is that the data, though robust, is difficult for non-technical audiences to work with because it is in large, difficult to manipulate spreadsheets, where tracing common ownership requires time-consuming data cleaning and cross referencing. For example, the public agency dataset currently includes agency name, and doing business as name, but not the ultimate controlling parent company. It identifies whether the agency is owned by a corporation or limited liability company, but not which one. It identifies whether the agency has multiple violations, but not the nature of these deficiencies. There are separate datasets of owners of home health agencies, cost reports, and deficiencies. Advocates are urging CMS to make the data more accessible so that users can search the data and generate profiles for large-scale providers in an intuitive way. The public database should combine the overlapping agency datasets, clearly identify any corporate affiliations such as chains, the ultimate corporate controlling parent, the type of corporate parent (non-profit, government, private, public, or

private equity), cost reports, and deficiency data that should be updated to reflect any changes in control on at least quarterly basis. The dataset should have an accessible interface that allows users to filter and download the data with sufficient granularity (geography, ultimate parent owner, banner doing-business-as name, affiliated chain, etc.) to provide meaningful utility to states, researchers, and advocates.

*Certificate of Need - **State/ Regulatory***

The state Certificate of Need (CON) application process could address private equity intrusion into the healthcare sector. Thirty-five states plus the District of Columbia have Certificate of Need (CON) laws for approving new or expanded health care services. State health agencies use CON authority to approve major capital expenditures and new or expanded health care services, with the purpose of restricting duplicative services to control health care costs. States also use CON authorities to consider communities' need for and access to services in reviewing CON applications.[261] These processes often entrench monopolistic providers (if incumbent firms act to exclude new entrants) that can raise prices, lower quality, and harm workers and care recipients, and the existing process needs substantial reform to address these significant shortcomings. Nonetheless, the CON process can provide an opportunity for families and advocates to raise important questions related to private equity ownership of agencies.

CON laws vary by state in terms of their scope and process, but many allow for comments from stakeholders on the merits of a health care providers' CON application. For example, in New York State, which has the oldest CON law in the country, the Department of Health accepts comments from interested stakeholders on the CON review criteria of public need, character and competence of the operator, and financial feasibility. The comments may be submitted in writing or in person before the Public Health and Planning Council.[262]

CON laws are a component of state health planning widely adopted by states in the 1970s and 1980s. Health planning was intended to contain costs (by reducing overcapacity inefficiencies) and help direct health care resources where they were needed, although these efforts were largely overshadowed by policies that favored market-oriented corporate health care investment. The Congress repealed a 1975 federal law providing funding and guidance on health planning for states in 1986. The states' ongoing challenges to address mounting health care costs and uneven capacity exacerbated and highlighted by the COVID-19 pandemic have revived interest in repurposing health planning for today's health care inequities and problems.[263] For services like home care, where there is a demonstrable shortage, the CON process should be refocused on expanding access to quality care, addressing the harms from monopolistic markets, carefully scrutinizing new corporate operators, and bolstering the overall stability of the system.

CON criteria may include such considerations as alignment with state health goals, the applicant's financial condition and impact on the costs of medical care, and the availability of less expensive alternatives.[f] Many of the states with CON laws that apply to home health agencies extend the CON review authority to transfers of ownership or control, including acquisitions or consolidations of existing facilities or entities.[g] Companies that are already providing services can be subject to oversight and review if they are acquired by or merge with another entity. State regulators, or other stakeholders through the public comments process, could oppose a private equity acquisition using the CON process to bring information of the sort presented in this report about private equity-controlled companies' poor stewardship of home care agencies or condition any proposed change of control on binding, enforceable commitments to providing high-quality care and working conditions.

*Multi-Sector Plan for Aging - **State/ Regulatory***

Stakeholders in several states have the opportunity to influence the constellation of providers that serve older adults and people with disabilities through involvement in a state's Multi-Sector Plan for Aging (MPA) process. An MPA is a multi-year blueprint for the design of state and local policies and the creation of a coordinated system of high-quality care and support services that promote healthy aging, independent living, and social engagement. MPAs address issues related to healthcare, housing, transportation, and other social determinants of health. HCBS are a prominent part of the healthcare component of the plan and the MPA platform offers an opportunity to help shape the care sector through policies that have broad stakeholder support. Eight states are currently implementing or refreshing their MPA, and another eight have authorized MPAs through legislation or executive order. Twenty-one more states are interested in or are actively planning an MPA.[264] While MPAs do not usually include an emphasis on provider ownership, advocates can urge policymakers to incorporate analysis of how debt-fueled private equity expansion into HCBS can introduce instability into care for older adults and take steps to mitigate these threats through the MPA process, using data from the related transparency and market stability recommendations in this section.

*Antimonopoly enforcement - **State** and **Federal/ Regulatory***

Federal and state authorities can prevent mergers and other anti-competitive behavior that distorts markets and harms consumers—including the significant consolidation driven by the private equity industry in care—through more active enforcement of existing laws and regulations. Antitrust enforcement can curb the illegitimate exercise of market power that can raise prices and costs, reduce

[f] For example, see Vermont's CON law, 18 V.S.A. § 9437.

[g] These are: Alabama, Arkansas, District of Columbia, Hawaii, Kentucky, Mississippi, New York, Vermont, and West Virginia.

the quality of services, and suppress wages and benefits of workers in the healthcare industry. The Federal Trade Commission (FTC) and US Department of Justice (DOJ) may prohibit proposed mergers or condition merger approval on divestitures or on binding, enforceable commitments to providing high-quality care and working conditions. The FTC also has authority over unfair methods of competition beyond antitrust law. The FTC and DOJ 2023 merger guidelines explicitly include merger review tools to address the anticompetitive impacts of serial acquisitions and roll-up strategies that slowly amass market power through small sequential acquisitions. The 2023 merger guidelines also address common private equity strategies such as sectoral conglomerates that control adjacent markets, exercising monopolistic market power over workers, and using partial ownership stakes and overlapping board membership to increase anti-competitive collusion. The agencies are already exercising this authority to break up firms that have used roll up strategies similar to those seen in home care, such as in a lawsuit challenging roll-up acquisitions of anesthesia practices in Texas.[265]

*Material transaction laws - **State/ Regulatory***

Several states have proposed legislation to strengthen material transaction reviews in healthcare, which could apply to the HCBS sector.[266] These oversight laws require health care companies to notify regulators (usually the attorney general or a health care agency) of closings or other material transactions, including mergers and acquisitions, affiliations and agreements, and changes in ownership or control involving health care entities. Most laws do not allow the health regulator to block transactions, but some allow an agency to refer transactions to the attorney general for further investigation if there are concerns about anti-competitive effects. Oregon's transactions law grants the Oregon Health Authority explicit approval authority of material transactions.[267] More states could adopt these stronger authorities to block potential private equity takeovers.

Indiana recently passed a law that requires a health care entity involved in a merger or acquisition with another health care entity to provide written notice to the office of the attorney general at least 90 days prior to the date of the merger or acquisition. This law is notable because it includes private equity partnerships among the health care entities subject to the law.[268] Four other states' laws—California, Indiana, Minnesota, and New Mexico—also explicitly cover private equity partnerships.[269]

Cost and market impact reviews are a part of material transaction reviews in several states and provide a way for regulators to substantively investigate private equity's impact on the quality and availability of care. In Massachusetts, for example, the state's Health Policy Commission (HPC) reviews transactions for their impact on health care costs for consumers and purchasers; quality of services and

clients' experience; market competition and access and availability of services; and health equity and other public interests.[270] The HPC may refer its findings to the Attorney General or Department of Public Health for "possible further action on behalf of consumers in the healthcare market."[271]

Raising standards for care through HCBS funding

Because so much of the HCBS system is publicly funded, there is a significant opportunity to raise standards in the sector through the power of the public purse. Tools that impose requirements on the payment of public funds could apply to current programs and benefits and to any future expansions of these programs, for example if Medicare were to add coverage for Long Term Services and Supports (LTSS) for its beneficiaries. Requirements around quality of services, staff training, person centered planning, and self-direction, for example, could be enforced on entities using public funds for services. These policy responses are not just about money—they are about reclaiming the autonomy and self-direction that took decades to build.

*Setting workforce adequacy and stability standards - **State** and **Federal/ Regulatory** and **Legislative***

The federal government and some states have enacted laws regarding adequate compensation for the direct care workforce to stabilize the workforce, treat workers fairly, and support the quality of client care that results from sufficient staffing. Because wages are the largest expense for companies that provide home-based care, these laws can undercut private equity firms' aggressive cost-cutting strategies to boost short-term profits and extract value from the home health firms they acquire. This is a common private equity tactic in other health care settings, such as nursing homes and hospitals, with a significant private equity presence. Guaranteeing adequate wages, benefits, and worker protections are equitable ways to improve care quality and availability and protect against extractive financial practices.

Under the Affordable Care Act,[272] states must have a sufficient direct care workforce to deliver services that are responsive to the changing needs and choices of Medicaid HCBS beneficiaries. The low wages paid to workers is one of the key causes of workforce shortages, so CMS's recent rule, "Ensuring Access to Medicaid Services" (CMS-2442-F) requires states to "ensure that each provider spends 80 percent of total payments for homemaker, home health aide, or personal care services on total compensation for direct care workers."[273] Unfortunately, states are not required to comply with this requirement until July 2030. State Medicaid programs may address their workforce shortages and help their low-wage workforce by implementing the requirement sooner.

Some states have used their authority to set Medicaid payments and regulate minimum wages to address the home and community-based care workforce:

- States have passed Medicaid wage pass-through laws, which require that HCBS providers or nursing facilities apply a percentage of a rate increase or supplemental payment to wages or other benefits for direct care workers. Indiana's Division of Disability and Rehabilitative Services, for example, increased Medicaid reimbursement rates by 14 percent and required that 95 percent of the increase be passed through to support workers through use for payroll tax liabilities, wages, or benefits.[274] In Utah, providers contracted with the Department of Services for People with Disabilities received a rate increase with the requirement that 100 percent be used to support direct care workers.[275] In both states, providers can be required to repay the increase if they fail to pass through the increases to the workers as intended.

- Some states have enacted minimum wage laws for direct care workers that set a wage floor for these workers above the general state minimum wage, either as a set amount or a percentage or dollar amount above the state minimum wage.[276] These states have wage floor laws for home care workers:

State	Wage floor	Reporting/Enforcement
Colorado	HCBS provider rate increase to support providers achieving $15/hr minimum wage. Providers already paying that can use rate increase for increasing wages further, recruitment and retention efforts	Providers must report wage changes at individual level. Non-compliant providers must return funds to the state.
Florida	HCBS rate increase to raise minimum wage to $15/hr	Attestation by provider. Employees may bring civil action if not receiving min. wage from provider that received rate increase.
Louisiana	HCBS rate increase and wage floor $9/hr	Sanctions/penalties based on magnitude of non-compliance. Could include disenrollment from Medicaid

State	Wage floor	Reporting/Enforcement
New York	HCBS Minimum wage $3 over prevailing regional minimum wage	Commissioner of Labor could require an employer to pay minimum wage underpayments and liquidated damages, plus interest and civil penalties up to 200% of unpaid wages. Home care aid (or Comm'r of Labor on their behalf) may bring civil action.

Source: National Governors' Association, Addressing Wages of the Direct Care Workforce Through Medicaid Policies.[277]

- A few states have established rate setting boards that determine wages for home care workers providing care in the state's Medicaid program. Washington's board consists of 14 people including caregivers, labor union (SEIU) representatives, and advocates for older people and people with disabilities. The board sets the hourly wage rate, which must be approved by the legislature.[278] Nevada's 10-member Home Care Employment Standards Board has a broader mandate, to recommend increases to the minimum wage for workers providing personal care services, among other authorities.[279] Massachusetts established a Personal Care Attendant (PCA) Quality Home Care Workforce Council, to "ensure the quality of long-term, in-home, personal care by recruiting, training and stabilizing the work force of personal care attendants." The majority of the Council's nine members are consumers. Among its activities is assisting PCAs to "achieve increased wages, benefits, professional development opportunities and other benchmarks of respected, dignified employment."[280]

- Nine states have established collective bargaining rights for home care workers: California, Connecticut, Illinois, Massachusetts, Michigan, Minnesota, Oregon, Vermont, and Washington.[281,282]

Direct care workers in states that have implemented one or more of these policies have seen the gap narrow between their wages and those of other entry-level workers, though gaps remain and many direct care workers still do not earn a living wage. These policies have resulted in some progress, suggesting that workers in states that do not have them would benefit if they did — especially if a state adopted all of them to work in combination. States and federal policymakers must devote resources to fully fund these policies.[283]

Direct Care Workforce laws can work synergistically: The 80-percent rule — requiring home care agencies to dedicate at least 80 percent of the payments they receive to direct care workers'

compensation — is less effective if underlying payment rates are inadequate. CMS could therefore require states that have "Interested Parties' Advisory Groups" (IPAG) — the Washington and Nevada rate boards are examples – to justify any departures from IPAG rate recommendations in its assurances of payment adequacy to CMS.[284]

*Regulating prices and revenue - **Federal/ Regulatory** and **Legislative***

The federal government could use its power to limit the excessive revenues companies realize through Medicare and Medicaid's pricing policies. One side of the profit equation is the revenue that home care companies generate from their services. Almost all of HCBS revenue comes from government sources and is projected to increase over the coming decade as the population ages. Medicare payments for home health services are high, with freestanding (i.e. not hospital-based) home health agencies generating average profit margins of over twenty percent.[285]

Congress could impose a wage floor for workers in home health and home care agencies, or require that a percentage of rate revenues in excess of a CMS-determined efficiency standard go to compensation of workers. This would be a parallel provision to the state-level Medicaid wage pass-through laws described earlier.

In the home health setting, an element of Medicare's value-based payment model is an adjustment for the functional status of patients in determining bonuses and penalties for providers. These adjustments are currently based on agency-reported functional status, which MedPAC reports appears "to be influenced by incentives in the application payment systems rather than assessments of patients' functions." Payment adjustments could be made less susceptible to gaming by profit seeking owners if CMS adopts an objective source for measuring client function and other quality measures (such as "discharge to community" rates) on bonuses are based on MedPAC recommendations that patient-reported surveys replace agency assessments for this purpose.[286]

At the same time, state Medicaid rates for home care agencies and other providers that employ direct care workers are often insufficient to pay adequate wages. States contribute a portion of Medicaid payments and state budgets, particularly in lower-income states, are often barriers to increased payments for Medicaid, one of the largest components of state budgets. The federal government can offer incentives to states to raise their rates (and, because of the 80 percent rule, workers' wages) by, for example, increasing the level at which it shares in state Medicaid expenditures (known as the Federal Financial Participation rate or match rate).

*Enact responsible contractor policies for HCBS administration contracts- **State** and **Federal/ Regulatory***

State and federal agencies can use their procurement processes to stop private equity's takeover of the assessment of home care needs for Medicaid beneficiaries and in running self-directed programs. Organizations representing older adults and people with disabilities have had some success in raising questions and slowing the shift to for-profit assessment entities through their advocacy during the public procurement process. In Massachusetts, advocates have been responsible for the state Medicaid agency delaying the procurement of an Independent Assessment Entity and issuing a request for information to inform its decisions.[287] In New York, the Department of Health announced in November 2023 the postponement of its Independent Assessor Program "due to stakeholder and other concerns,"[288] though, as discussed earlier, the contract was ultimately awarded to a private equity-owned entity. States that are considering any contracts for HCBS program administration could award these only to non-profit entities, and prohibit extractive tactics like dividend payouts, management fees, self-dealing referrals, and the like in the terms of the contract.

*Quality standards to ensure clients receive adequate and responsive care - **Federal/ Regulatory** and **Legislative***

States should us Conditions of participation (CoPs) that address operations and management to require that providers comply with all federal, state, and local laws related to health and safety in order to continue to participate in the Medicare and Medicaid programs.[289] Legislation could require home health and home care recipients of federal or state funding to spend all public funding on patient/client health and safety and appropriate overhead, and prohibit any of the most common financially extractive practices preferred by private equity firms, such as dividend payouts, stock buybacks, excessive executive compensation, sale-leasebacks that increase an entity's debt burden, or the payment of franchise or management fees.

CMS monitors the quality of the services Medicare-certified home health agencies deliver across several domains (for example, managing daily activities, treating symptoms, preventing harm) and compiles an agency's performance into an overall rating of one to five stars (a system that has suffered from significant grade inflation in the nursing home context). [290] Individual agencies' quality ratings are publicly available on CMS's Care Compare website.[291] While information about agency ownership is included in the record, it is difficult to look for patterns of poor quality and safety across agencies that are part of a corporate-owned chain. As described above, CMS now maintains a comprehensive database of home health agency ownership, which does allow users to link agencies within a chain. This capability could be integrated into public-facing websites such as Care Compare, to illuminate practices by private equity-owned companies that result in degraded care.

The Office of the Inspector General (OIG) in the Department of Health and Human Services is required to exclude from participation from Medicare and Medicaid individuals and entities convicted of fraud. The OIG makes available a downloadable database of the exclusions, known as the Medicare and Medicaid Exclusions list on its website.[292] Unfortunately, the exclusions are not well enforced, resulting in operators continuing to employ illegal practices in running a healthcare organization that no longer receive public funding.[293] Effectively enforcing the exclusions list would make it a stronger tool to prevent people and businesses who have committed fraud, including those owned by private equity, from doing further damage, as well as a more effective deterrent to fraud.

Legislation to curb PE abuses in healthcare - ***Federal /Legislative***

Senator Ed Markey and Representative Pramila Jayapal's "Health Over Wealth Act," introduced in 2024, and likely to be reintroduced in 2025, would require private equity-owned health care facilities to disclose their debt, executive pay, patient expenses, and reductions in services. It would also create an escrow system to protect the providers in the event of a financial downturn.[294] It was drafted after private equity firm Cerberus Capital Management looted Steward Health Care, leaving hospitals, patients, and workers hanging out to dry. The proposed law could be expanded to cover non-facility based care such as home health and home care entities.

The "Corporate Crimes Against Health Care Act," introduced by Senators Elizabeth Warren and Ed Markey in 2024, and likely to be reintroduced, would allow states to claw back all compensation — including salaries — from private equity and company executives in the event an acquired health care firm experiences serious, avoidable financial difficulties after a takeover. The bill would also authorize an associated civil penalty of up to five times the clawback amount and prohibit payments from Medicaid and Medicare to entities that loot.[295]

Using financial and tax policy levers to rein in private equity abuses

Tax and financial policy levers could reduce incentives and close loopholes that benefit the financial actors like private equity firms who are threatening the stability of the HCBS system.

Closing the carried Interest loophole - ***Federal/ Legislative***

The "carried interest" loophole lets private equity and hedge fund managers mis-classify their salaries as investment income, and pay the much lower capital gains tax rate instead of income tax like other salaried workers. This preferential tax treatment exacerbates private equity's excessive risk taking and encourages managers to prioritize outsized financial gains over the sustainability of portfolio

companies or the interests of customers, workers, or investors. Legislation to close the carried interest loophole has been introduced in at least the last four Congresses.

Tax enforcement that stops PE General Partner tax evasion - ***Federal/ Regulatory***

Private equity general partners (GPs)—private equity executives—use several tax evasion strategies the IRS has begun to crack down on through closer scrutiny of problems with partnership pass-through business returns. These include issues like obfuscated reporting of carried interest, use of foreign tax havens, the conversion of fee income to capital gains profits through fee waivers, monitoring fees used to disguise dividends and shareholder payouts, and more. The IRS should continue to crack down on tax evasion by GPs — and Wall Street partnership arrangements generally.

Eliminating regulatory loopholes that enable and reward PE abuses - ***Federal/ Legislative***

The "Stop Wall Street Looting Act," spearheaded by Senator Elizabeth Warren, was first introduced in Congress in 2021 and has been repeatedly reintroduced. It would reform the private equity industry by forcing firms to take responsibility for the outcomes of the companies they buy, closing regulatory loopholes, protecting investors, enhancing workers' rights if private equity drives employers into bankruptcy, closing the carried interest loophole and more.[296]

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As HCBS is becoming a growing part of our care infrastructure, private equity firms' rapacious expansion into several parts of the sector threatens its viability. Private equity's extractive and debt-fueled model takes millions of dollars out of the HCBS system, leaving less money for those who require care and the workers who provide it and endangering provider sustainability. While the advocacy community has worked hard to establish responsive, appropriate, and self-directed care, private equity's creation of super chains and incursion into family caregiving puts client autonomy and small-scale community-based providers at risk. Policymakers, advocates, and families can work together to push back against these worrisome trends and create protections that allow the HCBS sector to grow in a healthy and sustainable way, one in which resources go to care and communities, not Wall Street profits.

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