Health Care Market Oversight

Transaction 002–Falcon Hospice 30-Day Review Summary Report

July 14, 2022

Oregon Health Authority

About this Report

This report summarizes analyses and findings from Oregon Health Authority's preliminary (30-day) review of the proposed material change transaction of Falcon Hospice, L.P. It accompanies the Findings of Fact, Conclusions of Law, and Final Order ("Preliminary Review Order") issued by Oregon Health Authority on July 14, 2022. For legal requirements related to the proposed transaction, please reference the Preliminary Review Order.

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Executive Summary

The Health Care Market Oversight (HCMO) program reviews proposed heath care business deals to make sure they support statewide goals related to cost, equity, access, and quality. After completing a review, the Oregon Health Authority (OHA) issues a decision about whether a business deal, or transaction, involving a health care company should proceed. On June 14, 2022 OHA received a completed notice of material change transaction from Falcon Hospice, describing plans to acquire KAH Hospice.

Proposed Transaction

Falcon Hospice is seeking to acquire 60% ownership of KAH Hospice. KAH Hospice includes the hospice and personal care divisions of Kindred at Home, a national provider of home health, hospice, and personal care services. KAH Hospice is currently solely owned by a subsidiary of Humana, a national for-profit health insurance and health care company. The New York-based private equity firm Clayton, Dublier & Rice (CD&R) is a limited partner in Falcon Hospice. KAH Hospice is headquartered in Atlanta and provides hospice and personal care services at 441 locations in 36 states, including two Oregon Kindred locations in Lake Oswego and Salem. The entities are seeking to complete the transaction by July 15, 2022, pending regulatory approval. From 2017 to 2019, Kindred's Lake Oswego location served an average of 425 patients annually and the Kindred Salem location served an average of 215 patients annually. According to the notice, both locations combined had an average annual revenue of less than $6 million in the last three fiscal years.

OHA's Review

OHA conducted a 30-day preliminary review of the proposed transaction. During the review, OHA analyzed baseline data and assessed the likely impact of the transaction across four domains: cost, access, quality, and equity. OHA held a 14-day public comment period and received three public comment submissions, all of which raised concerns about potential negative impacts of the transaction.

Key Findings

Cost

Because Medicare covers hospice services for most Kindred patients and has set payment rates, OHA does not have concerns about regional price increases resulting from this transaction. Recent reports, however, have highlighted concerns about the billing practices of hospice providers with private equity ownership that seek to maximize profits without improving quality of care or patient experience. OHA will monitor for any impacts of the transaction on health care spending in follow-up analyses.

Access

Kindred Lake Oswego and Salem locations provided 14% and 9% of hospice care in their respective geographic service areas. Patients seeking hospice care in these regions have multiple provider options that deliver similar services at similar levels of care. Ownership change of the Kindred facilities is not expected to reduce access to hospice services in these areas. As long as the locations continue to meet requirements for state licensing and Medicare certification, these facilities should remain accessible to patients with Medicare and Medicaid insurance coverage.

Quality

Falcon Hospice maintains that the planned business deal will not impact quality. Kindred's Oregon locations have quality scores for patient care that are comparable to state and regional averages; but their patient and caregiver experience ratings have decreased in recent years. Public comments highlighted recent reports that suggest private equity firms' cost cutting strategies may result in poorer quality of care at hospice facilities. The US Senate Finance Committee has launched an investigation into Kindred's former private equity ownership. OHA will monitor quality outcomes in follow-up analyses.

Equity

Kindred's patient population is generally reflective of the demographics of the residents of each facilities' geographic service area, including those patients living in zip codes designated as rural. Kindred expects to continue to serve people with Medicare and Medicaid coverage at its Oregon locations.

Conclusions and Decision

Based on preliminary review findings, **OHA approved this transaction on July 14, 2022**. (See Review Order 002 – Falcon Hospice.) OHA approved the transaction after determining that it meets these criteria:

1. **The transaction is unlikely to substantially reduce access to affordable health care in Oregon.** This transaction will not result in consolidation in the hospice care market. As the majority of hospice patients are covered by Medicare, which has fixed reimbursement rates, this transaction is unlikely to result in price increases. As stated in the notice, Falcon Hospice expects that Kindred locations in Oregon will continue to serve a similar mix of patients covered by Medicare and Medicaid.
2. **The transaction is not likely to substantially alter the delivery of health care in Oregon.** Kindred Lake Oswego and Kindred Salem hold 14% and 9% of the market share in their respective service areas, giving patients other options for hospice care in those service areas. Any changes of care that result from this transaction are unlikely to substantially alter delivery of care for the region or the state. In its notice, Falcon Hospice states that the transaction will not affect access or quality of care at Kindred locations in Oregon.

OHA will monitor the impact of the transaction by conducting follow up analyses one year, two years, and five years after the business deal is completed. During these reviews, OHA will analyze the impact of the transaction on quality of care, access to care, affordability, and health equity, specifically following up on concerns or observations noted in the Key Findings. OHA will also assess whether Falcon Hospice has kept to the commitments stated in its notice of transaction regarding cost, access, and quality of care.

Introduction

In 2021, the Oregon Legislature passed House Bill 2362, giving the Oregon Health Authority (OHA) the responsibility to review and decide whether some transactions involving health care entities should proceed. In March 2022, OHA launched the Health Care Market Oversight program (HCMO). This program reviews proposed health care transactions such as mergers, acquisitions, and affiliations to ensure they support statewide goals related to cost, equity, access, and quality.

The HCMO program is governed by Oregon Revised Statute 415.500 et seq. and Oregon Administrative Rules 409-070-0000 through -0085.

In the authorizing statute, the Oregon Legislature specified what types of proposed transactions are subject to review and the criteria OHA must use when analyzing a given proposed transaction. The Oregon Legislature also authorized OHA to decide the outcome of a proposed transaction. After analyzing a given proposed transaction, OHA may approve, approve with conditions, or reject it.

The Health Care Market Oversight program fits within OHA's broader mission of ensuring all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality, affordable health care.

On June 14, 2022, OHA confirmed receipt of a complete notice of material change transaction from Falcon Hospice. The notice outlines the intent of Clayton, Dubilier and Rice (CD&R), a private equity firm, to acquire a majority share of Falcon Hospice from Gentiva, which is an entity owned by the health insurance company Humana.

OHA reviewed the notice of material change transaction and determined, based on the facts in the notice, that the transaction is subject to review. The entities party to the transaction meet the revenue thresholds specified in Oregon Revised Statute 409-070-0015 and the proposed transaction is otherwise covered by the program in accordance with Oregon Revised Statute 409-070-0010. After receipt of the complete notice of material change transaction, OHA began a preliminary review of the proposed transaction. Preliminary reviews must be completed within 30 days of OHA's confirmation of receipt of a complete notice. This report describes the transaction, OHA's approach to the review, its findings, and OHA's conclusions based on these findings.

Proposed Transaction

On June 14, 2022, OHA received a Notice of Material Change Transaction ("notice") from Falcon Hospice ("Entity"). The notice pertained to a transaction whereby CD&R Falcon Holdings, L.P. ("Falcon Holdings"), the sole limited partner of Falcon Hospice, would acquire a 60% ownership interest in KAH Hospice Company, Inc. ("KAH Hospice"). KAH Hospice is currently owned by Gentiva a wholly owned subsidiary of Humana.

Entities Involved

The main entities involved in this transaction are Humana (as parent company of the seller), Falcon Holdings (as the buyer), and KAH Hospice (the company being acquired).

Humana

Humana is a publicly owned company that offers health insurance products nationwide and delivers health care services in multiple states. Humana is organized as a Delaware corporation headquartered in Louisville, Kentucky. In the year ending December 31, 2021, Humana reported total revenues of $83 billion and profits (net income) of $2.9 billion. Humana operates three business segments: Retail Products, Group and Specialty Products, and Healthcare Services.

The Retail Products segment provides individual and group Medicare Advantage plans, whereas Group and Specialty Products offers employer-based commercial medical and specialty plans. Humana's medical benefit plans had approximately 17 million members in 2021. In Oregon, Humana's enrollment is mainly in Medicare Advantage plans, serving approximately 15,000 members out of 393,776 Medicare Advantage enrollees in Oregon as of December 31, 2021.[1]

Humana's Healthcare Services segment includes pharmacy solutions, provider services, and home solutions. Pharmacy solutions manages prescription drug coverage for individuals and employers. Provider services operates 206 primary care clinics serving over 350,000 patients primarily insured with Medicare Advantage or Original Medicare. Home solutions offers home health, hospice, and care management services. Home solutions includes Kindred at Home.

KAH Hospice

KAH Hospice, a publicly owned corporation registered in Delaware and headquartered in Atlanta, Georgia, includes the hospice and personal care divisions of Kindred at Home, a national provider of home health, hospice, and personal care services. KAH Hospice has 441 subsidiary hospice, community care, and palliative care agencies operating in 36 states. Under the terms of the proposed transaction, KAH Hospice is valued at $3.4 billion.[2]

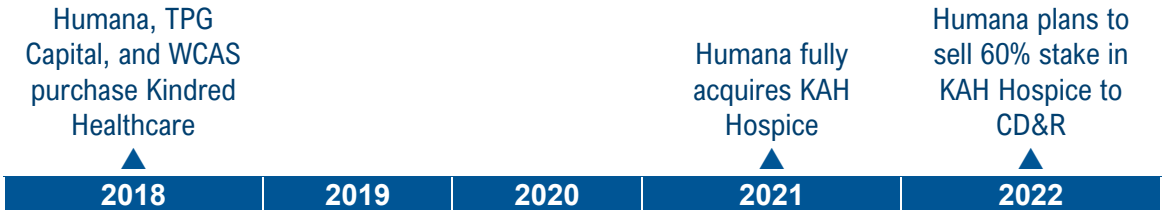
Ownership History

Kindred at Home was previously part of Kindred Healthcare, Inc., a publicly traded health care services company founded as Vencore, Inc. in 1985. Kindred Healthcare operated long-term acute care hospitals, a home health and hospice business, inpatient rehabilitation facilities, nursing centers and assisted living facilities across the country. In 2014, the company entered into a merger agreement with Gentiva Health Services Inc., a nationwide provider of home health and hospices services based in Atlanta, Georgia. As part of the agreement, Gentiva became a wholly owned subsidiary of Kindred Healthcare.[3]

In 2018, Kindred Healthcare was acquired by Humana and two private equity firms – TPG Capital and Welsh, Carson, Anderson, and Stow ("WCAS"). As part of the deal, Kindred Healthcare's home health, hospice and community care businesses were separated and operated as a

standalone company (Kindred at Home) owned 40% by Humana, with the remaining 60% owned by TPG and WCAS. (Kindred's long-term acute care hospitals, inpatient rehabilitation facilities, and contract rehabilitation services businesses would be fully owned by TPG and WCAS and operated as Kindred Healthcare.) Humana was given the right to buy the remaining interest in Kindred at Home over time.[4]

Humana fully acquired Kindred at Home in August 2021. In describing the acquisition, Humana noted the sizeable (65%) geographic overlap between Kindred at Home's locations and Humana's Medicare Advantage membership.[5] Humana is integrating Kindred at Home's home health operations into its home solutions business under the CenterWell Home Health brand.[6] Since the acquisition, Humana has publicly stated its intention to sell its majority interest in Kindred at Home's hospice business, maintaining a strategic minority interest in the long term.[7]



Oregon Operations

KAH Hospice operates two hospice agencies in Oregon:

1. Odyssey Healthcare Operating A, LP d/b/a Kindred Hospice – Lake Oswego (4500 Kruse Way Suite 100, Lake Oswego, OR 97035)
2. Odyssey Healthcare Operating A, LP d/b/a Kindred Hospice – Salem (698 12th Street SE Suite 230, Salem OR 97301)

Both hospice agencies are identified as for-profit and are licensed in the state of Oregon.[8] Each location is certified and approved for Medicare participation and met the Center for Medicare and Medicaid Services (CMS) requirements for the Hospice Quality Reporting Program in 2020.[9] Combined, the Lake Oswego and Salem locations of Kindred Hospice accounted for 1,920 (or 3%) of approximately 66,800 hospice episodes identified in Oregon's All Payer All Claims (APAC) database from 2017 to 2019.[10] CMS (through the Medicare program) paid for most hospice episodes at the two Oregon locations (at least 90%), followed by the state Medicaid program (approximately 7%) and commercial payers (less than 3%). The combined annual revenue for the two hospice agencies averaged below $6 million in the last three fiscal years, according to the Entity.[11]

Kindred Hospice – Lake Oswego ("Kindred Lake Oswego") had an average daily census of 52.9 patients over the past two years according to the Entity. (Data reported to CMS in May 2022 indicates an average daily census of 63.0 patients in 2019.) The facility served an average of 420 patients annually between 2017 and 2019, according to APAC data.

Kindred Hospice – Salem ("Kindred Salem") had an average daily census of 34.8 patients over the past two years according to the Entity. (Data reported to CMS in May 2022 indicates an average daily census of 16 patients in 2019.) The agency served an average of 212 patients annually between 2017 and 2019.

Falcon Holdings

Falcon Holdings, a Cayman exempted limited partnership, is the sole limited partner of Falcon Hospice. Falcon Holdings' limited partners include investment fund entities of Clayton, Dubilier & Rice, LLC ("CD&R").

CD&R is a private equity firm based in New York, founded in 1978. A private equity (PE) firm is a company not listed on a public stock exchange that invests in or acquires other private companies. PE firms raise funds from third-party investors such as retirement funds, pension funds, wealthy individuals, and endowments. They usually hold a "portfolio company" for 3-7 years before selling or taking the company public. During this time, they provide advice on strategy, financial management, and operations to generate a profit for the investors. Their degree of involvement in the company's management generally depends on the size of their ownership stake.[12] CD&R's website states:[13]

> *"The vast majority of the value we create results from strong collaborations with management to spur operational performance improvements by accelerating growth strategies, injecting new talent, and boosting productivity."*

As of December 2020, CD&R had 34 companies in its investment portfolio with a total revenue of $60 billion. Since 2005, CD&R has invested in 16 companies operating in the health care industry offering a wide range of products and services, such as physician group management services (Agilon Health), primary care (Vera Whole Health), wound care clinics (Healogics), ambulance services (AMR), ER physician services (Envision Healthcare), durable medical equipment (Drive Devilbiss Healthcare), post-acute care management (naviHealth), and pharmacy compounding (PharMEDium).[14]

Transaction Terms

On April 20, 2022, Falcon Holdings (the "buyer") and Gentiva (the "seller"), together with other affiliated entities, entered into a Stock Purchase Agreement and Plan of Merger (the "agreement"). Under the agreement, Falcon Holdings will purchase 60% of the shares of KAH Hospice from Gentiva, which is owned by Humana. Humana will receive proceeds of approximately $2.8 billion in connection with this transaction.

After closing the transaction, KAH Hospice will be 100% owned by Falcon Hospice, and the latter will be majority (60%) owned by Falcon Holdings, with Gentiva maintaining a 40% stake.

Rationale for the Transaction

The Entity describes the objectives of the transaction as maintaining patient care, generating operational efficiencies, and ensuring adequate resources to maintain the current operations of KAH Hospice.[15]

In its press release announcing the agreement, Humana's Chief Financial Officer said the company was confident it could "deliver patient outcomes and improved customer experiences through partnership models rather than fully owning KAH Hospice."[16]

After announcing its 2021 purchase of the remaining 60% of Kindred at Home from its private equity partners, Humana's CFO Brian Kane said it was planning to divest its majority stake in the hospice business to "capitalize on a robust market for hospice assets."[17]

Post-Transaction Plans

The Entity states that the transaction will not involve any changes to the two Oregon hospice agencies' names, federal tax ID numbers, direct ownership, direct governance, management/leadership, contracts with Coordinated Care Organizations, or operations generally. Specifically, Falcon Hospice has no plans to change locations, number of staff, services offered, service areas, quality of care, or the type of insurance coverage accepted at either of the two locations.[18]

The notice of material change transaction submitted by Falcon Hospice, L.P. includes multiple commitments to maintain the current level of services, quality, and cost. The notice states:

- *"The transaction […] is not expected to have any negative impact on patient costs, patient access, equity or quality of health care in Oregon."*
- *"[The] proposed transaction will allow […] entities to maintain patient care at Kindred Hospices while optimizing the efficiency of shared operations."*
- *"[T]here will be no changes to the Kindred Hospices' locations and no reduction in the number or quality of staff or services."*
- *"The Kindred Hospices will continue to be accredited through the Accreditation Commission for Health Care and will continue to provide the same high-quality services to those in their service areas."*
- *"The transaction is not expected to have any impact on the price of or access to health care services within Oregon, as the transaction will not involve any change to the Kindred Hospices (including, e.g., name, federal tax ID number, direct ownership or governance, management or leadership, Kindred Hospices' contracts with Oregon coordinated care organizations, or operations generally)."*
- *"Kindred Hospices are also expected to continue serving Medicare and Medicaid beneficiaries."*
- *"The payor mix of the Kindred Hospices is 95% Medicare; therefore, there are no anticipated rate increases by payors, nor any anticipated increases to the costs to Oregon patients."*

Additionally, according to Humana's press release announcing the transaction, David Causby, current President and CEO of KAH Hospice, will continue to lead business operations under the new structure.[19] In the announcement he said:

> *"We are excited by the new strategic partnership structure with Humana and look forward to working closely with CD&R to pursue growth that is centered on improved access, equity and quality of care across an expanded group of patients […] we share a common set of values and, like the CD&R team, are focused on driving quality care for patients and continuing to ensure that our company remains an employer of choice for health care professionals."*

Overview of Hospice Care

What is hospice?

Hospice services focus on comfort and quality of life for people with serious medical conditions who are approaching the end of their lives. Rather than attempting to cure a medical condition or slow its progress, hospice care aims to reduce pain and suffering and provide comfort and support patients and their caregivers.

People covered by Medicare who have a terminal illness and a life expectancy of six months or less are eligible for Medicare's hospice benefit. When a patient opts for hospice care, they stop all curative treatment for their terminal illness and instead receive care intended to relieve pain and provide comfort and support as they near end of life.

Hospice care encompasses a range of supportive services, including physician and nursing services, pain management, physical or occupational therapy, medical social services, spiritual and grief counseling, and home maintenance support. Services align with a plan of care that is designed collaboratively with the patient and caregiver(s).

Hospice services can be provided in a person's home, in other care settings (e.g., skilled nursing or assisted living facilities), in an inpatient hospital, or in a specially designated inpatient hospice facility. As a patient's illness progresses, they may need to transition to or from any of these settings, but the hospice staff can continue to provide supportive care.

An episode of hospice care begins when a patient elects hospice care and ends when the patient dies, is discharged to another kind of care facility, or opts out of hospice care.

Hospice, palliative care, & home health

The term "hospice" is often used interchangeably with "home health" and "palliative care." While all three offer similar services delivered by similar providers, there are some important distinctions:

Hospice care focuses on pain relief and comfort at the end of life. Hospice is provided for patients who forgo attempts to cure illness and who are expected to have six months or less to live. Hospice care can take place in home or at a facility.

Palliative care focuses on pain relief and comfort, regardless of life expectancy. Patients may receive palliative care along with treatment intended to cure serious illness. Palliative care can take place in home or at other care locations.

Home health refers to services aiming to maintain or improve functionality for patients who recently had a hospital stay or received treatment for a serious medical condition. Home health takes place in a person's home.

Who provides hospice care?

Hospice care engages an interdisciplinary team to meet the needs of patients, including doctors, nurses, social workers, counselors, hospice aides, and pastoral care providers.

Hospice agencies must meet specific requirements to receive Medicare payments, as outlined in CMS regulations. The State of Oregon further requires hospice agencies to be licensed under ORS 443.850-443.869.

There are separate licensing and Medicare certification processes for agencies that provide home health care, but some hospice agencies will obtain both licenses and offer both types of services, given the overlap in types of care and qualifications of staff required to both. Palliative care is billed and delivered similarly to hospice care and is often offered by licensed hospice facilities but is not limited to patients with a 6-month life expectancy.

How do payments work for hospice services?

Each year the Centers for Medicare and Medicaid Services (CMS) sets reimbursement rates for hospice services for Medicare recipients. Rates are set nationally based on the intensity of services provided and adjusted to account for regional differences in staffing costs. CMS publishes their annual wage index adjustments for rural and urban regions across the country.[20]

Medicare pays a daily rate for each patient enrolled in hospice care. CMS also sets a per-person cap on annual payments; the proposed cap for fiscal year 2023 is $32,142. The daily rate varies based on level of care and services provided:

Table 1: CMS daily rates for hospice services

Level of Care	Payment	Requirements
Routine Home Care	First 60 days (high RHC rate): $203 per day Subsequent days (low RHC rate): $161 per day	Paid each day patient is in routine hospice care, regardless of service delivery
Continuous Home Care	$61 per hour, maximum of $1,463 per day	Provided only in crisis to keep patient at home; must deliver 8 hours of services each 24-hour period
Inpatient Respite Care	$474 per day	Paid a maximum of consecutive 5 days, additional days paid at RHC rate; patient must be at a certified inpatient hospice facility, hospital, or skilled nursing facility
General Inpatient Care	$1,068 per day	Patient must receive care at a certified inpatient hospice facility, hospital, or skilled nursing facility

FY2022 CMS Hospice Payment rates[21]

Under Medicare, patients pay a coinsurance (maximum of $5) for drugs received in the home and 5% of inpatient respite care days (taken when caregivers require a rest from ongoing home care). Patients without Medicare can still have hospice services covered by Oregon's Medicaid program or commercial health insurance. Benefit coverage for the patient and reimbursement rates to providers may vary by commercial plan but are likely indexed to the Medicare rate.

OHA's Review

OHA performed a preliminary review of the transaction to assess its potential impact on Oregon's health care delivery system. The review explored impacts in four areas (domains): cost, access, quality, and equity. OHA's analysis followed the guidelines and methods set out in the HCMO Analytic Framework published January 31, 2022.[22] The framework is grounded in the goals, standards and criteria for transaction review and approval outlined in OAR 409-070-0000 through OAR 409-070-0085.

Analytic Approach

OHA's analysis assessed the current or baseline performance of the Kindred Lake Oswego and Kindred Salem hospice agencies and the likely impact of the proposed transaction on the agencies' performance in each domain (cost, access, quality, and equity). OHA assessed key outcomes in each domain (as specified in HCMO's analytic framework) by analyzing relevant performance measures calculated from administrative claims and enrollment data or obtained from publicly available sources. Many of these analyses relied on defining a geographic service area for each of the two hospice agencies and identifying comparison entities within that service area.

Geographic Service Areas

OHA defined the geographic service areas for the Kindred Lake Oswego and Kindred Salem locations using the primary service area (PSA) approach described in HCMO's Analytic Framework. This involved identifying the contiguous zip codes of patient residence around the location of the hospice agency that accounted for 75% of the agency's total episodes of care**.** For this analysis, OHA used administrative claims and enrollment data submitted by insurance carriers operating in Oregon for the years 2017 - 2019, the period for which most recent and complete data was available. See Appendix B: Methodology for details on OHA's methodology and the All Payer All Claims (APAC) program.

Primary service areas were used for calculating market shares to identify comparison entities and to define regional populations for access and equity comparisons.

Comparison Entities

OHA identified two sets of comparison entities consisting of other Oregon state licensed and Medicare certified hospice agencies located within the geographic service area of Kindred Lake Oswego and Kindred Salem, respectively. All comparison entities offered hospice services at the same level of care—none operated specially designated inpatient hospice facilities. This analysis assessed the combined performance of comparison entities on measures of cost, quality, equity, and access relative to the performance of Kindred Lake Oswego and Kindred Salem to understand how these agencies involved in this transaction operate compared to similar agencies in their geographic regions.

Outcomes and Measures

The subsections below describe outcomes and measures under each domain.

Cost

Analyses under the cost domain explore how the transaction may affect the prices consumers and payers (e.g., insurers, employers, and governments) pay for health care services in Oregon and overall spending on health care services for Oregonians. Prices and spending for health care services may be affected by the degree of competition between providers offering similar services

within a primary service area. Cost domain analyses therefore include an assessment of the degree of competition, as measured by market shares and the Herfindahl-Hirschman Index (HHI**)**. HHI is a standard metric used by courts, federal and state regulators, and researchers to measure competition and consolidation. It is calculated based on the market shares of individual suppliers. Applied to health care services, market shares are often measured as each provider's percentage of total health care services delivered in the service area (measured in visits, admissions, or episodes of care), or each provider's percentage of total patients receiving those services. An HHI value of less than 1,500 indicates a competitive market; values between 1,500 and 2,500 suggest moderate market concentration; and values above 2,500 points to highly concentrated markets. If a lone provider has 100% of the market share, the HHI value for the market is 10,000.

Analysis of potential price impacts for hospice is unique in that most hospice services are paid for by Medicare, with Medicaid being the second largest payer. Medicare sets the reimbursement rates paid to certified hospice agencies in the form of a daily rate for each patient enrolled in hospice, depending on the level of care provided. Annual reimbursement for a given patient is capped and patient out-of-pocket costs for hospice care are limited. Cost difference can vary by region primarily due to the wage index adjustment that Medicare applies to hospice payments. Consolidation in the hospice care market does not have the ability to impact pricing as it can in other health care markets less heavily dominated by regulated government payers, but clinical and billing practices at individual facilities can result in variations in costs for hospice services.[23]

OHA used claims data for the period beginning January 1, 2017, and ending on December 21, 2019, to analyze spending at three levels:

- Total annual payments: The total paid amount from primary insurance, coinsurance, and patient contributions (excluding insurance premiums) for billed hospice services each year (2017 – 2019). Coinsurance payments were only observed for patients dually eligible for Medicare and Medicaid, where the coinsurance amount was covered by Medicaid.
- Payment per episode: The total paid amount for hospice episodes initiated during the year divided by the number of episodes of hospice care initiated during the year.
- Payment per month of hospice care: Analogous to a per member per month payment for hospice, this is the total paid amount for episodes initiated during the year divided by the number of hospice months provided during those episodes (total length of stay in days divided by 12). This measure seeks to normalize payments across hospice facilities that serve different volumes of patients.

Table 2 below summarizes the measures OHA used to assess market shares, HHI, and spending. Spending measures were calculated relative to other licensed hospice agencies located in the service area. Standardized payment measures for hospice care are not readily available (CMS data collection focuses on clinical quality measures and patient and caregiver satisfaction survey data), so OHA is utilizing measures that approximate other standard spending indicators, including total, per person, and per member per month spending.

Each of these measures was calculated with three levels of comparison: Oregon statewide, the two Kindred hospice locations, and their respective PSAs.

Table 2: Cost Outcomes and Measures

Outcome	Assessment Method/Measure	Data
Market shares & HHI	• Hospice agency share of total of hospice episodes provided by licensed hospice agencies in the geographic service areas of Kindred Salem and Kindred Lake Oswego, respectively • HHI calculated as the squared sum of market shares	APAC claims, 2017-2019
Spending	• Total annual payments • Payment per episode • Payment per month of hospice care	APAC claims, 2017-2019

Access

Analyses under the access domain explore how the transaction may affect the range of services available in the market, types of providers and provider-patient ratios, characteristics of the patient population, and any barriers to access, including transportation burdens and limitations by insurance type.

Consolidation and change of ownership in the health care market can impact the range and type of services offered in the service area. Changes in population demographics can alter demand for some services and shifts in the labor market can impact availability of specific provider types, potentially affecting the financial viability and profitability of offering certain health care services in a region.

Access analyses therefore build on the findings in the cost domain around competition and assess the potential impact of the transaction on availability of services for all populations within a regional market.

Demographic information for patients with hospice claims is only available for individuals with corresponding enrollment data (see Data Sources section below).

Table 3: Access Outcomes and Measures

Outcome	Assessment Method/Measure	Data
Availability of services	• Number and type of hospice episodes annually for Kindred Lake Oswego and Salem compared to respective service areas • Average and median length of stay in hospice care	APAC data
	• Average daily census • Proportion of hospice episodes by terminal illness type	CMS data
Payer mix	• Number of episodes by payer	APAC data
Patient demographics	• Number of hospice patients by race, sex, and age	APAC data

Quality

Analyses in the quality domain explore how the transaction may affect patient outcomes and the experience of care. Consolidations and ownership changes in health care can impact clinical practice, including staffing ratios, time spent or number of visits with patients, timeliness of care, and the patient's experience of care, all of which can have adverse effects on patient outcomes. Analyses in the quality domain consider current indicators of quality and assess potential impacts of the transaction on quality of care.

Administrative data can elucidate some indicators of quality, but many quality indicators rely on other data sources, including clinical data from providers' electronic health records (EHR) or well-validated surveys administered to patients and caregivers. OHA utilized all publicly available sources of hospice quality data for this analysis but recognizes the limitations of this data in assessing performance by specific hospice location or patient subpopulation.

Table 4: Quality Outcomes and Measures

Outcome	Assessment Method/Measure	Data
Clinical processes	• Hospice Item Set (HIS) data on clinical process measures • Hospice Visits When Death Is Imminent	Clinical and claims data submitted to and reported by CMS
Patient outcomes	Number of hospice episodes by discharge type	APAC data
Patient experience	Caregiver evaluation of hospice staff and patient experience from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey	CAHPS Hospice Survey results submitted to and reported by CMS

Equity

Analyses in the equity domain explore how the transaction may affect the Entity's ability to assess for and equitably meet the needs of the population it serves. Consolidations and ownership changes in health care can disproportionately impact availability of health services for populations who already experience health inequities, including people of color, low-income families, and residents of rural areas. Policy changes regarding payer mix can limit access for patients who are uninsured, underinsured, or insured by government programs like Medicaid and Medicare that reimburse for services at lower rates. Less profitable facilities in socioeconomically underserved areas are more likely to be shuttered, severing important provider-patient relationships and forcing patients to travel farther to seek care with new providers less connected to their community.

Equity-focused analysis considers the entities' ability to serve a patient population that is representative of the community in which they operate. OHA also looks for evidence that the Entity is actively identifying and addressing inequities in access to or quality of care across their patient population, through community engagement or provision of equity-enhancing services (e.g., culturally- or linguistically appropriate services).

Comparison of patient population demographic characteristics is possible through administrative enrollment data, albeit with serious limitations in data completeness. Information about health care entities' equity-related efforts is not readily available in administrative data and is limited to publicly available sources. Additional information was not requested of the Entity for this preliminary review.

Table 5: Equity Outcomes and Measures

Outcome	Assessment Method/Measure	Data
Equitable access	• Demographic comparison of hospice patient population to regional population • Demographic comparison of length of stay	APAC data
Equitable cost	Demographic comparison of per episode payments	APAC data

Sources of Information

In addition to the materials provided as part of the Notice of Material Change, OHA's analysis was informed by administrative claims data, other publicly available data, public comments on the proposed transaction, and other sources.

Data

OHA analyzed administrative claims and enrollment data from Oregon's All Payer All Claims (APAC) database. Since 2012, the APAC program has been gathering claims and enrollment data from commercial insurance carriers and government agencies offering Medicare and Medicaid coverage to at least 5,000 people residing in Oregon. Some smaller insurance companies and self-insured organizations not required to report data to government agencies are exempt, but more than 90% of the Oregon population is represented in the database. Reported data includes claims data for medical, dental and pharmacy encounters, along with demographic information such as patients' residence (zip code), age, race, ethnicity, sex, and languages spoken. For race, ethnicity and language in particular, data is unavailable or unreported for a large percentage of people (between 50% and 70%), but completeness of data varies by insurance type. Additionally, race and ethnicity data in APAC is not consistent with OHA's Race, Ethnicity, Language and Disability (REALD) standards and therefore does not reflect the diversity in race, ethnicity, and language needed to accurately identify health inequities.

Data is reported each quarter, reflecting enrollment and services delivered in the prior 12 months. Given the time it takes to fully process all claims, it is understood that claims from the last quarter of the reporting may not be complete. As the reporting period shifts forward three months for every submission, each quarter of data is ultimately submitted four times, ensuring that all claims are fully processed, and any deletions or corrections are captured. Given this allowance for claims lag and processing, a calendar year's data is not considered 'complete' until the October submission of data the following calendar year. So, 2021 APAC data would not be complete until October 2022. OHA typically receives an annual submission of enrollment and claims data from CMS that is also lagged for completeness. The 2020 CMS data was expected in spring 2022 but has not yet been received. Given the significance of Medicare as a payer for hospice services, analyses looked at APAC data for services received in the 2017 - 2019, the most recent three years of available data that included complete Medicare, Medicaid, and commercial data.

OHA counted all patients who received hospice care from 2017 to 2019 to determine the patient population of Kindred locations and the broader hospice patient population served in their respective geographic service areas. OHA reports two counts for patient population: total patients and total patients with enrollment data. To calculate total patients, OHA used claims information for all individuals who received hospice care. Some of these individuals (19,496 or 31%) do not have corresponding enrollment data and are therefore missing demographic and residence information.

These individuals represent a significant portion of patient and service volume in hospice care, so their claims data were included in access and cost analyses. For analyses requiring demographic or residence information, OHA only included individuals for whom enrollment data was available.

As the payer for the majority of hospice episodes nationally and in Oregon, CMS is an important source of information about hospice facilities and services. Certified hospice agencies are required to report data to the Hospice Quality Reporting Program, which looks at three key data sources to determine quality of hospice care:

- Hospice Item Set: includes clinical information for all admissions into and discharges from hospice care during the reporting period; data supports performance evaluation on process and clinical measures
- CAHPS Hospice Survey: this hospice-specific survey is administered monthly from a third-party vendor to caregivers of hospice patients; data supports performance evaluation on quality and experience of care and is the foundation for CMS' Star Ratings for hospice facilities
- Administrative claims: submission of claims for billing purposes supplies CMS with administrative data that supports performance evaluation for certain process measures that point to quality of care (e.g., visits within the last days of life)

CMS makes these data sources publicly available at the national and provider level, allowing for comparison of performance at the regional and statewide level as well.[24]

OHA also utilized data provided in the Entity's notice, including average daily census, average patients served annually, and average annual revenue. These data were reported to be from the most recent two- or three-year period (assumed to be 2019 – 2021). This data is more recent than the administrative data available in APAC and the publicly available data reported by CMS. Therefore, OHA's analysis does not attempt to validate this information but rather considers this part of the continuum of information over time that describes the service capacity and payment patterns for the two Kindred hospice facilities.

Public Comments

OHA solicited public comments on the proposed transaction during the preliminary review. On June 14, 2022 OHA posted a comment form to the Transaction Notices and Reviews page of the HCMO website and emailed subscribers to HCMO program updates to inform them about the opportunity to provide comment. OHA accepted comments through June 28, 2022, via the form and by email to hcmo.info@dhsoha.state.or.us.

OHA considered all comments received by the deadline prior to arriving at a decision on the proposed transaction. The Findings section below includes a summary of these comments.

Other Sources

OHA considered additional publicly available sources of information regarding the proposed transaction, the entities involved, and recent developments in the hospice sector. Materials included press releases, financial reports filed with the Securities & Exchange Commission (SEC), websites of the entities involved in the transaction, reports commissioned by the U.S. Congress and other relevant communications issued by the federal government.

OHA also considered academic articles and research reports about private equity ownership of health care entities.

Findings

OHA analyzed data to understand baseline performance of Kindred Hospice locations in Oregon and examined the projected impact of the transaction across four domains: access, cost, quality, and equity.

Baseline

To measure baseline performance, OHA used data for calendar years 2017, 2018, and 2019. These baseline data will be used as a comparison for future monitoring and follow-up analyses.

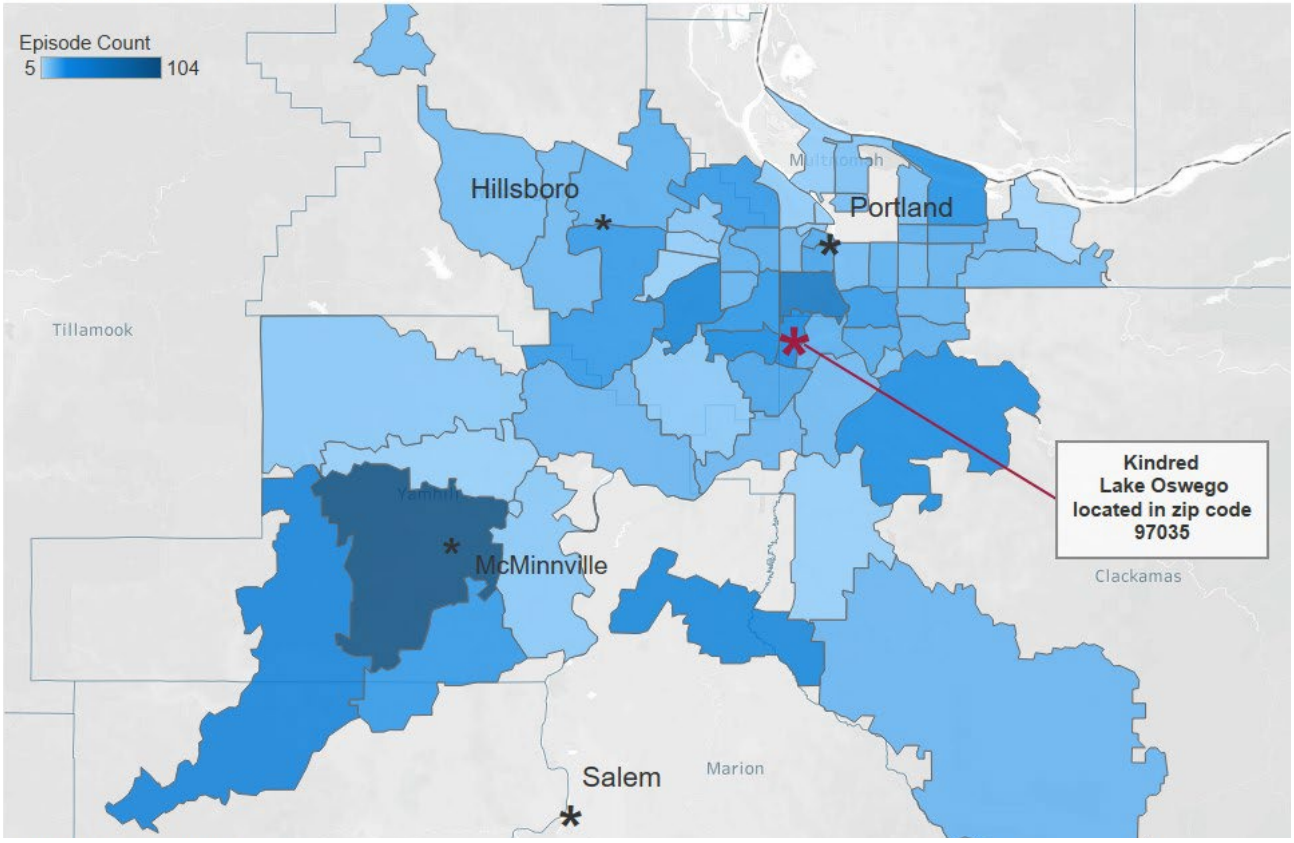
Overview

Primary Service Areas

To understand what geographic region and population Kindred Lake Oswego and Kindred Salem primarily serve, OHA defined primary service areas (PSAs) for each hospice location. (For details, please see the Analytic Approach section.)

The maps below display the geographic PSA for Kindred Lake Oswego and Kindred Salem, respectively. The PSA includes all shaded zip codes, with darker shades indicating more care episodes for patients residing in that area. The hospice location within the PSA is also indicated.

Kindred Lake Oswego Primary Service Area



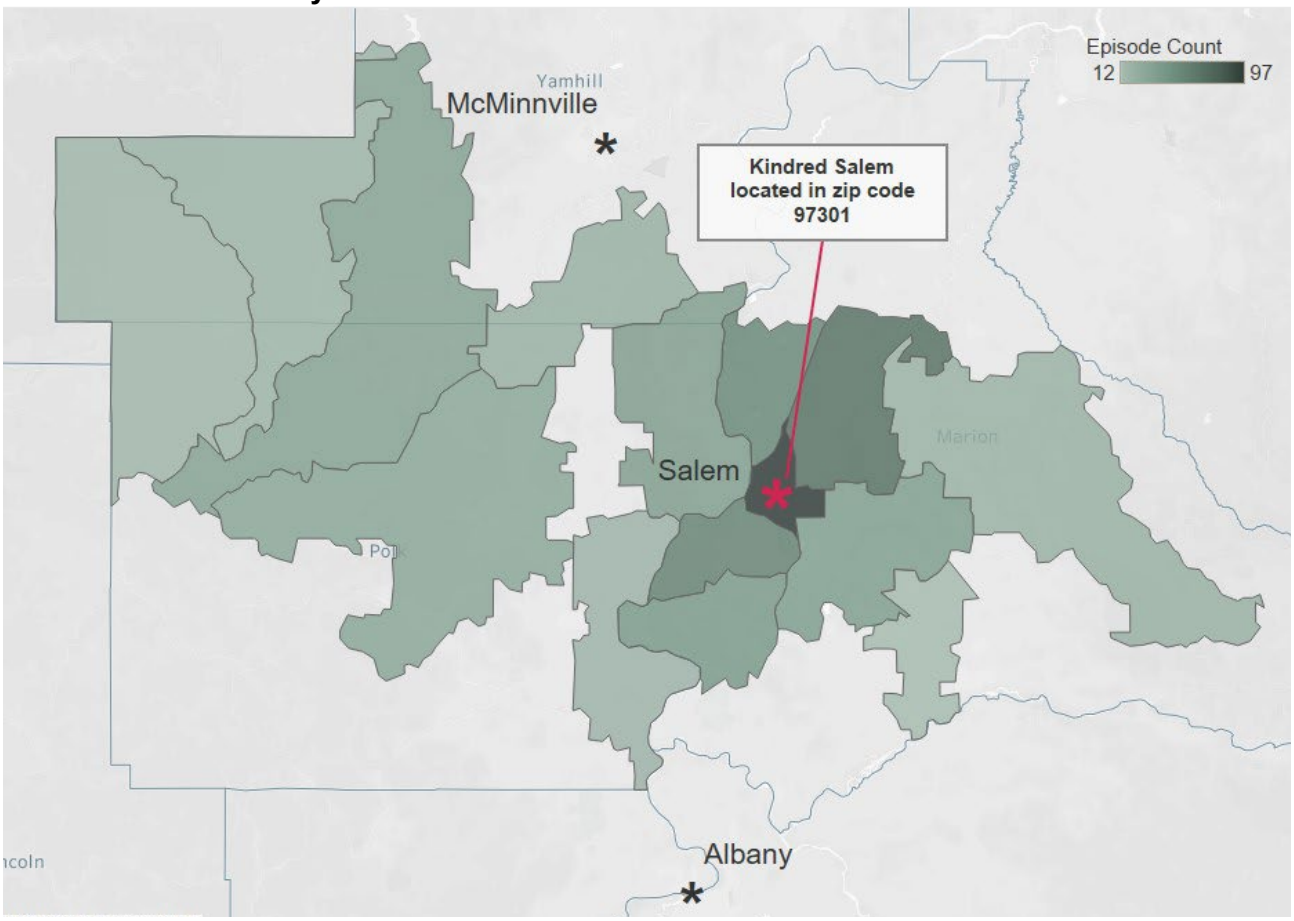
The Kindred Lake Oswego PSA includes areas of Multnomah, Washington, Clackamas, Yamhill, Polk, and Marion counties. Kindred Lake Oswego provided 1,276 episodes of care to 1,256 individuals during the 2017 – 2019 period.

Table 6: Top Five Zip Codes for Kindred Lake Oswego Patients

Town	Zip Code	Episode count
McMinnville	97128	104
Portland	97219	52
Sheridan	97378	33
Aloha/Kinton	97007	32
Woodburn	97071	31

Shaded zip codes represent the area comprising 75% of all hospice episodes for Kindred Lake Oswego, but unshaded zip codes that are contiguous with the PSA or surrounded by zip codes included in the PSA may still be home to a small number of Kindred Lake Oswego patients that comprise the remining 25% of episodes for the facility. The Lake Oswego PSA is more defuse than the Salem PSA, comprising 58 zip codes verses 15. (See Appendix B: Methodology for details.)

Kindred Salem Primary Service Area



The Kindred Salem PSA includes areas of Marion, Polk, Yamhill, and Tillamook counties. Kindred Salem provided 644 episodes of care to 632 individuals during the 2017 – 2019 period.

Table 7: Top Five Zip Codes for Kindred Salem Patients

Town	Zip Code	Episode count
Salem	97301	97
Hayesville	97305	68
Salem	97302	56
Keizer	97303	53
Rosedale	97306	40

Market Share & Consolidation

OHA identified 11 comparison licensed hospice agencies physically located in the Lake Oswego service area. Market share was calculated based on the number of hospice episodes attributed to hospice agencies in the service area in calendar years 2017 through 2019. The agency with the largest market share accounted for 20.9% of hospice episodes. Kindred Lake Oswego had an 8.8% market share.

Kindred Lake Oswego Market Share

For the 2017-2019 time period, **Kindred Lake Oswego** had the fourth largest market share of licensed hospice agencies in the Lake Oswego service area.

Additional licensed and unlicensed hospice facilities located outside the zip codes of the Lake Oswego service area also provided services to residents in this region during the 2017 – 2019 time period. Accounting for all hospice agencies that delivered care to residents of the service area, Kindred Lake Oswego's market share was 4.5%

Considering only the licensed hospice facilities physically located in the Lake Oswego service area, the HHI for the Lake Oswego market is 1,220, an indication of a competitive market.

OHA identified four comparison licensed hospice agencies physically located in the Salem service area. The agency with the largest market share accounted for 54% of hospice episodes, while Kindred Salem had a 13.8% market share.

Kindred Salem Market Share

For the 2017-2019 time period, **Kindred Salem** had the third largest market share of licensed hospice agencies in the Lake Oswego service area.

As with the Lake Oswego region, other licensed and unlicensed hospice facilities located outside the Salem service area delivered care to residents of the region during this period. Accounting for all hospice agencies that delivered care to residents of the service area, Kindred Salem's market share was 10.5%.

Considering only licensed hospice facilities physically located in the Salem service area, the HHI for the Salem market is 3,637, an indication of a moderately concentrated market. A notable portion of patients residing in the Salem service area received care from hospice facilities located outside the geographic region, with many accessing facilities located in the Portland area. Including these facilities in an HHI calculation (2,190) still suggests the market is moderately concentrated and therefore more susceptible to possible impacts on cost and access.

Access

Total Patient Population

OHA measured hospice patients served using claims data (Total Patients in the table below). Some patients had claims information, but no enrollment data. OHA also calculated the number of hospice patients served who also had reported enrollment data, which includes demographic and residency information (Total Patients with Enrollment Data in the table below).

Table 8: Total Patients by Location, 2017-2019

Location	Total Patients (based on claims)	Total Patients with Enrollment Data
Kindred Lake Oswego	1,256	895
Lake Oswego Service Area	9443	5521
Kindred Salem	632	394
Salem Service Area	3321	1969

Since hospice provides care at the end of life, the majority of patients are older adults (65 or older). However, hospice services are available for patients of all ages and some hospice facilities exclusively serve pediatric patients. The two Kindred hospice locations in Oregon served patients ranging from ages 20 to 107. Comparison entities in the Lake Oswego service area served adults aged 16 and older, while the Salem service area hospice entities also served children.

Table 9: Total Patients by Age, 2017-2019

Age	Kindred Lake Oswego	Kindred Salem
0-19	0	0
20 - 44	30	12
45 - 64	129	88
65 – 84	433	178
85+	303	116
Total	895	394

Average Daily Census

CMS reported the following average daily census data for 2019, indicating the average number of hospice patients being actively served by the facility on any given day:

Kindred Lake Oswego: 63.0

Kindred Salem: 16.0

These data suggest that Kindred's Lake Oswego location had four times the capacity of the Salem facility in 2019. The Entity indicated that average daily census for these locations from the last two years (presumed to mean 2020 and 2021) were 52.9 and 34.8, respectively. This suggests the

Lake Oswego location has decreased capacity since 2019 while the Salem location's capacity has more than doubled.

Total Hospice Episodes

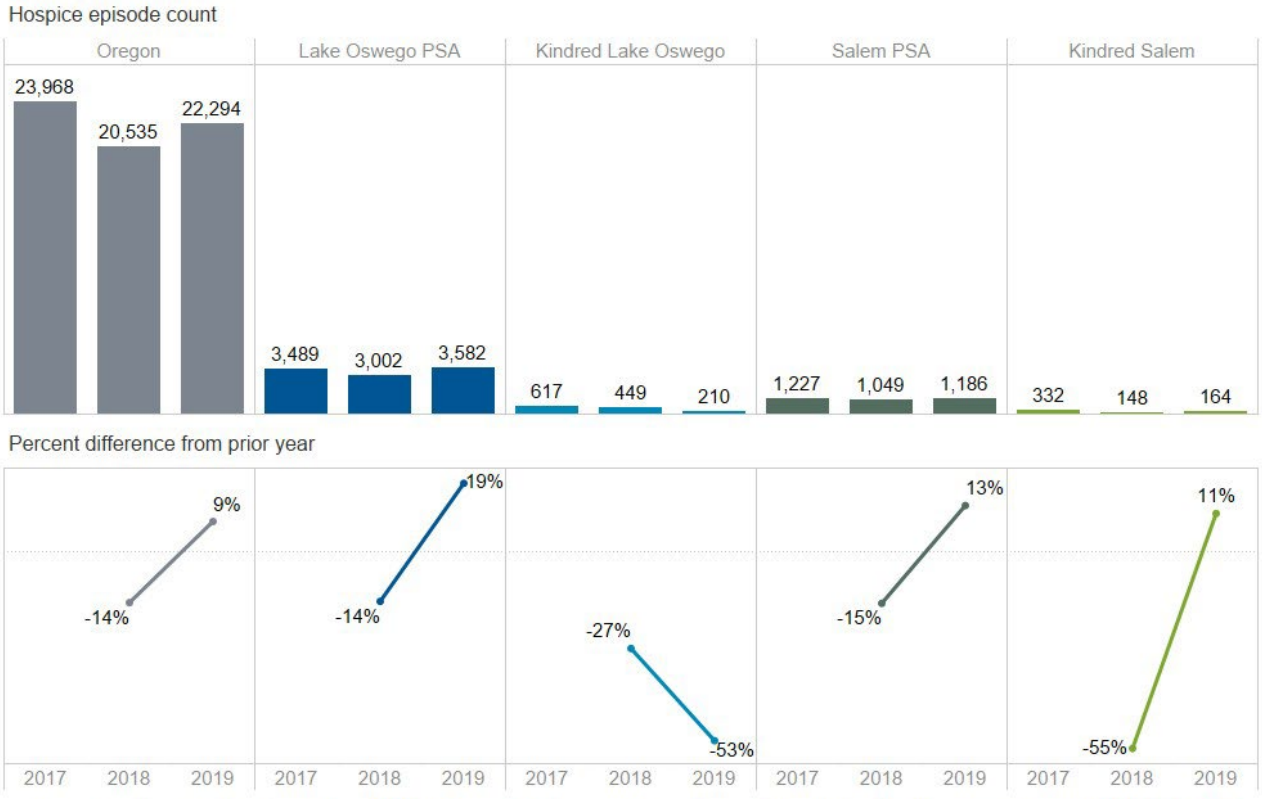
While average daily census highlights a facility's capacity to serve patients day by day, a count of total episodes indicates how many patients they are able to serve each year.

Occasionally a patient may discharge from hospice care then re-elect for another hospice episode later in the year. Care that is re-initiated beyond 60 days of discharge is considered a new episode, both for CMS and this analysis. Over this three-year period, care was provided to 1,256 patients in 1,276 episodes at Kindred Lake Oswego and 632 patients in 644 episodes at Kindred Salem. For purposes of this analysis, per episode calculations are considered equivalent to per person calculations and only per episode calculations are presented.

Statewide, the volume of hospice episodes declined then increased during this 2017 – 2019 analysis period. Other hospice facilities in the Lake Oswego and Salem PSAs experienced a similar pattern of episode volume, but the Kindred hospice locations episode count looked notably different, especially the Lake Oswego facility.

Hospice Episodes by Year

Statewide and in the **Lake Oswego PSA** and **Salem PSA**, hospice episode counts decreased in 2018 but rebounded in 2019. By contrast, **Kindred Lake Oswego** experienced a continued decrease in episode count in 2019 and **Kindred Salem**'s episode count rebounded only slightly in 2019.



Count of hospice episodes from 2017 - 2019 and percent difference from prior year by region and facility: Oregon total, **Lake Oswego PSA**, **Kindred Lake Oswego**, **Salem PSA** and **Kindred Salem**

Length of Stay

A hospice facility's capacity depends on how long each patient requires care, and at what level of intensity. Hospice facilities that serve a greater proportion of patients requiring longer periods of intensive care may be limited in the overall volume of patients they are able to serve at any given time and over the course of a year.

Some patients enter hospice care very late in the progression of their terminal illness and receive hospice services for a week or less. Other patients are referred to hospice early and remain in care much longer than 6 months. In 2019, the average and median length of stay (LOS) for episodes initiated during the year at Kindred Lake Oswego exceeded those for Oregon overall and the surrounding PSA. Conversely, the average and median length of stay (in days) at Kindred Salem were lower than statewide and Salem PSA calculations.

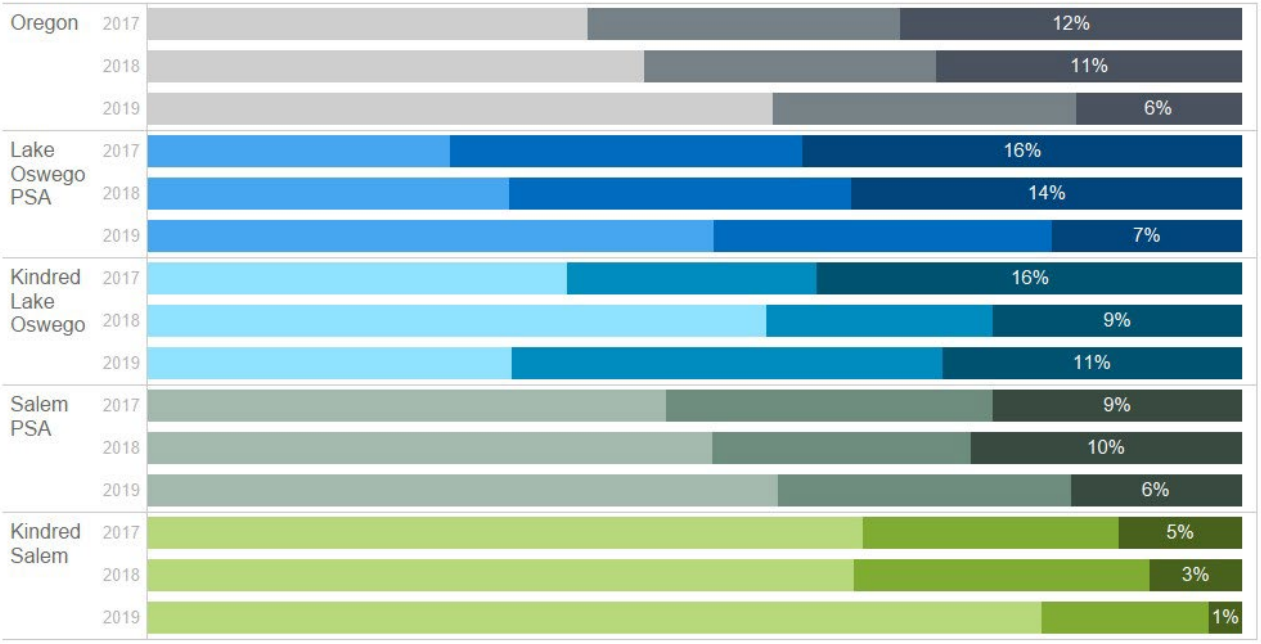
Table 10: Length of Stay, 2019 (in days)

Region	Shortest stay	Longest stay	Average stay	Median stay
Oregon	1	365	48.6	20.0
Lake Oswego PSA	1	365	53.6	25.0
Kindred Lake Oswego	1	301	66.7	35.0
Salem PSA	1	358	47.9	19.0
Kindred Salem	1	300	30.3	12.5

The decrease in average daily census and episode volume at Kindred Lake Oswego appears to correlate to a higher proportion of patients receiving hospice care beyond the initial 6-month period. Conversely, the increased capacity at Kindred Salem corresponds to a decrease in extended episodes from 2017 to 2019 that allowed this location to serve a higher volume of patients each year.

Length of Stay by Region and Year

Statewide, the proportion of hospice stays extending beyond 6 months decreased from 2017 to 2019 (to 6%) but at **Kindred Lake Oswego** the proportion of these extended stays increased in 2019 (to 11%), beyond the statewide and PSA rate. Hospice stays beyond 6 months at **Kindred Salem** represented only 1% of episodes in 2019, below the **Salem PSA** rate (6%).



Proportion of hospice visits from 2017 - 2019 lasting from 1 to 90 days (lightest shades), 91 to 180 days (middle shades), and visits 181 days or longer (darkest shades) by year and region.

Length of Stay and Acuity

Length of stay in hospice care is dictated by the acuity of a patient's terminal illness and how quickly they reach end of life after electing for hospice services. Some conditions cause a patient's health status to deteriorate quickly while others can be less debilitating but result in a patient requiring significant support from a hospice team before reaching acute terminal state.

According to recent reports, the number of hospice patients with conditions of the nervous system (such as dementia and Alzheimer's) has been increasing. Additionally, providers may be referring patients to hospice care earlier, to ensure patients and their caregivers receive the full benefit of the range of services provided.[25]

Percent of Hospice Patients with Specific Conditions

Variation in lengths of hospice episodes may be related to the proportion of patients with longer-term conditions, such as **dementia** and **stroke**. In 2019 Kindred Lake Oswego had the longest average and median lengths of stay (67 and 35) and the highest proportion of patients with dementia or stroke (41% compared to 30% statewide). Kindred Salem had the shortest average and median lengths of stay (30 and 12) and the lowest proportion of patients with dementia or stroke (25%)

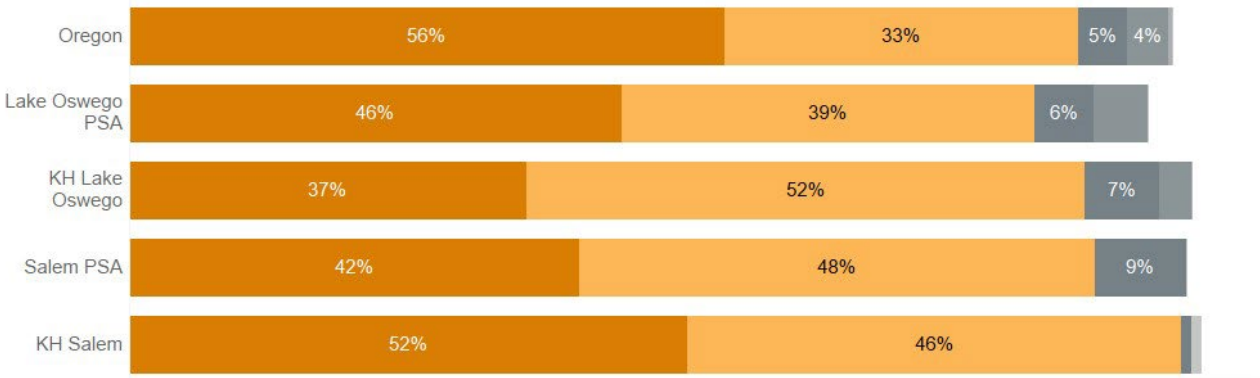
Relative percent of hospice patients with specific conditions in 2019, including **cancer**, **dementia**, **stroke**, **circulatory/heart disease** and **respiratory disease**

Hospice Setting

Hospice care can be delivered in a range of settings, depending on a patient's circumstances and needs. In Oregon, most hospice care is delivered in the home, but the proportion of patients at both Kindred locations receiving services in an assisted living facility is higher than the statewide rate. This is likely correlated to the high number of assisted living facilities available in the Portland and Salem metro areas, compared to other parts of the state.[26]

Location of Care Delivery

Kindred Lake Oswego served the lowest proportion of patients at **home** (37% compared to 56% statewide) and the highest proportion of patients in an **assisted living facility** (52% compared to 33% statewide). KH Salem served a greater proportion of patients at **home** than other facilities in the Salem PSA, which provided more services in **nursing facilities** than any other region (9% compared to 5% statewide).

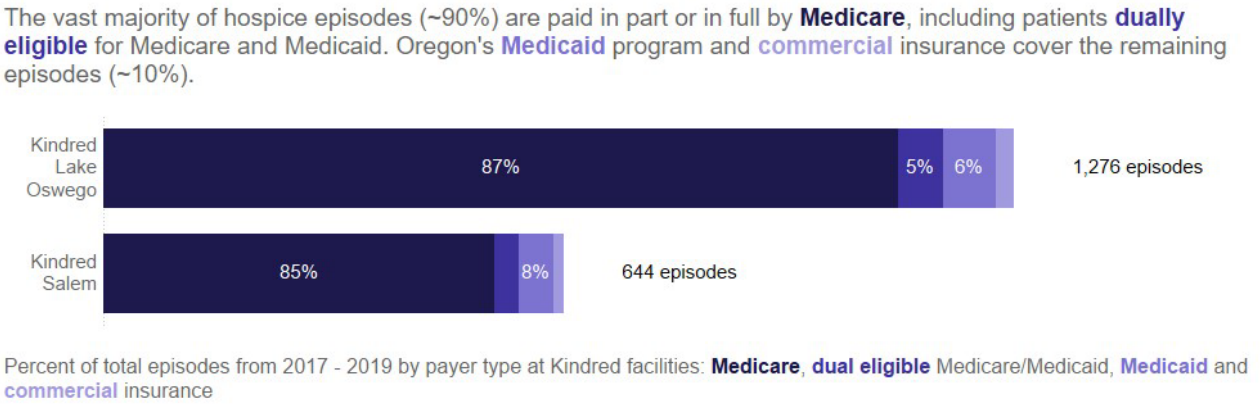


Location of care delivery in 2019, including **home**, **assisted living facility**, **nursing facility**, **skilled nursing facility**, **inpatient hospice**, and **inpatient hospital**

Payer Mix

Hospice services are typically covered by all insurance types, but most hospice patients are Medicare beneficiaries. Nationally, statewide and regionally, Medicare covers nearly 90% of all hospice episodes. In Oregon, Medicaid and commercial plans cover all other hospice care, typically for patients who too young to be eligible for Medicare. Acceptance of all insurance types makes hospice care accessible to the whole population. Kindred Hospice facilities need to continue to meet CMS certification and Hospice Quality Reporting Program requirements, as well as maintain their Oregon license, in order to remain eligible for Medicare and Medicaid reimbursement and ensure these services remain available to all older adults.

Percent of Hospice Episodes by Payer Type



Staffing

Both Kindred hospice locations provide non-hospital-based services, meaning they are not certified as an inpatient hospice facility. However, staff at each location do provide care at each of the four levels of Medicare reimbursement: routine home care, continuous care, inpatient respite and general inpatient.

The Kindred Hospice website outlines the composition of a typical care team at any of their facilities across the country, including a hospice physician, nurse case manager, hospice aide, hospice volunteer, spiritual care coordinator, social worker and other practitioners as needed.[27] The subsites specific to each Oregon location do not provide staffing details.

Recent studies indicate that some hospices have had to turn down referrals due to staffing shortages.[28] Case studies at hospice facilities owned by private equity firms have highlighted a lack of investment in staffing that resulted in poor outcomes for patients.[29] This preliminary review did not include gathering data on staffing at each Kindred facility, but maintenance of current staffing ratios is critical to ensuring availability of timely services post-transaction.

Cost

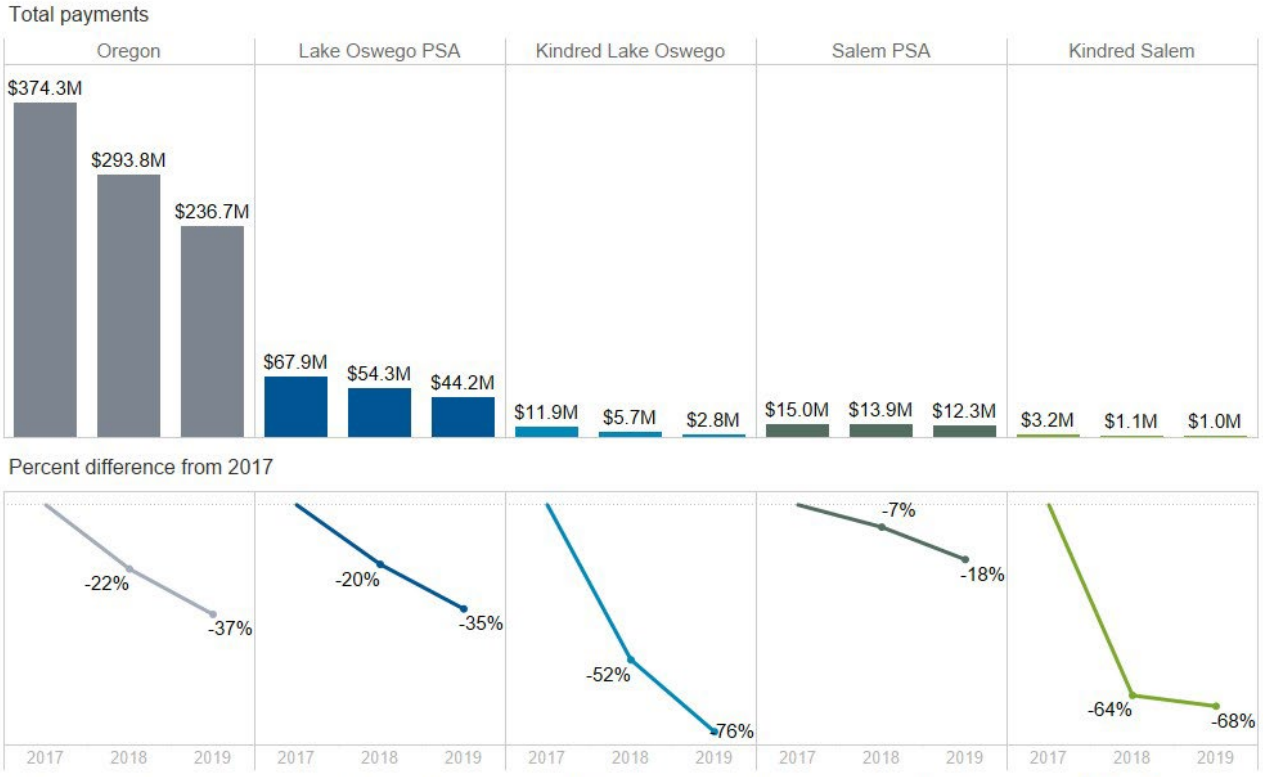
Analysis of total payments for hospice services, payment per episode and payment per month of hospice care included all services delivered by the two Kindred hospice locations and other licensed hospice facilities in their respective PSAs. Because this includes palliative care services, which are delivered and billed identically to hospice services but are not subject to caps in Medicare reimbursement, cost calculations of per episode and per month of hospice care may exceed payment limitations outlined in CMS regulations. Inclusion of palliative care in this analysis elucidates the full spectrum of payments earned by these hospice facilities.

Total Payments

Total payments for hospice care decreased steadily from 2017 to 2019, despite a rebound in hospice episode volume from 2018 to 2019 (see Access section above). Total payment in the Lake Oswego and Salem PSAs mirrored statewide trends, but the Kindred hospice facilities in these regions steeper declines in total payments were more in line with the observed reduction in episode volume.

Total Payments for Hospice Services by Region and Year

Statewide, hospice facilities experienced a decrease in total payments from 2017 to 2019 that does not match the pattern of total episodes during this period. The **Kindred Lake Oswego** and **Kindred Salem** locations saw a steeper drop in total payments than peer facilities located in their respective service areas, particularly in the Salem region.

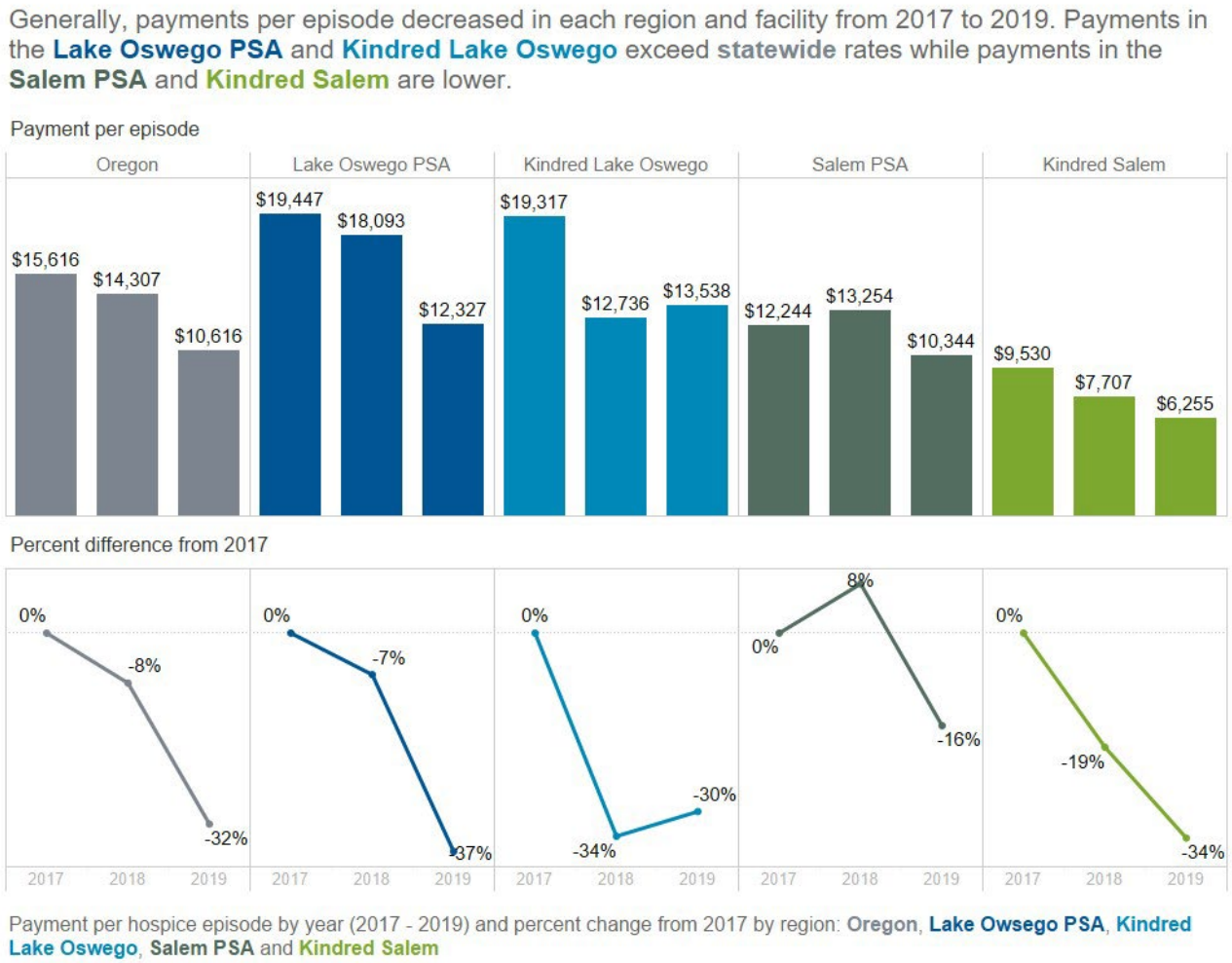


Total payment for hospice services 2017 - 2019 and percent difference from 2017 by region and facility: Oregon total, **Lake Oswego PSA**, **Kindred Lake Oswego**, **Salem PSA** and **Kindred Salem**

Per Episode Payments

To account for differences in hospice episode volume, OHA assessed payment per episode during this period. Payments per episode decreased steadily statewide but differences were observed in the Lake Oswego and Salem regions. Higher rates of per episode payments in the Lake Oswego region is due in part to higher wage index adjustment factor CMS applies to hospice payments for the Portland-Vancouver-Hillsboro area (of which Lake Oswego is a part) than for the Salem area.

Payments per Hospice Episode by Region and Year



Payment per hospice episode by year (2017 - 2019) and percent change from 2017 by region: **Oregon**, **Lake Owsego PSA**, **Kindred Lake Oswego**, **Salem PSA** and **Kindred Salem**

Table 11: CMS Wage Index

Region	Wage Index		
	2017	2018	2019
Lake Oswego (P-V-H)	1.2315	1.2216	1.2065
Salem	1.0724	1.0489	1.0715

Per episode payments in the Lake Oswego PSA closely mirror the changes in wage index adjustment across this period, but per episode payments in the Salem PSA increased in 2018 while the wage index adjustment decreased for this area.

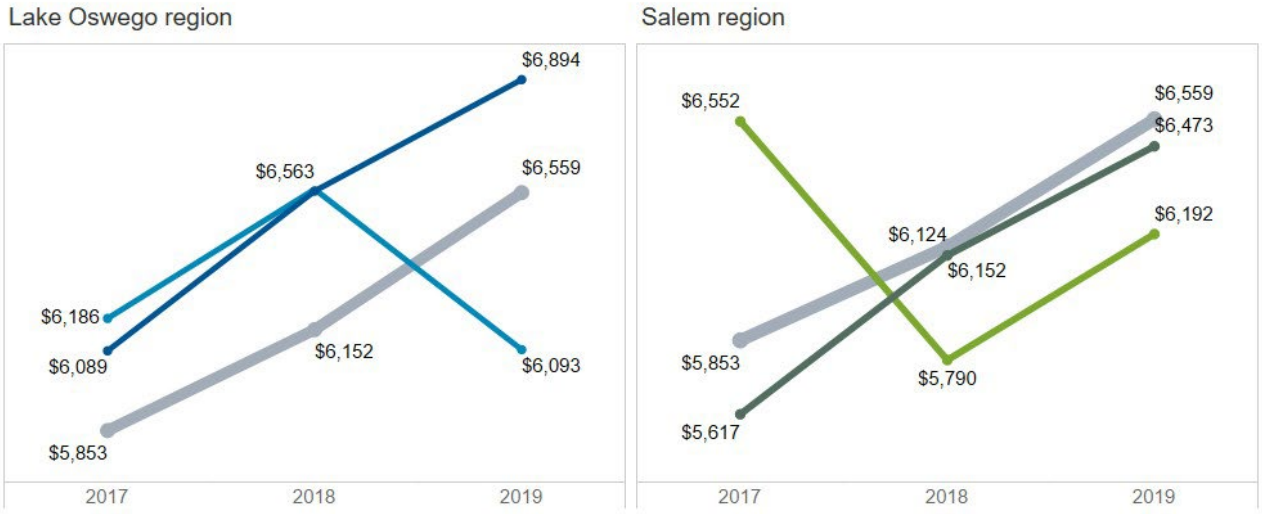
Payment per Hospice Month

Analysis of length of stay per hospice episode revealed observable differences in average and median lengths of stay by region and facility, as well as the proportion of episodes extending beyond 6 months (see the Access section above). To understand patterns in payment by a standardized unit, OHA calculated payment per month of hospice care, analogous to a per member per month payment measure.

Payment per hospice month trends for both PSAs followed the steady increase seen at the state level. However, both Kindred facilities in Oregon saw more volatility in their per hospice month payments during the 2017 – 2019 period. Kindred Lake Oswego's payment per hospice month was closely aligned with the PSA but diverged well below PSA and state rates in 2019. Kindred Salem's per hospice month payment was much higher than the Salem PSA or statewide rates in 2017 then dropped below both rates in 2018.

Payments per Month by Region

Payment per month for the 11 other hospice facilities in the **Lake Oswego PSA** exceeded the **statewide total** but followed the overall upward trend from 2017 to 2019 while **Kindred Lake Oswego** payment decreased below the statewide total in 2019. Payment per month for the 4 other hospice facilities in the **Salem PSA** was slightly below the **statewide payment** but also followed the overall upward trend from 2017 to 2019. Payment for **Kindred Salem** was much higher than the state total in 2017 but decreased considerably in 2018.



Payment per month of hospice service from 2017 to 2019 by facility and region: Oregon total, **Lake Oswego PSA**, **Kindred Lake Oswego**, **Salem PSA**, and **Kindred Salem**

One factor that could influence payment per hospice month may be the ratio of care provided at different levels throughout the hospice episodes each year. Hospice services delivered to a patient in an inpatient respite setting or receiving general inpatient care are reimbursed at a much higher daily rate (see Table 1 above in the Overview of Hospice Care section). It is difficult to explain these divergent trends for the individual Kindred facilities without a deeper dive into the claims data, which fell beyond the scope of this preliminary review. Level of care delivery and corresponding reimbursement will be included in OHA's follow-up reporting on the impact of this transaction one, two, and five years after closing.

Quality

To assess quality, OHA utilized claims data and existing CMS quality reporting for patient outcomes, clinical quality, and patient experience.

Patient Outcomes

The main outcome of hospice care is patient death, but patients may end services when transferring to other levels of care (e.g., hospital or skilled nursing facility) or electing to end hospice care. The rate of live discharges from hospice is a quality concern for hospice facilities nationally, as it may indicate that patients may not require hospice-level care and unnecessary services are being billed to Medicare.

Around 80% of all hospice episodes in Oregon during this 2017 – 2019 period ended in patient death. No hospice episodes ended with a discharge to other levels of care, indicating that hospice services appropriately followed patients as their medical needs escalated. This analysis also captured the interim outcome of transfer from one hospice facility to another (1% of episodes statewide, 3% at Kindred Lake Oswego). Given the cut-off of claims in 2019, this data also captures the discharge status of 'continued patients' for a portion of episodes that continued into 2020 (~8% statewide). 1% of episodes ending in 2017 and 2018 also indicated the patient was continuing care but this is likely due to unresolved billing. Discharge status was unreported for 10% of episodes statewide.

There were no observable differences in episode outcome between each Kindred facility, their respective PSAs and statewide rates and no concerns raised about rates of live discharges from care.

Clinical Quality

OHA assessed performance on measures of clinical quality and patient experience reported by CMS for the Kindred facilities in Oregon, compared to regional PSA and statewide rates. Most recent data coinciding with this 2017 – 2019 analysis period was from 2018.

Certified hospice facilities submit clinical data from their medical records to CMS that support calculation of performance on clinical process and quality measures in the Hospice Item Set (HIS). The two clinical quality measures reported for 2018 were provision of a bowel regimen for patients receiving opioids for pain management and visits provided when death was imminent. In 2018, the latter measure specifically assessed the percent of patients who received at least one visit from a physician, registered nurse, nurse practitioner, or physician assistant in the last three days of life.

Performance for all regions and facilities was universally high (98% and above) for provision of a bowel regimen for patients receiving an opioid (data not shown), but performance diverged for imminent end-of-life visits.

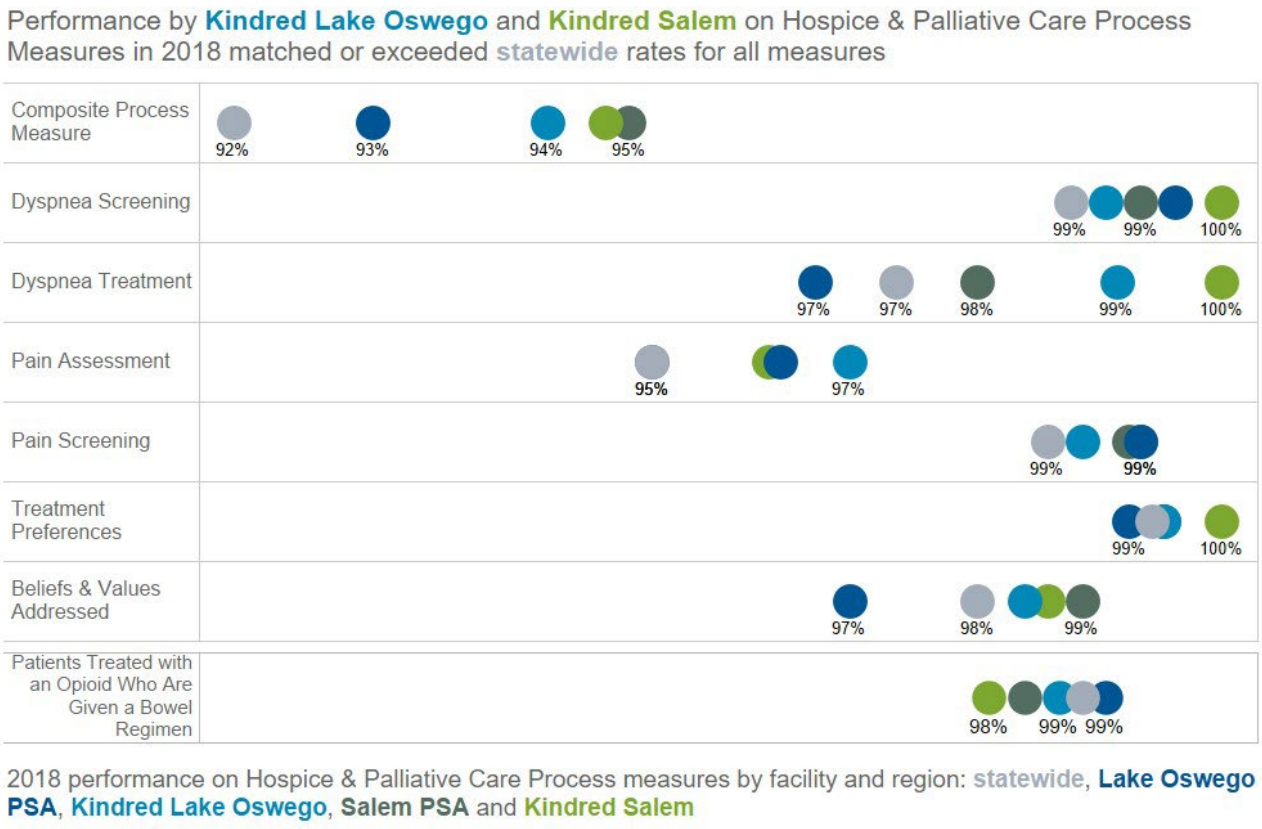
2018 Measure Performance: Hospice Visits When Death is Imminent

2018 performance on Visits When Death is Imminent (Measure 1) from the Hospice Item Set by region and facility: statewide, **Lake Oswego PSA**, **Kindred Lake Oswego**, **Salem PSA** and **Kindred Salem**

Six additional HIS clinical process measures serve as standard indicators for clinical outcomes and responsiveness to patients' clinical and social needs and the seven measures collectively comprise the Hospice Comprehensive Assessment composite measure (National Quality Forum measure #3235).

For all 7 measures and the composite, performance at the two Kindred locations was equal to or higher than statewide and PSA rates.

2018 Measure Performance: Hospice & Palliative Care Process Measures



Patient Experience

Certified hospice facilities are required to administer the hospice-specific Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey through a third-party vendor each quarter. The survey captures caregiver evaluation of their experience with the hospice team and how the staff cared for the patient.

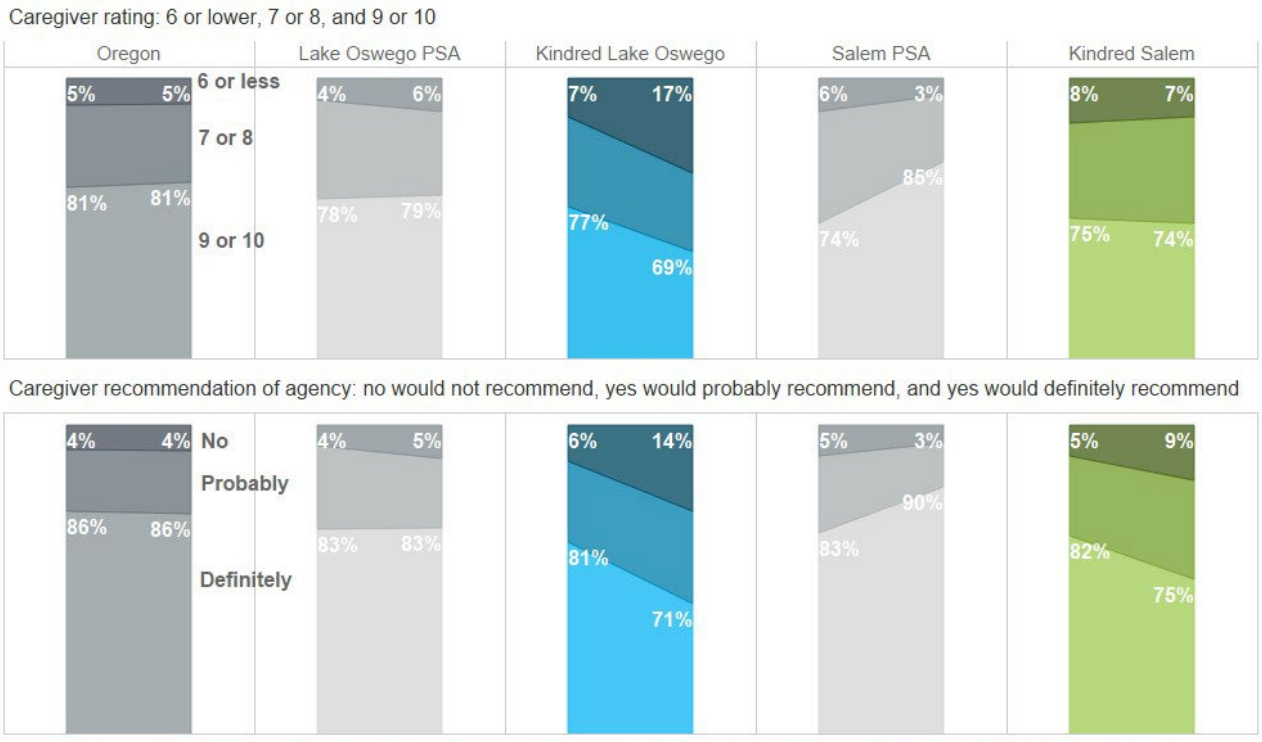
Available CAHPS Hospice Survey results that correspond to this 2017 – 2019 analysis period cover calendar years 2017 and 2018 (reported together as a single reporting period) and the 2019 calendar year (reported as a single year reporting period).

CAHPS results show a marked decline in caregiver satisfaction at the two Kindred locations while results statewide and at each PSA remained consistent or improved during this period.

Caregivers of patients at Kindred Lake Oswego and Kindred Salem reported lower rates of overall satisfaction with the facility, demonstrated by an increase in lowest facility rankings (out of 10 points) and responses that they would not recommend the hospice agencies.

Measure Performance: CAHPS Caregiver Rating and Recommendation

The percent of negative responses from caregivers increased at the **Kindred Lake Oswego** and **Kindred Salem** locations while scores remained consistent or improved **statewide** and for other facilities within the **Lake Oswego PSA** and **Salem PSA.** A greater proportion of caregivers gave the 2 Kindred facilities the lowest ranking (6 or lower) and indicated they would not recommend the agency.

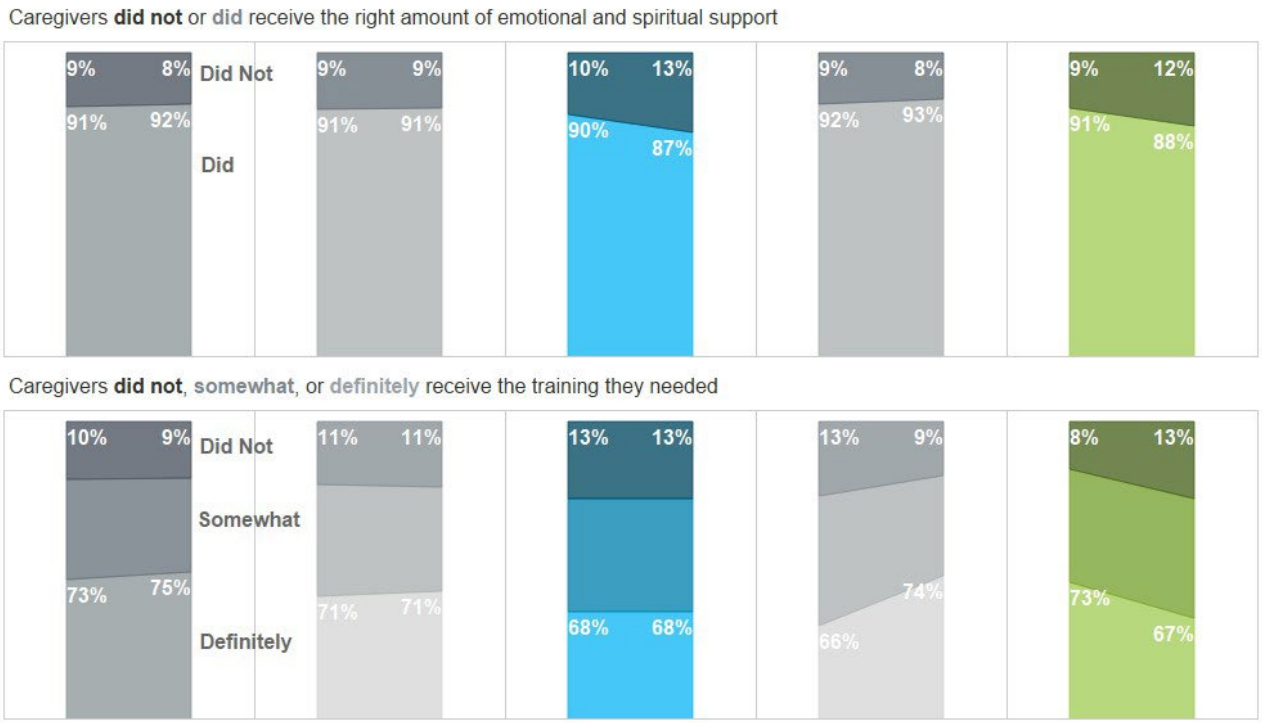


Rate of patient caregiver responses to CAHPS Hospice Survey questions from 2017/2018 and 2019 regarding satisfaction with the hospice facility by region and facility. Overall ranking on a 10 point scale: 6 or lower (darkest shades), 7 or 8 (medium shades) and 9 or 10 (lightest shades). Recommendation of the hospice agency: no would not recommend (darkest shades), yes would probably recommend (medium shades) and yes would definitely recommend (lightest shades).

Caregivers of patients at the two Kindred locations also reported a decrease in satisfaction with their interactions with the hospice team in 2019, also while response rates to these questions remained steady or improved statewide and in each service area.

Measure Performance: CAHPS Caregiver Emotional Support and Training

A greater percent of caregivers at **Kindred Lake Oswego** and **Kindred Salem** indicated the hospice team did not provide the right amount of emotional and spiritual support statewide and at each PSA. Caregivers at **Kindred Salem** reported a notable decrease in feeling they received the training they needed from the hospice team, compared to improvement in the Salem PSA.

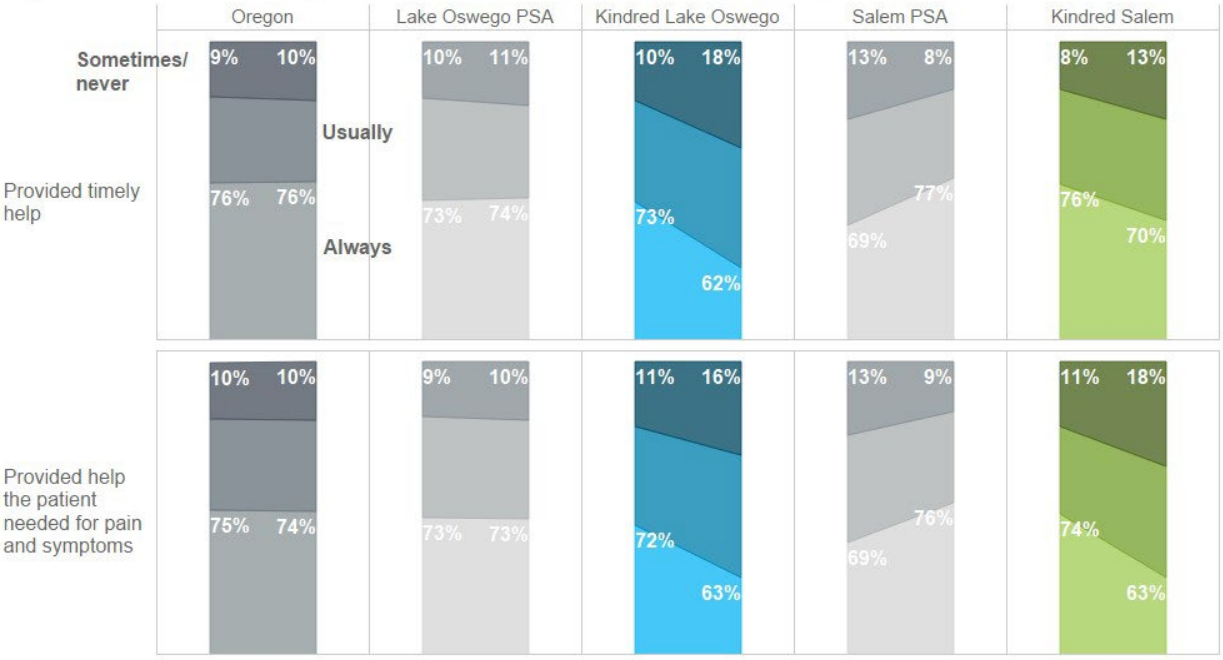


Rate of caregiver responses to CAHPS Hospice Survey questions regarding support from the hospice team from 2017/2018 to 2019 by region and facility. Top chart, responses that the hospice team did not (darkest shade) or did (lightest shade) provide the right level of emotional and spiritual support. Bottom chart, responses that caregivers did not (darkest shade), somewhat (medium shade) or definitely (lightest shade) receive the training they needed from the hospice team.

Following a similar pattern, caregiver satisfaction with patient interaction (communication and respect) and patient support (timely help and help with pain) at the two Kindred facilities declined in 2019. Notable decreases in satisfaction with timeliness of help were reported by caregivers of patients at Kindred Lake Oswego, and caregivers at both facilities responded less favorably to the question regarding provision of help for pain and symptoms.

Measure Performance: CAHPS Patient Support

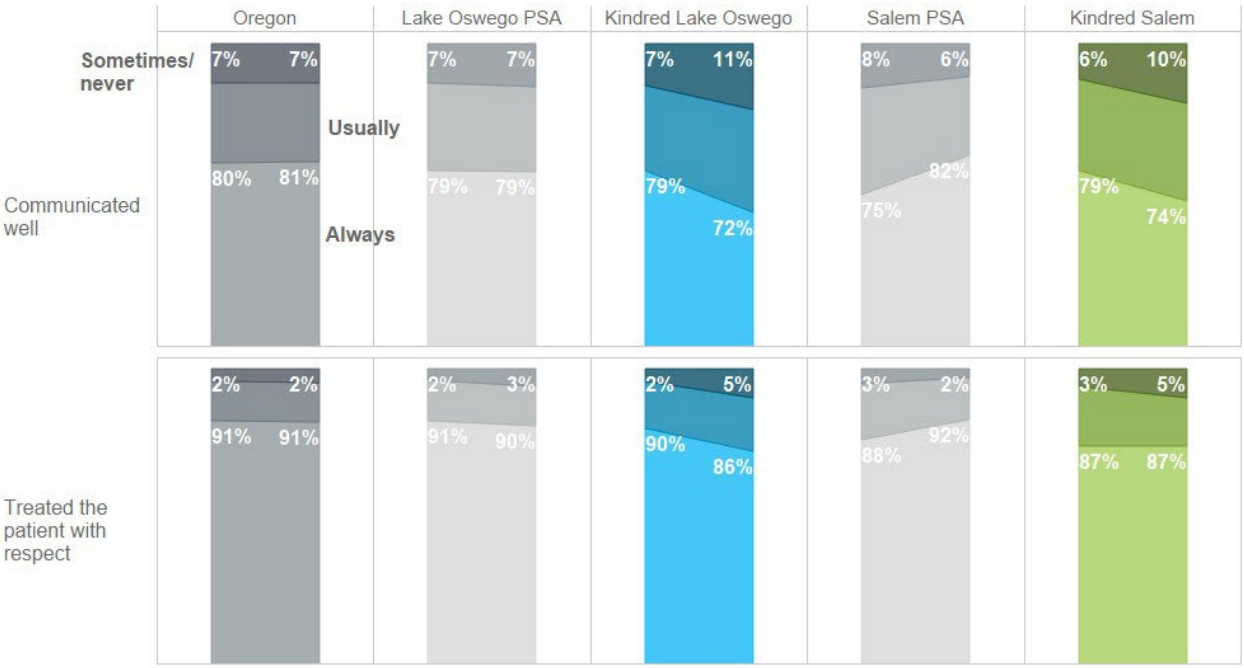
The rate of **sometimes or never** responses to questions related to patient support remained consistent statewide and in Lake Oswego PSA and even improved in Salem PSA in 2019, but unsatisfied responses increased from patient caregivers at **Kindred Lake Oswego** and **Kindred Salem**



Rate of 'always' responses (lightest shades), 'usually' responses (medium shades), and sometimes/never responses (darkest shades) for patient care-related CAHPS Hospice Survey questions from 2017/2018 and 2019 by region and facility

Measure Performance: CAHPS Patient Interaction

The rate of **sometimes or never** responses to questions related to patient interaction remained consistent statewide and in Lake Oswego PSA and even improved in Salem PSA in 2019, but unsatisfied responses increased from patient caregivers at **Kindred Lake Oswego** and **Kindred Salem**



Rate of 'always' responses (lightest shades), 'usually' responses (medium shades), and sometimes/never responses (darkest shades) for patient interaction-related CAHPS Hospice Survey questions from 2017/2018 and 2019 by region and facility.

CMS uses CAHPS Hospice Survey results to assign star ratings to hospice facilities. Their methodology for the 2019 measurement period creates cut-off points for the most positive CAHPS responses at each of the five star levels.[30] This corresponds to the lightest color bands in the figures above, where caregivers indicated they always received appropriate care or support, would definitely recommend the hospice agency, or gave the facility the highest rating (9 or 10).

Later this year CMS will display Star Ratings on their Care Compare website for hospice facilities, so this information will be more publicly accessible.

Technical Notes for CAHPS® Hospice Survey Star Ratings

August and November 2022 Public Reporting Periods

Appendix B: Average Measure Scores Among Hospices Assigned Each Star Category for the August 2022 Reporting Period

	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Composite Measures					
Communication with Family	70.3	75.5	80.2	84.3	88.4
Getting Timely Help	61.8	68.7	75.5	81.3	86.9
Treating Patient with Respect	81.5	85.8	89.2	92.3	95.8
Emotional and Spiritual Support	80.9	84.9	88.3	91.0	93.8
Help for Pain and Symptoms	62.4	69.0	74.1	78.6	83.7
Training Family to Care for Patient	61.1	69.4	74.6	78.8	84.1
Global Rating Measures					
Rating of this Hospice	65.4	72.3	79.5	85.2	90.3
Willingness to Recommend this Hospice	67.7	76.2	82.3	87.4	92.8

The 2019 rates of most positive responses for these key CAHPS questions used in OHA's analysis are not adjusted for sample size according to CMS' methodology, but the raw scores presented above would place the Kindred Lake Oswego and Kindred Salem facilities in the 1 Star or 2 Star tier.

The observed decrease in caregiver satisfaction with hospice care was reported after full ownership of Kindred at Home transitioned to Humana, in conjunction with the two private equity firms TPG Capital and WCAS. This raises concerns about the potential impact majority ownership by another private equity firm may have on the experience of care at these facilities in Oregon after this transaction.

Currently both facilities have active state licenses, are certified with CMS and have met requirements to participate in the Hospice Quality Reporting Program and are accredited with the Accreditation Commission for Health Care (ACHC). Accreditation from ACHC is recognized by CMS and comes only after demonstrating the ability to meet certain regulatory, reporting and quality standards.[31] OHA will monitor HIS and CAHPS results in post-transaction impact reviews and note any changes to certification, accreditation, or licensure.

Equity

Representative Patient Populations

OHA analyzed characteristics of the patient populations served by Kindred Lake Oswego and Kindred Salem and how representative this was of the population in their respective service areas.

Since most Kindred hospice patients were aged 65 or older (~80%) and were covered by Medicare or Medicaid (~90%), equity analyses compared patient population characteristics to the population of residents in each facility's PSA for residents aged 65 or older who also had Medicare or Medicaid coverage at any point during the 2017 – 2019 period.

In the Lake Oswego service area, 19% of the population is aged 65 or older and 43% are covered by Medicare or Medicaid. Intersecting age and insurance coverage, the subgroup of residents aged 65 or older who are covered by Medicare or Medicaid represents 10% of the total Lake Oswego service area population.

In the Salem service area, 21% of the population is 65 or older and 51% are covered by Medicare or Medicaid. The subgroup of people aged 65 or older with Medicare or Medicaid coverage represents 10% of the total Salem PSA population.

The next two pages provide a more detailed comparison for each of the service areas.

Lake Oswego Service Area

OHA compared Kindred Lake Oswego patient demographics to those of the broader Lake Oswego service area. In the Lake Oswego service area, most hospice patients are ages 65 and older. Compared with other hospices in the service area, Kindred Lake Oswego served a lower percentage of patients ages 85 and older (43% and 34%, respectively).

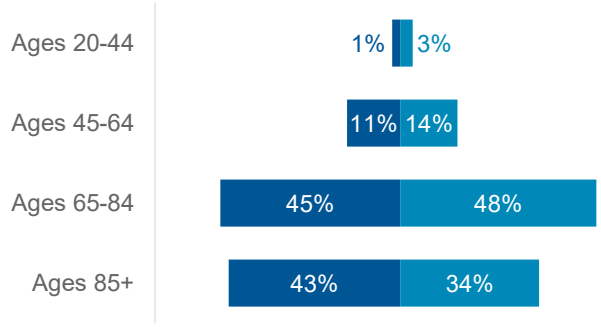
In the Lake Oswego service area, 56% of hospice patients were female and 44% were male. Kindred Lake Oswego served a lower proportion of female patients (49%) and a higher proportion of male patients (51%). Claims data only include male and female sex categories. APAC does not include data for gender or sex categories outside of male/female; therefore, this report does not capture accurate sex data for non-binary or transgender people.

APAC enrollment records did not include race information for 21% of Lake Oswego service area hospice patients. Kindred Lake Oswego had unreported race information for 14% of patients.

Most patients of Kindred Lake Oswego were White (82%). Patients identified as American Indian/ Alaska Native, Asian, Black/ African American, Native Hawaiian/ Pacific Islander, and other races comprised 8% of patients served.

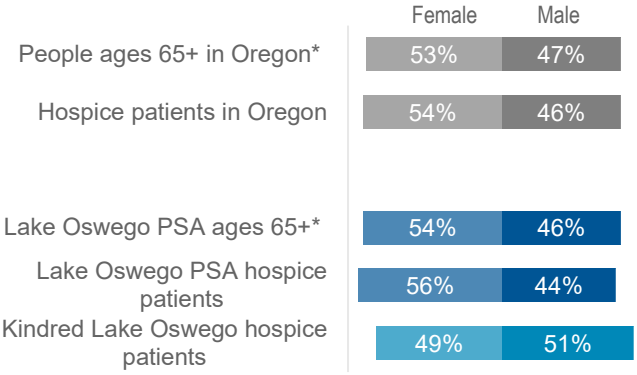
Lake Oswego PSA Hospice Patients by Age

Kindred Lake Oswego served a lower percentage of patients ages 85+ than other hospices in the **Lake Oswego service area**.



Lake Oswego PSA Hospice Patients by Sex

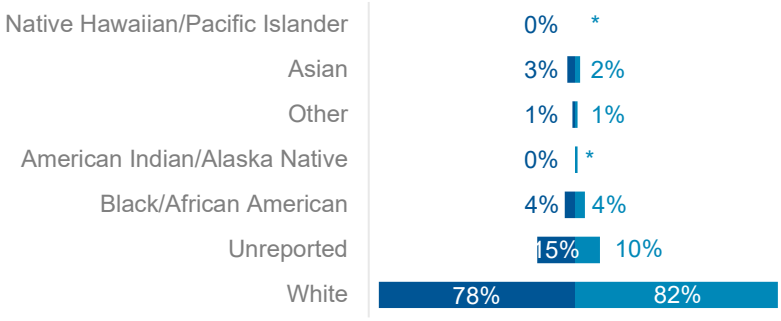
Kindred Lake Oswego served fewer female patients, compared with other hospice providers in the **Lake Oswego service area** and **statewide**.



*Includes only people with Medicare and/or Medicaid coverage

Lake Oswego PSA Hospice Patients by Age

Kindred Lake Oswego had less unreported race data than comparison hospices in the **Lake Oswego service area**.



*Data are suppressed due to small numbers.

Salem Service Area

OHA compared Kindred Salem patient demographics to those of the broader Salem service area. In the Salem service area, most hospice patients were ages 65 and older. Compared with other hospices in the service area, Kindred Lake Oswego served a lower percentage of patients ages 85 and older (38% and 29%, respectively).

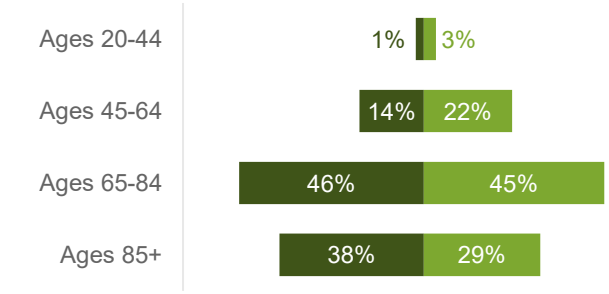
In the Salem service area, 54% of hospice patients were female and 46% were male. Kindred Salem served a lower proportion of female patients (49%) and a higher proportion of male patients (51%). Claims data only include male and female sex categories. APAC does not include data for gender or sex categories outside of male/female; therefore, this report does not capture accurate sex data for non-binary or transgender people.

APAC enrollment records did not include race information for 20% of Salem service area hospice patients. Kindred Lake Oswego had unreported race information for 18% of patients.

Most patients of Kindred Salem were White (79%). Patients identified as American Indian/ Alaska Native, Asian, Black/ African American, Native Hawaiian/ Pacific Islander, and other races comprised nearly 9% of patients served.

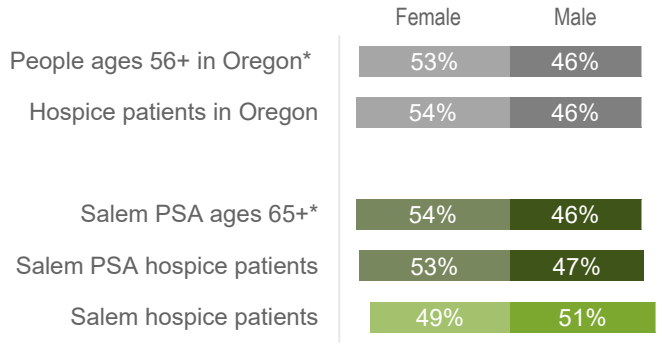
Salem PSA Hopsice Patients by Age

Kindred Salem served a lower percentage of patients ages 85 and older than other hospices in the **Salem service area**.



Salem PSA Hospice Patients by Sex

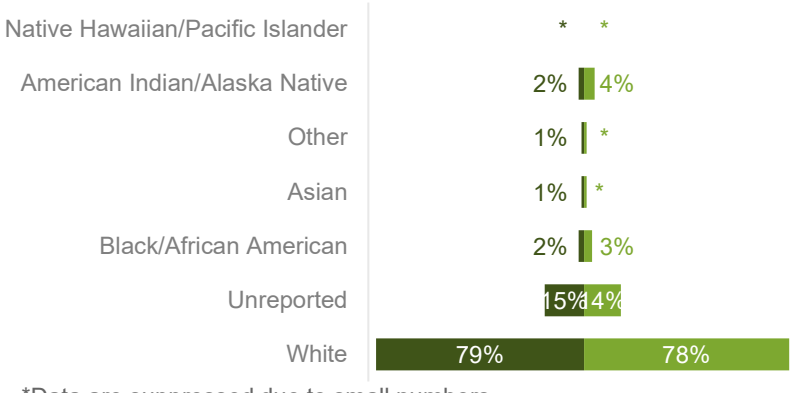
Kindred Salem served fewer female patients, compared with other hospice providers in the **Salem service area**



*Includes only people with Medicare and/or Medicaid coverage

Salem PSA Hospice Patients by Age

Compared with the **Salem service area**, **Kindred Salem** served a higher proportion of American Indian/Alaska Native patients.



*Data are suppressed due to small numbers.

Discussion

There are observed differences between the distribution of age, sex, and race among the patient population at each Kindred hospice facility and the comparison population in their respective service areas. While coverage of hospice services is available across all insurance types, there may be other factors that present barriers to accessing hospice care. The experience of homelessness or unstable housing and the absence of family or caregivers can challenge the provision of hospice care. There may be differing cultural attitudes about hospice care and end-of-life experiences.

The Kindred hospice locations in Oregon have both demonstrated they serve patients that do represent members of the surrounding community, but it is unclear to what extent they are assessing community need and engaging with other providers or community-based organizations to better understand how best to communicate about hospice care to all members of the service area region and to facilitate timely access to care to populations with special health needs.

The Kindred Lake Oswego and Kindred Salem location-specific websites indicate that both facilities participate in the We Honor Veterans program, a program developed by the National Hospice and Palliative Care Organization and the Department of Veterans Affairs. There are five tiers of recognition within the program, indicating a progression toward meeting veterans' needs and developing relationships within the community and other institutional partners. Both Oregon Kindred facilities have achieved level 4 participation in the We Honor Veterans program.[32]

The Entity did not mention this program or any other activities related to meeting the needs of any other priority population. OHA does not collect information about veteran status as part of the APAC enrollment data, so this analysis was unable to identify how many veterans were served by these two Kindred hospice facilities during this period or what proportion of the surrounding PSA population identifies as veterans.

Kindred's participation in the We Honor Veteran's program fills an important gap in veteran-specific hospice care in both the Lake Oswego and Salem service areas. Only eight of the 11 comparison entities in the Lake Oswego PSA participate in the program and only one at level 4. In the Salem PSA, only two of the 4 comparison entities participate, but they are also engaged at level 4.

Stratification of Cost and Access Measures

Cost analyses identified differences in per episode and per hospice month payments between the Lake Oswego PSAs and the Kindred hospice facilities, and access measures indicated variation in length of stay among entities and regions as well. OHA disaggregated the data by patient age, sex, and race to assess for differences in cost of care and access based on patient demographics.

Further breakdown of episodes by patient characteristics yields small numbers for certain categories, particularly for race. This analysis presents the true experience of small groups of patients without drawing conclusions about the statistical significance of differences observed across populations.

Per Episode Payments by Race

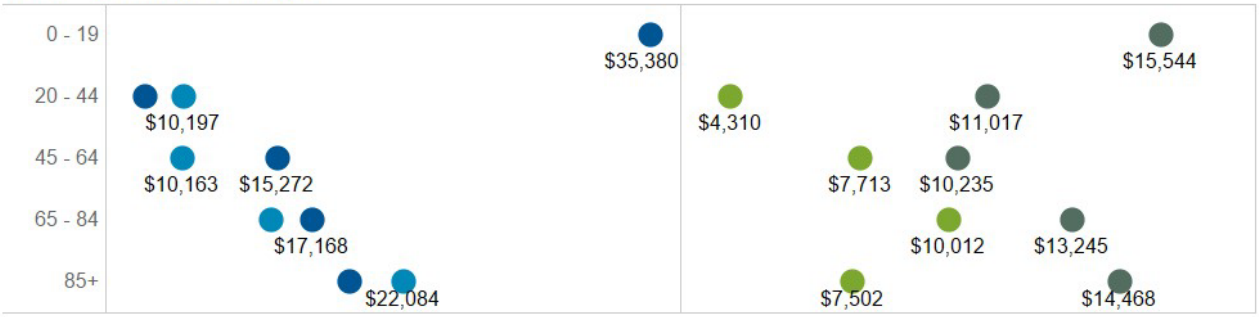
Per episode payments for patients of American Indian/Alaska Native (8) and Other races (14) were higher at **Kindred Lake Oswego** than other facilities in the **Lake Oswego PSA**. Payment per episode for patients of all races at **Kindred Salem** were lower than for **Salem PSA**, particularly for patients of Black/African American (11), Asian (4) and Other races (4).

Per episode payments for all episodes from 2017 - 2019, disaggregated by race for each PSA and facility

Per Episode Payments by Age and Sex

Payment per episode follows length of stay trends, increasing with age at **Kindred Lake Oswego**. Per episode payments are higher for female patients than male patients in both regions and facilities.

Per episode payment by age group



Per episode payment by sex

Payment per episode for all episodes from 2017 - 2019 disaggregated by age group and sex for all regions and facilities.

Median Length of Stay by Race

Median lengths of stay at **Kindred Lake Oswego** were generally longer than in the **Lake Oswego PSA** except for patients of Native Hawaiian/Pacific Islander (1) and American Indian/Alaska Native races (8). Conversely, median LOS at **Kindred Salem** was generally shorter than in the **Salem PSA**, but median LOS for patients of American Indian/Alaska Native race (15) was longer.

Median length of stay for 2017 - 2019 period disaggregated by race for each PSA and facility

Median Length of Stay by Age and Sex

Median lengths of stay increased with age in the **Lake Oswego** region (excepting pediatric patients) while median LOS remained relatively consistent in the **Salem region**. Female patients had longer median lengths of stay in both regions but the median LOS at each Kindred facility was notably lower than the median for its respective PSA.

Median length of stay for all hospice episodes from 2017 - 2019 disaggregated by age group and sex for each PSA and facility: **Lake Oswego PSA**, **Kindred Lake Oswego**, **Salem PSA** and **Kindred Salem**

Access for Rural Communities

OHA's enrollment data designates enrollee zip codes as being in urban or rural areas of the state. Access to essential services for residents of rural regions is a significant concern and an equity issue.

While both Kindred hospice facilities are physically located in urban zip codes and primarily serve larger metro areas, many of the zip codes in each Kindred facility's PSA are designated as rural. Analysis of episodes of care delivered to patients residing in rural versus urban regions confirmed equitable access to hospice services for patients from both areas (data not shown).

Stratification of Quality Measures

Quality of care and patient experience data published by CMS is not available by patient demographic characteristics.

CAHPS Hospice Survey results are tabulated by respondent demographics and this data can be requested for post-transaction impact reporting.

Potential Impacts

To assess the potential impacts of the proposed transaction on Oregonians' equitable access to affordable health care, OHA considered the following factors:

- Terms of the proposed transaction and change in ownership structure associated with those terms.
- Characteristics of the market for hospice services.
- The baseline (2017-2019) performance of the Kindred Lake Oswego and Kindred Salem hospices.
- Statements made by Falcon Hospice about expected impacts of the transaction on access, quality, equity, and cost in the notice of material change transaction.
- Public comments on the transaction received during the July 14th – July 28th comment period.
- Impact of the transaction on consolidation among providers of hospice services in Oregon.
- Academic research and research reports on ownership of U.S. health care entities by private equity firms.

The notice of material change transaction submitted by Falcon Hospice, L.P. includes multiple commitments to maintain the current level of services, quality, and cost. Many of the Entity's commitments are noted in the subsections below.

Public Comments

OHA received public input from the Oregon State Public Interest Research Group (OSPIRG), SEIU Local 49, and the Private Equity Stakeholder Project (PESP). Public comment letters are included as Appendix A: Public Comment All three public comments letters raised concerns with the transaction, surfacing some key themes, which we have summarized below.

Private equity approaches may result in negative outcomes for patients.

All three public comments cited reports of private equity ownership and profit-maximizing models resulting in lower quality of care and worse health outcomes.

Commenters cited reports with examples of poor outcomes for patients, health care professionals, and agencies owned by private equity firms.

Two commenters highlighted the recent U.S. Senate Finance Committee investigation into private equity ownership of Kindred at Home.

The Private Equity Stakeholder Project noted that Kindred at Home has changed ownership multiple times in the past several years, with ownership by different private equity firms from 2017-2021.

> *"…common private equity strategies of saddling companies with large amounts to debt and generating large returns over relative short periods of time can spell disaster for hospice and home health companies… As caregivers were made to focus on profit maximation and overextend themselves… patient care ultimately suffered."*
>
> - PESP public comment

OHA should continue to monitor the impacts of the transaction.
SEIU Local 49 urged OHA to apply conditions to the transaction to ensure that Falcon Hospice adheres to its commitments. They also recommended adopting specific metrics related to access to services, health equity, consumer cost, and quality.

National ownership may not be responsive to local Oregon needs.
The notice states that transaction is occurring between out-of-state entities ten levels above the Oregon hospice locations. Though both Oregon locations are currently owned by a national entity, public comments highlighted the risk that local concerns will not be factored into decision-making for the hospice locations.

> *"…this poses a serious concern that ownership from afar will not take the specific needs of the Oregon centers into consideration… which could have further negative consequences on cost, quality, and outcomes now or in the future."*
> - OSPIRG public comment

Consolidation

OHA does not have concerns about consolidation resulting from this transaction.
Falcon Holdings, the buyer of KAH Hospice, does not own any other providers of hospice services in the Kindred Lake Oswego or Kindred Salem PSAs. The same is true of CD&R, Falcon Holdings' limited partner. The proposed transaction will therefore not result in an increase of consolidation among hospice providers in either PSA. Based on the information provided on CD&R's website, the firm's investment portfolio does not include any other providers of hospice services in Oregon, or anywhere else in the country.[33]

Cost

OHA does not have concerns about price increases resulting from this transaction.
Falcon Hospice committed in the notice that the transaction will not impact the price of services provided by Kindred at Home. The Entity states "The payor mix of the Kindred Hospices is 95% Medicare; therefore, there are no anticipated rate increases by payers, nor any anticipated increases to the costs to Oregon patients." The rates Medicare pays for hospice services, and out-of-pocket costs (e.g., coinsurance) for patients are set annually by CMS. Given that Medicare pays for nearly all patients served by Kindred at Home, OHA does not have specific concerns about price increases resulting from this transaction.

OHA has some concerns about the potential for this transaction to increase health care spending.
The private equity business model creates strong incentives to focus on improving short-term profitability of acquired companies, which could result in higher health care spending. Private equity firms generally hold portfolio companies for 3-7 years and seek to generate returns for investors during that time frame. They typically appoint the board of directors of their portfolio companies and work with the acquired company's CEO to achieve performance goals.[34]

To enhance profits, hospice providers may seek to increase the total reimbursement they receive for a given hospice patient, for example by targeting certain types of patients or providing a higher level of care than what is clinically justified.

A 2019 federal review of Medicare's hospice program found that for-profit hospices received a higher proportion of Medicare hospice payments than non-profit hospices in 2014-2017, despite treating approximately the same number of beneficiaries.[35] Patients of for-profit hospices had longer lengths of stay, which resulted in higher payments per patient. These findings are consistent with recent academic studies of for-profit and private equity ownership of hospices, nursing homes, and other health care providers.

- Teno (2021) discusses possible strategies private equity firms may use to increase profits from hospice operations, including enrolling persons with longer anticipated lengths of stay and less need of intensive hospice services, and shifting the cost of expensive medications to Medicare Part D.[36]
- Braun et al (2021) found stronger cost growth for nursing homes owned by private equity firms relative to for-profit non-private equity nursing homes.[37]
- Aldridge et al (2014) and Stevenson et al (2016) both found that for-profit hospice patients had longer lengths of stay and higher rates of disenrollment from hospice care (live discharge).[38]
- Aldridge et al (2014) also found that for-profit hospices were more likely to exceed Medicare's aggregate annual cap on per-patient spending.

In 2016, Kindred Healthcare, Inc., the corporate entity that preceded Kindred at Home, was fined $3 million by the federal government for failing to correct improper billing practices. The company was found to have billed Medicare for hospice care for patients who did not qualify for hospice services and for higher levels of services than patients were eligible for. These practices occurred in 2013-2015 and led to significant overpayments by Medicare. In 2016, Kindred Healthcare Inc. implemented corrective measures to address these issues.[39]

OHA will monitor future spending for Kindred locations in Oregon.
The percentage of Medicare beneficiaries receiving hospice services from publicly traded corporations and private equity firms has increased considerably in the past decade.[40] Recent reports have highlighted concerns about billing practices and other conduct by hospice providers to increase payments from Medicare. As mentioned above and in public comments, evidence is also accumulating on the potential adverse impacts of private equity ownership of health care entities.

For these reasons, OHA will monitor spending trends for Kindred Salem and Kindred Lake Oswego in the statutorily mandated impact assessment reports one, two, and five years after the transaction concludes.

Access

Falcon Hospice, L.P. states that there will be no changes to the Kindred Hospices' locations and no reduction in the number or quality of staff or services. They state that they expect to continue serving Medicare and Medicaid beneficiaries.

OHA does not have concerns about reductions in access to hospice services.
Based on OHA's calculations using claims data for 2017-2019, Kindred Hospice Salem accounted for a 14% market share of care episodes provided by licensed hospice agencies in its service area. Similarly, Kindred Hospice Lake Oswego provided 9% of care episodes in its service area in 2017-2019. These data suggest that most patients seeking care at the two Kindred locations have several alternative options for accessing hospice services.

Additionally, the business structure of hospice organizations seems to correlate with which patients access hospice care. The U.S. Government Accountability Office (2019) found that longer lengths of stay among for-profit hospices compared to non-profits were partly due to for-profit hospice patients being more likely to have a diagnosis other than terminal cancer. Patients with non-cancer diagnoses (e.g., dementia) often have longer lengths of stay because life expectancy is harder to predict, and they are more likely to be enrolled in hospice care earlier than six months before dying.

Despite this finding, the impact of the transaction is unlikely to affect access in the two Kindred service areas.

Quality

In the notice, Falcon Hospice stated that the transaction is not expected to have any negative impact on quality of care. While OHA does not currently expect negative quality outcomes to result from the transaction, historical quality data suggest a need for monitoring.

OHA will monitor quality of care for Kindred locations in Oregon.

In August 2021, the U.S. Senate Finance Committee, chaired by Oregon Senator Ron Wyden, launched an investigation into private equity ownership of for-profit hospice companies and subsequent reductions in quality of care. The investigation centered on Kindred at Home, specifically the period (2017-2021) when Kindred at Home was owned by Humana, TPG Capital and Welsh, Carson, Anderson & Stowe.[41]

In a letter to Kindred at Home's President and CEO David Causby, the committee wrote:[42]

> *"We are concerned that when applied to hospice care the private equity model of generating profit on a rapid turnaround can occur at the expense of dying patients and their families. Given Kindred at Home's history of private equity-driven growth, we are requesting additional information in order to better understand this national trend."*

The letter requested information on Kindred at Home's hospice locations, patient lengths of stay, rates of live discharge, and billing data for hospice patients during the last week of life (including patient race/ethnicity and discipline of visiting staff). The Committee also asked for information about the level of involvement of TPG Capital and Welsh, Anderson & Stowe in Kindred at Home's management, financial, and patient care decisions, as well as information on policies for executive compensation, staffing, productivity requirements, hospice enrollment, and referral procedures.

Private equity firms' profit focus has been associated with aggressive cost-cutting strategies that may come at the expense of quality. Teno (2021) mentions decreased home visits by professional staff or use of less skilled persons to conduct visits as an attractive strategy for enhancing profits in the short term. A 2022 National Academies Press report cites evidence that private-equity-owned nursing homes have lower staffing, poorer resident outcomes, and more deficiencies than nonprofit or public nursing homes.[43]

Kindred Lake Oswego and Kindred Salem both showed a decline in some survey-based measures of quality between 2017 and 2019, resulting in scores lower than the statewide average. While this is concerning, both locations maintained their accreditation and continued to receive payments from CMS for serving patients covered by Medicare. OHA will monitor quality metrics following the transaction's close. Given the Entity's assurances in the notice of the transaction that quality will not be impacted, OHA currently does not have a reason to believe that the transaction would exacerbate the downward trend in quality measures.

Equity

OHA will monitor equity impacts of the transaction.

Kindred at Home's patient population is generally reflective of the demographics of the residents of each facilities' geographic service area, including those patients living in zip codes designated as rural. In the notice, the Entity states that they do not anticipate a change in the mix of Medicare and Medicaid individuals served. They state that they do not plan to reduce or relocate services and will continue to provide charity care.

Data source limitations currently prevent OHA from reporting quality measures by demographic groups. Claims data supports reporting age, sex, and race data, but unreported data prevented us from stratifying by ethnicity or language. For future analyses, OHA will seek to incorporate additional data and approaches to improve our ability to conduct analyses of the impact on equity.

OHA will monitor for negative impacts of the transaction on equity. Follow-up analyses will look at outcomes for different demographic groups to see if there are disparities in outcomes. Follow-up analyses may also assess the impact of the transaction on equity-enhancing services, such as charity care. OHA may request additional information from the entities involved if needed to support follow-up reporting.

Conclusions

Based on preliminary review findings, **OHA approved the transaction on July 14, 2022.** See Findings of Fact, Conclusions of Law, and Final Order in the Matter of the Proposed Material Change Transaction of Falcon Hospice, L.P (Transaction ID: 002), dated July 14, 2022.

The transaction was approved, per ORS 415.501(6)(b), because OHA determined the transaction does not have the potential to have a negative impact on access to affordable health care in Oregon. Specifically, the transaction satisfies the following criteria:

- The transaction is unlikely to substantially reduce access to affordable health care in Oregon.
- The transaction is not likely to substantially alter the delivery of health care in Oregon.

These criteria are specified in administrative rules for the Health Care Market Oversight Program and are consistent with Oregon law. Below is a summary of the main reasons, based on the findings described in this report, why OHA considers each criterion satisfied.

Approval Criteria

The transaction is unlikely to reduce access to affordable health care.

The Entity asserts that the transaction will not reduce access to health care services for Oregonians. Specifically, the Entity states there will be no impact on the services offered, number or quality of staff, locations, or other operations of Kindred Lake Oswego or Kindred Salem. The two hospices will continue to offer the same level of access for Medicare and Medicaid beneficiaries relative to commercially insured patients. Given these commitments, OHA concludes that the transaction is unlikely to reduce access to affordable health care for Oregonians.

Medicare pays for nearly all services provided by KAH Hospice to Oregonians. Provider payment rates and patient coinsurance amounts for hospice services are set annually by the federal government. OHA therefore has no specific concerns that the transaction could increase prices for health care services in Oregon.

Based on OHA's calculations using claims data for 2017-2019, Kindred Salem accounted for a 14% market share of care episodes provided by licensed hospice agencies in its service area. Similarly, Kindred Lake Oswego provided 9% of care episodes in its service area in 2017-2019. These data suggest that most patients seeking care at the two Kindred locations have several alternative options for accessing hospice services.

The transaction is unlikely to alter health care delivery in Oregon.

As noted above, the relatively small market shares of the two agencies in their respective PSAs suggests that access to hospice services is unlikely to be reduced because of the transaction. In addition, OHA does not expect any impact on prices for hospice services, as these are regulated by the federal government. Falcon Hospice, L.P. states in the notice that the transaction will not affect access to services or the quality of care at Kindred Salem or Kindred Lake Oswego. Provided that these commitments are upheld, the transaction is unlikely to alter health care delivery in Oregon.

Post-Transaction Monitoring

As required by statute, OHA will conduct follow-up analyses one, two, and five years after the transaction is complete. The cost and quality impacts of the transaction are of particular interest, given the findings described in this report.

OHA's monitoring will assess whether the Entity keeps the commitments included in the notice that the transaction will not affect Oregon residents' equitable access to affordable, high-quality hospice services. More broadly, OHA will monitor changes in the measures of cost, quality, access and equity presented in this report and may also assess other measures relevant to each domain.

As part of the required monitoring activities, OHA may request additional information from the entities. OHA will publicly publish findings and conclusions from follow-up analyses.

Acronyms & Glossary

Acronyms

APAC	Oregon's All Payer All Claims database
CD&R	Clayton, Dubilier & Rice, LLC
CMS	Centers for Medicare and Medicaid Services
HCMO	Health Care Market Oversight
HHI	Herfindahl-Hirschman Index
OHA	Oregon Health Authority
OHP	Oregon Health Plan
PE	Private equity
PSA	Primary Service Area

Glossary

Market: A collection of buyers and sellers that enter into agreements to purchase and sell a product or service. Markets are typically defined in terms of product/service and geographic reach (e.g., local, state, national, international, global).

Market share: In this report, market share is the hospice agency's share of total of hospice episodes provided by licensed hospice agencies in the geographic service areas of Kindred Salem and Kindred Lake Oswego, respectively.

Competition: A situation in a market in which firms or sellers independently strive to attract buyers for their products or services by varying prices, product characteristics, promotion strategies, and distribution channels.

Concentration: A measure of the degree of competition in the market; highly concentrated markets are generally characterized by a smaller number of firms and higher market shares for individual firms.

Consolidation: The combination of two or business units or companies into a single, larger organization. Consolidation may occur through a merger, acquisition, joint venture, affiliation agreement, etc.

Health equity: OHA defines health equity as follows:

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling, and rectifying historical and contemporary injustices.

Hospice episode: An episode of hospice care begins when a patient elects hospice care and ends when the patient dies, is discharged to another kind of care facility, or opts out of hospice care. This analysis also identified transitions from one hospice agency to another as separate episodes of care in order to capture services and costs associated with individual facilities.

Appendix A: Public Comment

Public comments are also posted to the HCMO website.

PRIVATE EQUITY STAKEHOLDER PROJECT

28 June 2022

Barbara Roberts Human Services Building
500 Summer Street NE, E-65
Salem, OR 97301
Fax: 503-945-5872

Re: Public input related to a proposed acquisition of Kindred at Home by Falcon Hospice

Dear Director Jarem,

The Private Equity Stakeholder Project (PESP) writes in opposition to the proposed transaction between Kindred at Home and Clayton, Dubilier & Rice through its subsidiary Falcon Hospice.

PESP is a financial watchdog organization that researches and reports on private equity investments and their impacts on various communities. We have written extensively about the potential negative consequences of private equity investment in healthcare companies, including hospice.

As stated in our March, 2022 report, Private Equity at Home: Wall Street's Incursion into the Home Healthcare and Hospice Industries, private equity investment in hospice has real potential to exacerbate issues already present in the largely for-profit hospice industry due to profit maximization. These issues include: decreased visits to hospice patients by professional staff, using under-licensed employees for visits and prioritizing patients who are anticipated to remain in hospice for longer periods of time than those who are predicted to die sooner, among others.[1]

Combining the existing problems with the common private equity strategies of saddling companies with large amounts of debt and generating large returns over relative short periods of time can spell disaster for hospice and home care companies, as was observed in Bloomberg's report on private equity's ownership of Aveanna Healthcare. As caregivers were made to focus on profit maximization and overextend themselves at that company, patient care ultimately suffered.[2]

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[1] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2784807
[2] https://www.bloomberg.com/news/features/2019-10-22/death-and-deals-sick-children-suffer-private-equity-profits; https://pestakeholder.org/wp-content/uploads/2022/03/Home-Healthcare-and-Hospice-report.pdf; ("Multiple former employees interviewed by Bloomberg believed there was a nexus between increased financial incentives under private equity ownership and lapses in quality of patient care at Aveanna. One former employee stated that the company would often decline to send nurses if it was short-staffed and had to pay overtime. 'If I had a 20-year-old in Temple, Texas,

June 28, 2022

To: Oregon Health Authority, Health Care Market Oversight Program
From: SEIU Local 49
RE: Public Comment on Proposed Transaction Between KAH Hospice and Falcon Hospice

First, SEIU Local 49 is pleased to see the Health Care Market Oversight Program up and running. We view it as a critical tool in the state's toolbox to protect the interests of Oregon's patients, communities, and economy. We offer the comments below regarding the proposed acquisition of KAH Hospice by Falcon Hospice in hopes that the state will use this opportunity to ensure this transaction will not result in any erosion of care and that the company will uphold the promises it makes in its application.

SEIU Local 49 is comprised of healthcare and property service workers throughout Oregon and SW Washington. Our mission as a union is to achieve a higher standard of living for our members, their families, and dependents by elevating their social conditions and by striving to create a more just society. Like many others, our members struggle to access affordable, high-quality care. Because of this, we have been tracking the impact of private equity's increasing investments in the healthcare field and have concerns about the proposed transaction between KAH Hospice and Falcon Hospice.

Falcon Hospice states that Oregon's facilities will experience no changes to the hospice locations, and no reduction in the number or quality of staff or services.[i] In short, they will continue to provide the same service Oregon has been experiencing. However, the private equity model is centered around short-term profits, which can result in aggressive tactics around cost-cutting and profit maximization.[ii]

Therefore, we urge the Oregon Health Authority to put in place conditions on the transaction that will ensure the applicants stay true to their word. We suggest that OHA adopt metrics that revolve around the four focus areas of the HCMO program. These could include:

- *Access To Services:* Average and median lengths of stays by location and payer; number of patients served by payer.
- *Health Equity*: Billing data for hospice patients during the last week of life, including information on patient race/ethnicity; discipline of the visiting staff; and branch location for each patient (to monitor for disparate number of hospital visits by professional staff based by race and geographic region).
- *Consumer Cost*: Patient days by billing category.
- *Quality*: Live discharge rates by case setting, staff breakdown of professional and non-professional.

Our concerns over the role of private equity within hospice care, and within Kindred Hospice specifically, are not unique to SEIU. Last fall, the United States Senate Finance Committee, chaired by Oregon Senator Ron Wyden, opened an investigation on Kindred Hospice seeking information about services provided and the impact of private equity investment on patients and their families. Wyden and other

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June 28, 2022

TO: Oregon's Health Care Mergers Oversight Program
FR: Maribeth Guarino, Oregon State Public Interest Research Group (OSPIRG)
RE: Falcon Hospice GP, LLC purchase of Kindred at Home Hospice

OSPIRG is a consumer advocacy organization with members across the state. We were strong supporters of the Health Care Mergers Oversight Program and thank you for the opportunity to provide comment on one of the first transaction notices filed in the state.

We have some concerns about this merger that I'd like to highlight here, namely regarding the transfer of majority ownership to a private equity partner. Private equity involvement in health care can provide some benefits like efficiency, but that efficiency can come at the cost of lower quality care and worse health outcomes.[1] In addition, the filing indicates that this transaction is happening out-of-state and ten entity levels above the Oregon hospice centers that will be affected. Though intended to be reassuring, this poses a serious concern that ownership from afar will not take the specific needs of the Oregon centers into consideration during decisionmaking processes, which could have further negative impacts on cost, quality, and outcomes now or in the future.

These hospice centers serve many Medicare and Medicaid beneficiaries, which are typically vulnerable populations and hospice care puts them in a more vulnerable position. We urge the oversight program to take these factors into consideration when conducting their review of this transaction.

We would also remind the reviewers that the program requires continued monitoring of transactions post-review, and regardless of the outcome of the review, the concerns noted here should merit vigilance over the effects of the transaction in the future. Although the filing states that there should be no effect on the current state of Kindred Hospices, continued monitoring will show any undue effects on cost, quality of care, or health outcomes that contradict the filing. In addition, it will also inform the program as to how to conduct future reviews, including what to look for and probable outcomes of these transactions. As one of the first notices filed for this oversight program, it is important to make these considerations thoughtfully, and we urge your careful review of this transaction.

[1] Maanasa Kona, "Understanding the Role of Private Equity in the Health Care Sector. Georgetown Center on Health Insurance Reform," 21 June 2022. https://chirblog.org/understanding-role-private-equity-health-care-sector/

Appendix B: Methodology

The methods described in this Appendix are consistent with HCMO's Analytic Framework.

Primary Service Area Calculation

OHA calculated the primary service area of the Kindred Salem and Kindred Lake Oswego hospice agencies as follows:

- Associated each episode of hospice care with the patient's zip code at the start of the episode
- Calculated 75% of total episodes
- Sorted zip codes in descending order by hospice episode count
- Starting with the zip code with the highest episode count, built a geographic area of zip codes contiguous to the hospice facility zip code that encompassed 75% of total episodes. Some zip codes with higher episode counts were not included in the PSA if they were not contiguous with other zip codes surrounding the hospice facility

Some zip codes adjacent to the PSA were not included if their episode count was low enough to place them below the 75% threshold.

Zip code reliability may vary. People move and zip codes may not be updated in billing data or zip codes may not reflect where a person actually resides; for example, a hospice patient may be staying with a close relative or friend while receiving services. Administrative enrollment data captures patient zip code at a point in time, often when coverage begins. As patients relocate, address or zip code information may not be updated with their insurance carrier in a timely manner, and updated data is not always incorporated into the data file submitted to APAC.

Patients with terminal illness often require additional support in concert with the hospice team, and patients frequently relocate to be with family members who can support them with their end-of-life care. When patients relocate for hospice care their original zip code of residence may be quite far from the hospice facility's primary service area, lending the appearance of a wide-reaching range in the data. The methodology of identifying the PSA through zip codes with the highest episode counts helps account for this anomaly in the data but OHA acknowledges limitations in the timeliness and accuracy of the information used in these analyses.

Measure Specifications

Total annual payments: The total paid amount from primary insurance, coinsurance, and patient contributions (excluding insurance premiums) for billed hospice services each year (2017 – 2019). Coinsurance payments were only observed for patients dually eligible for Medicare and Medicaid, where the coinsurance amount was covered by Medicaid.

Payment per episode: The total paid amount for hospice episodes initiated during the year divided by the number of episodes of hospice care initiated during the year. Claims data were pulled for the period beginning January 1, 2017 and ending on December 31, 2019; hospice care is generally billed monthly, so episodes were strung together analytically based on consecutive service end dates and service start dates; some hospice episodes identified in this truncated data may have begun prior to 2017, or continued beyond 2019 but this analysis only considers the delivery of care and accrued costs during this 3 year period; for year over year comparisons, episodes were indexed to the year of the start of the episode, and all length of stay and payment totals were associated with that year (not split across years if the episode spanned calendar

years); only a few patients had multiple episodes during this period, so this is essentially equivalent to per person hospice spending

Payment per month of hospice care: Analogous to a per member per month payment for hospice, total paid amount (as above) for episodes initiated during the year divided by the number of hospice months provided during those episodes (total length of stay in days divided by 12); this helps normalize payments across hospice facilities that serve different volumes of patients.

CMS Clinical Quality measures: the seven individual clinical process measures and the Hospice Comprehensive Assessment measure (NQF #3235) evaluate a patient at admission to hospice care and screen for common conditions needing to be addressed by the hospice team

Treatment Preferences (NQF #1641): patient was asked about preferences regarding resuscitation, life support options and hospitalization

Beliefs & Values Addressed (NQF #1647): patient was asked about spiritual or existential concerns

Pain Screening (NQF #1634): patient was screened for pain within 2 days of admission

Pain Assessment (NQF #1637): patient was given a comprehensive assessment of severity of pain within 1 day of a positive pain screening

Dyspnea Screening (NQF #1639): patient was screened for shortness of breath within 2 days of admission

Dyspnea Treatment (NQF #1638): patient was treated for shortness of breath within 1 day of a positive dyspnea screening

Patients Treated with an Opioid Who Are Given a Bowel Regimen: patients started a bowel regimen (typically a stool softener to combat opioid-induced constipation) within 1 day of starting opioid treatment

Hospice Care, Episodes, and Licensing

For purposes of OHA's analysis, all care billed according to CMS' guidelines for hospice care is considered 'hospice care' and is included in this evaluation. OHA defined "hospice services" as all services billed with the specific revenue codes defined by CMS' Medicare Claims Processing Manual for hospice care (0650, 0651, 0652, 0655, 0656, 0657, 0658 and 0659).[44] Claims with bill type codes beginning with 81- were identified as non-hospital-based hospice services and bill type codes beginning with 82- were identified as hospital-based hospice services.

For a Medicare beneficiary, an episode of hospice care begins with a Notice of Election, which waives their right to payment for curative treatment for their terminal illness or other medical conditions. The hospice benefit can be renewed for two 90-day periods, followed by unlimited 60-day periods as needed. Hospice care may be interrupted during these periods (e.g., a patient is hospitalized or temporarily opts out of hospice care) but can be resumed within the approved time frame without requiring a new Notice of Election. A patient may transition to another hospice facility within an approved period, but this does not reset the timeframe. The new hospice provider is responsible for renewing the hospice benefit when the current 90- or 60-day period ends. A hospice episode ends and the hospice benefit terminates when a patient either expires, discharges to another kind of care facility, or permanently opts out of hospice care.

For purposes of OHA's analysis, focused on costs and market share of individual hospice agencies, when a patient transitioned from one hospice agency to another, this signaled the end of the initial episode, even though the Medicare benefit hospice period was still open. All prior services and costs were associated with the initial agency and all subsequent care and costs were attributed to the second agency in a new episode of hospice care. A small number of patients received care from more than two hospice facilities.

Analysis of administrative claims data identifies a small portion of patients at licensed hospice facilities in Oregon whose length of stay in care far exceeds 6 months (e.g., 2 or more years of continuous care). This is presumed to be episodes of palliative care, which deliver identical services and are billed using the same codes above but are not subject to the renewal requirements and payment caps CMS applies to services delivered under the elected hospice benefit. There is intermittent use of the diagnosis code Z51.5 to indicate 'an encounter for palliative care,' but this is not a reliable indicator to differentiate episodes of care at hospice facilities that are intended for end-of life from those episodes providing longer-term palliative support.

Hospice agencies that operate multiple locations within a 60-mile radius may license all locations under a single application, connected to a single physical address. Oregon state licensing mirrors CMS certification, so data at the state and federal level is reported for the physical location indicated on the license or certification, but it is unclear whether this data is inclusive of service delivery at any other locations associated with the license. For purposes of this analysis, data was assumed to reflect care provided to patients served only at the physical address of the license. Consequently, no data was available for two comparison entities in the Salem region that are likely licensed under a Portland metro area location.

Herfindahl-Hirschman Index (HHI)

HHI is a standard metric used by courts, federal and state regulators, and researchers to measure competition. It is calculated based on the market shares of individual suppliers. Applied to health care services, market shares are often measured as each provider's percentage of total health care services provided in the service area, or each provider's percentage of total patients receiving those services.

The prices (or reimbursement rates) paid by commercial health insurance companies to providers for the services plan members receive are determined through negotiations between insurers and providers. When competition is limited, e.g., there are few alternative providers who can offer similar services, negotiated prices tend to be higher. In addition, providers that serve more patients (in proportion to the total number of patients in the service area) may be able to obtain higher reimbursement for a given service.

An HHI value of less than 1,500 indicates a competitive market; values between 1,500 and 2,500 suggest moderate market concentration; and values above 2,500 point to highly concentrated markets. If a lone provider has 100% of the market shares, the HHI value for the market is 10,000.

Market Share

OHA's preliminary review analysis for this transaction assessed market shares of hospice agencies located in the respective service areas of Kindred Lake Oswego and Kindred Salem. Service volume was measured as the number of care episodes provided in the 2017 – 2019 period. The review team calculated market shares for hospice services as follows:

$$Hospice\ A\ Market\ Share = \frac{Number\ of\ episodes\ provided\ by\ Hospice\ A}{Total\ episodes\ provided\ by\ hospices\ in\ PSA}$$

As a sensitivity analysis, and to assess the significance of providers located outside the service area, OHA also calculated market shares as the percentage of total hospice episodes provided to PSA residents (regardless of the location of the provider).

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