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Private Equity Pathways into Home Care: The Case of New York State

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Abstract

Long-term care for aging and disabled people is increasingly provided in the home, given individuals' preferences for community living and aging in place coupled with the rebalancing of government spending toward home- and community-based services rather than nursing home care. As more government spending has focused on home-based care and the system has simultaneously become dominated by for-profit agencies, it has increasingly become an attractive target for financial actors seeking new sectors for deal-making and extracting profit. Private equity firms, among other financial actors, have accelerated their financial activity in home-based care. As part of a broader research project examining the presence of private equity in home care in New York State, this paper sets the foundation for understanding the implications of private equity acquisitions for job quality and quality of care in this sector. Our focus on the home care sector is designed to understand how financialization affects a low-wage workforce that is disproportionately made up of women, people of color, and immigrants. A growing body of research already demonstrates the negative effects of new financial actors—including private equity (PE) firms, insurance conglomerates, and other types of investors—buying up healthcare organizations. Their growing penetration into home care specifically has raised the specter that poor working conditions and low pay may be perpetuated or deteriorate even further.

The first section of this paper provides a brief overview of private equity's incursion into healthcare and home care in the United States, while the second part maps how private equity's footprint in New York State home care has grown over the past 20 years. The third part explores the policy and regulatory context that has enabled the expansion of private equity into home care. In examining the policy and regulatory context, this paper explores both health and labor market policies to demonstrate how they are closely intertwined and together create the context that has enabled the proliferation of new financial actors extracting wealth from the home care system. This paper therefore links the complexity and opacity of the U.S. healthcare system and weak labor protections to structural racism and the rise of financialization. We demonstrate how financial actors' profit extraction has been enabled by weak federal and state regulation of health and labor policy as well as opaque public and private payment systems. A primary pathway of wealth extraction occurs through the exploitation of a workforce with historically poor wages and working conditions, thereby perpetuating the long-standing effect of structural racism on women of color in healthcare and the labor market. As private equity's footprint sharply expanded in 2025 to control more than half of New York State home care delivery—as described below—it has become ever more urgent to examine the implications of private equity ownership for job quality and care quality.

Private Equity Pathways into Home Care: The Case of New York State[1]

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[1] This paper sets the foundation for a research project funded by the Robert Wood Johnson Foundation under their authorization, "Financialization in Healthcare and Structural Racism." This research project explores the degree to which the incursion of private equity in home care in New York State exploits the legacy of structural racism by examining changes in the quality of pay and working conditions for home care workers and how this, in turn, impacts home care workers' ability to provide quality care. A forthcoming report will share the full findings of this research.

I. INTRODUCTION

Long-term care for aging people and people with disabilities is increasingly provided in the home, driven by decades of advocacy and consumer preferences to move care out of institutions, as well as the rebalancing of government spending toward home- and community-based services. As more government funds have been directed toward home-based care, for-profit agencies have come to dominate the sector. This in turn has encouraged other financial actors, like private equity firms, to target home-based care as a new avenue for extracting wealth. A growing body of empirical research shows that when private equity firms buy out healthcare organizations, the quality of care deteriorates, leading in some cases to higher mortality rates, while the costs to Medicare and Medicaid also rise.[2] A central cause is understaffing, lack of training and supervision, and poor wages and working conditions that prevent healthcare staff from effectively doing their jobs. Existing research has focused on hospitals, nursing homes, and physician practices, with less attention paid to the recent expansion of financial actors in home-based care. Yet as financial actors like private equity firms have begun to buy up and consolidate home care, home health, and hospice agencies to extract profit across the continuum of services for aging and disabled people, more researchers, policymakers, and advocates are turning their attention to the implications of these changes for the quality of jobs and quality of care.

Labor is the lynchpin linking financial actors' strategies for making profits to the quality of care. Labor represents the largest portion of healthcare operating costs, including in the sector of home-based care. As a result, it is the easiest target to cut for boosting profit margins or extracting wealth by financial actors who own healthcare agencies. At the same time, adequate staffing of workers trained to meet the needs of patients is the most important factor for ensuring high-quality care. Examining how financial actors affect the wages and working conditions of home care workers is critical for understanding the impact on workers themselves and whether patients receive the care they need and deserve. Home care represents a distinct labor context, with each worker caring for individual clients in private homes; further, the workforce—disproportionately made up of women of color and immigrants—has long endured low wages and poor working conditions. As private equity expands into home care, it is necessary to examine to what extent it perpetuates, leverages, or exacerbates these conditions.

As part of a broader research project examining the impact of private equity ownership in New York State home care, this paper sets the foundation for exploring the implications of private equity ownership for quality of jobs and quality of care. Part II is a brief overview of private

[2] Ferdinand, P. (2026, January 21). When Profit Kills: How Private Equity is Eroding Health Care. U.S. Right to Know. https://usrtk.org/healthwire/when-profit-kills-how-private-equity-is-eroding-health-care/

equity's increasing presence in healthcare and home care in the United States; Part III maps private equity's expanding footprint in New York State home care over the past 20 years; and Part IV explores the policy and regulatory context that has enabled the incursion of private equity into home care.

Financialization, structural racism, and home care

Financialization in healthcare jeopardizes the provision of stable, quality care, while contributing to worsening health inequities. We use "financialization" to refer to the heightened use of financial strategies, calculations, and actions designed to extract wealth from the companies owned by private equity and other financial actors.[3] Given the long-standing role structural racism has played in driving health inequities and occupational segregation in the United States, there is a need to understand how a financially driven healthcare system can entrench and perpetuate structural racism. Structural racism refers to the ways racism is produced and reproduced by laws, rules, practices, and norms within government and within our social, cultural, and economic system.[4]

Our focus on the home care industry is motivated by the aim of understanding how financialization affects a workforce that is disproportionately made up of women, people of color, and immigrants. Structural racism and sexism have fundamentally shaped who does home care work in the United States and under what conditions.[5] Home care workers perform physically and emotionally demanding labor, yet they endure low pay, job insecurity, irregular hours, and limited or no access to labor and social protections. The ascent of new financial actors—primarily private equity firms and insurance conglomerates, alongside other types of financial actors—into healthcare generally and increasingly into home care specifically—has raised the specter of poor working conditions and low pay even further, and raises questions about the attendant impact on the quality of care.

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[3] Appelbaum, E. and Batt, R. (2021). "Financialization in Health Care: The Transformation of US Hospital Systems." CEPR Working Paper 2022-1. September 9. https://cepr.net/report/working-paper-financialization-in-health-care-the-transformation-of-us-hospital-systems/

[4] Bailey, Z. D., Feldman, J. M., & Bassett, M. T. (2021). How Structural Racism Works—Racist Policies as a Root Cause of US Racial Health Inequities. *New England Journal of Medicine*, 384(8), 768-773.

[5] Glenn, E. N. (1992). From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Reproductive Labor. *Signs: Journal of Women in Culture and Society*, 18(1), 1-43; Boris, E. and Klein, J. (2012). *Caring for America: Home Health Workers in the Shadow of the Welfare State*. Oxford University Press; Smith, P. R. (2007). Aging and Caring in the Home: Regulating Paid Domesticity in the Twenty-First Century. *Iowa Law Review*, 38(8).

This paper therefore links the complexity and opacity of the U.S. healthcare system and weak labor protections to structural racism and the rise of financialization. We demonstrate how weak federal and state health and labor regulations and opaque public and private payment systems create incentives for financial actors like private equity firms to use financial strategies and management practices to extract wealth in the home-based care sector. A primary pathway of wealth extraction occurs through the exploitation of a workforce with historically poor wages and working conditions, thereby perpetuating the long-standing effect of structural racism on women of color in healthcare and the labor market. Given that private equity's footprint sharply expanded in 2025 to own more than half of New York State home care delivery—due to changes in the administration of the state's consumer-directed home care program, as detailed below—it has become ever more urgent to examine the implications for our care system.

II. PRIVATE EQUITY'S INCURSION INTO HEALTHCARE AND HOME CARE: A BRIEF OVERVIEW

Private equity in healthcare

As the healthcare sector has dramatically expanded and become increasingly commercialized and financialized in recent decades, it has become a major site of financial actors seeking to extract profit. Private equity firms have been doing financial deals in healthcare for more than 30 years, with a sharp acceleration since 2010.[6] Private equity deals totaled approximately $750 billion between 2010 and 2020 in healthcare—including hospitals, nursing homes, clinical and outpatient services, medical groups, pharmaceuticals, hospices, home health, and others—and 2025 was the second-highest year on record for private equity deals in healthcare.[7] As private equity dealmaking in healthcare has accelerated, many have raised the alarm that its ownership model—relying on extractive financial tactics, high amounts of debt, and the promise of reaping large profits on a short timeline—presents significant risks to patients, workers, and the overall stability of the healthcare system.

The private equity business model centers on the leveraged buyout—the use of significant debt (leverage) to buy a company in order to extract wealth through the management and sale of that

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[6] Appelbaum, E. and Batt, R. (2020). "Private Equity Buyouts in Healthcare: Who Wins, Who Loses?" Working Paper No. 118. *Institute for New Economic Thinking.* March 15. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3593887

[7] Appelbaum and Batt, 2020; Scheffler, R. M., Alexander, L. M., & Godwin, J. R. (2021). Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk. Berkeley (CA): American Antitrust Institute. https://www.antitrustinstitute.org/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL-1.pdf; Edlich, A., Llewellyn, C., Croke, C., Schneider, R., & Teichner, W. (2026, February 10). Private Equity: Clearer View, Tougher Terrain. McKinsey & Company. https://www.mckinsey.com/industries/private-capital/our-insights/global-private-markets-report/private-equity

company, promising investors outsized returns on a relatively short timeline.[8] To make these acquisitions, private equity firms sponsor investment funds that raise capital from "limited partner" investors, who may be institutional investors (such as pension funds, endowments, sovereign wealth funds) and/or wealthy individuals. Most of the capital invested in the private equity fund (typically 98%) comes from these limited partners, while the "general partner"—a committee of partners and principals from the private equity firm—usually provides only 2% of the equity. The general partner makes decisions about which companies the fund will buy and then acquires companies using the leveraged buyout model. This entails using high levels of debt—often 70% of the purchase price—to acquire a company, by using that company's assets and cash flow as collateral for the debt; the remaining 30% of the cost is paid in equity from the investment fund. The acquired portfolio company then becomes responsible for paying back this debt.

The promise to yield high returns for investors on a short timeline creates incentives for private equity firms to take risks, including the extensive use of debt—yet these risks are mainly borne by their portfolio companies and investors, while the private equity firms are effectively shielded and guaranteed profits. Private equity firms generally seek to hold on to acquisitions for only four to seven years, before exiting through sale of the portfolio company to another company or to a private equity firm (the latter being a "secondary buyout"), through an initial public offering (IPO) on the stock exchange, or through "spinning off" a company into a separate business entity. Upon sale of the portfolio company, private equity firms generally take "carried interest" that amounts to 20% of the profits above a certain threshold of return.[9] The short timeline of private equity ownership—along with the fact that most of the capital they deploy is not their own—can motivate private equity firms to use strategies for increasing profits that are oriented toward short-term extraction and equity gains, rather than the long-term stability and performance of the company.

One distinct feature of private equity leveraged buyouts, in comparison with other types of private capital investment, is that they generally entail the private equity firm(s) taking full ownership or a majority stake in their portfolio companies, enabling them to have a high level of control in the company's operations and to therefore more directly shape strategies for

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[8] Appelbaum and Batt, 2020. See also Appelbaum, E. and Batt, R. (2014). *Private Equity at Work: When Wall Street Manages Main Street*. New York: Russell Sage Foundation.

[9] U.S. Department of Health and Human Services. (2025). HHS Consolidation in Health Care Markets RFI Response. Report prepared by the HHS Office of the Secretary (OS), in consultation with the U.S. Department of Justice and the U.S. Federal Trade Commission. Private equity firms benefit from the fact that carried interest is taxed at a lower rate as capital gains rather than as income.

increasing profit on a relatively short timeline. This can entail selection of the portfolio company's board of directors—including placing principals of the private equity firm on the board, selection of the CEO, and driving plans for restructuring operations. The private equity firms promise substantial performance-based pay incentives to top management of portfolio companies if they meet the firm's targets, and if they do not, the firms may swiftly replace them.[10]

Private equity owners reap their gains through operational changes that increase the valuation of their portfolio companies (and thereby increase their profit upon exit); fees assessed on investors and portfolio companies; and financial engineering strategies.[11] Operational changes may include growth strategies (through acquisitions or new approaches to marketing), restructuring and/or downsizing, changes in management of operations, or investments in new systems or technologies. Within healthcare, strategies to reduce portfolio companies' operational costs and increase revenue often center on cutting labor costs[12] while inducing demand through increased patient volume,[13] and in the case of hospitals, tests and procedures.[14]

Private equity firms also extract wealth through fees for the duration of time they are holding the acquisition. This can include charging investors annual management fees (typically 2% of assets under management), as well as a range of fees often charged to portfolio companies—including annual monitoring or management fees and transaction fees. These fees do not depend on the portfolio company's performance, thereby largely guaranteeing a stream of revenue for the private equity firm.

Private equity firms also use a range of extractive financial tactics to increase gains for the firm and for investors, which can include the sale of a portfolio company's assets in ways that benefit the investors and owners, or the use and manipulation of debt to channel gains toward investors.[15] For example, "dividend recapitalizations" entail the private equity firms taking on additional debt for the portfolio company in order to finance one-time cash payouts to owners and often to finance additional acquisitions as well. Such financial engineering can leave portfolio

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[10] Appelbaum and Batt, 2020; Appelbaum and Batt, 2014.
[11] Ibid.
[12] Harrington, C., Olney, B., Carrillo, H., & Kang, T. (2012). Nurse Staffing and Deficiencies in the Largest For Profit Nursing Home Chains and Chains Owned by Private Equity Companies. *Health Serv Res.*, 47(1 Pt 1): 106-28.
[13] Braun, R. T., Bond, A. M., Qian, Y., Zhang, M., & Casalino, L. P. (2021). *Private Equity in Dermatology: Effect on Price, Utilization, and Spending*. Health Affairs. https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.02062; Singh, Y., Song, Z., Polsky, D., Bruch, J. D., & Zhu, J. M. (2022). Association of Private Equity Acquisition of Physician Practices with Changes in Health Care Spending and Utilization. JAMA Health Forum. 2022;3(9):e222886.
[14] Scheffler et al., 2021; Americans for Financial Reform. (2020, August 6). *Report: The Deadly Combination of Private Equity and Nursing Homes During a Pandemic*. https://ourfinancialsecurity.org/2020/08/report-3-private-equity-nursing-homes-coronavirus.
[15] Appelbaum and Batt, 2020; Appelbaum and Batt, 2014.

healthcare companies in financially vulnerable positions, and often necessitates extensive cost-cutting that can, among other things, jeopardize quality of care.[16]

The fragmented nature of the healthcare sector has made it ripe for a favorite strategy of private equity—consolidation through a "platform and add-on" strategy, where the private equity firm buys a "platform company" in a specific industry and then acquires smaller companies that are merged onto the platform.[17] Because of how the sale price is calculated, the sale of this larger company can generate higher profits than the sum of its parts; the consolidation strategy also gives the private equity firm better access to debt and increased market power.[18] Private equity has been at the forefront of merger and acquisition (M&A) activity, leading to health system consolidation, which allows healthcare systems to garner concentrated market power and engage in anticompetitive behavior.[19] Private equity has also been at the forefront of buying up and consolidating physician practices, leading to higher prices.[20]

The existing evidence on how private equity ownership affects quality of care at hospitals and nursing homes (sectors where substantial research has been done) shows negative outcomes for patients, raising sharp concerns about private equity's expansion into other healthcare sectors. For example, a study of private equity nursing home buyouts from 2000 to 2017 showed "robust" evidence of declines in resident health and compliance with care standards related to nursing staff cuts and higher bed utilization compared with acquisitions by non-private-equity owners and chains.[21] Private equity ownership increased the short-term mortality of Medicare patients by 10% (20,150 lives) over a 12-year period and increased patient expenditures by 11%.[22] Another study of 543 private-equity-owned nursing homes found higher Covid-19 infection rates than government-owned homes.[23] Hospitals have fared less well too. A national study of quality of care in hospitals acquired by private equity showed worsening of fall and infection risks and other measures of quality and safety. Some post-procedure adverse events

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[16] In 2025, private-equity-owned companies accounted for 44% of the largest healthcare bankruptcies. See Flores, J. (2026, February 20). Private Equity Bankruptcy Tracker. Private Equity Stakeholder Project. https://pestakeholder.org/reports/private-equity-bankruptcy-tracker/.

[17] Appelbaum and Batt, 2020.

[18] See Appelbaum and Batt (2020) for a more detailed explanation of these mechanisms, including how sale price is calculated.

[19] Appelbaum and Batt, 2020.

[20] Scheffler, R., Alexander, L., Fulton, B., Arnold, D., & Abdelhadi, O. (2023). *Monetizing Medicine: Private Equity and Competition in Physician Practice Markets.* American Antitrust Institute (AAI). https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.

[21] Gupta, A., Howell, S. T., Yannelis, C., & Gupta, A. (2021, February). *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes.* University of Chicago, Becker Friedman Institute for Economics Working Paper, No. 2021-20.

[22] Ibid.

[23] Braun et al., 2020.

increased even though private equity hospitals performed fewer procedures among younger and less disadvantaged patients.[24] Such findings bolster existing concerns about the growth of the private equity ownership model in the healthcare sector.

Private equity in home care

Significant and increasing government investment in home- and community-based services (HCBS) has made it an attractive target for financial actors, including private equity firms. Over the past 15 years, private equity firms have substantially expanded their activity in the home healthcare industry[25]—where the provision of specialized medical care in the home yields relatively high reimbursement rates from Medicare with relatively little regulatory oversight. In recent years, private equity firms have accelerated their activity in non-medical home care (personal care services) as well.[26] Indeed, the large private-equity-owned HCBS chains generally provide both home healthcare and home care services, giving them access to multiple revenue streams and reflecting a strategy of providing services across the "care continuum."[27] After years of heavy spending on acquisitions in the home care industry—almost $70 billion since 2020—private equity firms now own some of the largest companies in the industry.[28] Americans for Financial Reform (AFR) estimated that approximately 10% of the home health and home care sector in the United States was private equity backed, as of 2025.[29]

Private equity's footprint in the industry is only outweighed by the acquisitions of large Medicare Advantage insurance conglomerates that have been taking over home healthcare and home care agencies and driving consolidation across the industry.[30] Medicare Advantage is the privatized system of Medicare in which eligible participants can choose a private insurance corporation, like

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[24] Kannan, S., Bruch, J. D., & Song, Z. (2023). Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition. JAMA, 330(24), 2365-2375.

[25] Moss, D. L. and Valdes Viera, O. (2023). *The Growth of Private Equity Ownership in the Home Healthcare Market*. American Antitrust Institute and Americans for Financial Reform. https://ourfinancialsecurity.org/wp-content/uploads/2023/06/AFFR_AAI_PE-Home-Health_Complete_6.6.23-1.pdf; Appelbaum, E., Batt, R., & Curchin, E. (2023, September). *Profiting at the Expense of Seniors: The Financialization of Home Health Care*. Center for Economic and Policy Research. https://cepr.net/wp-content/uploads/2023/09/2023-09-Profiting-at-the-Expense-of-Seniors-Appelbaum-Batt-Curchin.pdf.

[26] Bugbee, M., O'Grady, E., & Fenne, M. (2025, February). *Private Equity Healthcare Deals: 2024 in Review*. Private Equity Stakeholder Project. https://pestakeholder.org/wp-content/uploads/2025/02/PESP_Report_HC-Acquisitions_2025.pdf.

[27] Salcedo, G., Seifert, R., & Sen, A. (2025, May). *Wall Street on Your Doorstep: Protecting Home Care From Private Equity Abuses.* Americans for Financial Reform Education Fund. https://realbankreform.org/wp-content/uploads/2025/05/Wall-Street-on-Your-Doorstep.pdf.

[28] https://archive.is/HXQrD#selection-2516.0-2516.6; Eastabrook, D. (2025, February 14). *Private Equity Delays Home Care Investments Amid Uncertainty*. Modern Healthcare. https://www.modernhealthcare.com/providers/private-equity-home-care-acquisitions/.

[29] Salcedo et al., 2025.

[30] For more on large insurers buying home health companies and driving consolidation, see Salcedo et al., 2025 and Appelbaum et al., 2023.

UnitedHealthcare or Humana, to administer their Medicare benefits. Over 50% of Medicare enrollees are now covered by Medicare Advantage plans, which only cover the costs of their "in-network" providers, including home health agencies. This has led Medicare Advantage insurers to buy up home health, home care, and hospice agencies, as they have a captive clientele under Medicare rules.[31]

The growing private equity interest in home care corresponds to the growing reliance on and increased public financing of long-term care provided in the home, resulting from decades of advocacy for the rights of people with disabilities to live in community and for older adults to age in place. This shift away from institutional care toward home-based care has aligned with government-driven strategies to reduce Medicaid costs. Demand for home care services continues to expand with the growth of the U.S. aging population and states' expansion of coverage for young people and adults with disabilities.[32] As discussed in more detail in section IV, the "rebalancing" of Medicaid long-term services and supports (LTSS) systems has expanded access to home- and community-based services (HCBS), leading to a steady increase in the proportion of Medicaid spending directed to HCBS. In 2022, the United States spent $284 billion on HCBS, with $196 billion of that paid by Medicaid.[33]

Our research focuses in particular on home care (also referred to as "personal care" or "non-medical home care"), as distinct from home healthcare—although it is important to note, as described above, that private-equity-owned chains often make acquisitions that increase their footprint across the continuum of care needs.[34] Home care services are a form of long-term care for individuals who need assistance with the activities of daily living (ADLs) such as bathing, dressing, grooming, and mobility. Medicaid can cover the cost of home care for eligible beneficiaries, with home care aides assigned to them through a licensed home care agency or by selecting their own caregiver (who may be a friend or family member) through a consumer-directed care program. Those who are not eligible for Medicaid must pay out of their own pocket or through private long-term-care insurance. Home healthcare, on the other hand, is the provision of specialized medical care in the home (e.g., by a registered nurse or an occupational,

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[31] Appelbaum et al., 2023.

[32] *Report to Congress on Medicaid and CHIP.* (2023, June). The Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/wp-content/uploads/2023/06/MACPAC_June-2023-WEB-508.pdf

[33] Chidambaram, P. and Burns, A. (2024, July 8). 10 Things About Long-Term Services and Supports (LTSS). KFF. https://www.kff.org/medicaid/10-things-about-long-term-services-and-supports-ltss/

[34] Quote from Mertz Taggart Managing Partner Cory Mertz. According to a managing partner at one healthcare mergers & acquisitions (M&A) firm, there has been a strong interest in home- and community-based services from "private equity groups seeking platform opportunities and strategic buyers executing on their care continuum strategies." *Five Reasons Why Investors Love Home and Community Based Services (HCBS) Providers.* (2023, April 11). Mertz Taggart. https://www.mertztaggart.com/post/five-reasons-why-investors-love-home-and-community-based-services-hcbs.

physical, or speech therapist). This type of care is usually short-term and prescribed by a doctor. Home healthcare is delivered through certified home health agencies and paid for by Medicare parts A and B. Medicare Advantage plans also cover home healthcare, though coverage may differ depending on the state.

It may seem surprising that private equity firms have targeted the home care industry, as it is largely funded by Medicaid, which offers relatively low reimbursement rates. But the growth in demand for home care services and the corresponding increase in Medicaid (and Medicare) funds have created a steady, predictable revenue stream that is attractive to private equity firms.[35] The industry has historically been a fragmented one, presenting the opportunity for consolidation through the private equity "platform and add-on" strategy. Private equity firms can buy up local home care agencies, consolidate them, and garner concentrated market or monopoly power; this allows them to raise prices for services.[36] Their labor market (or "monopsony" power) allows them to push down wages and working conditions below what a competitive market, according to economic theory, would allow. In recent years, the non-medical side of the home care industry (providing long-term care/personal care services) has become an attractive site for such consolidation, as the home health and hospice service providers have already seen a greater level of consolidation, particularly driven by large Medicare Advantage insurers and private equity.[37]

Some reports suggest that financial actors view the personal care side of home-based care as potentially less risky than home healthcare in recent years, where the Centers for Medicare and Medicaid Service's annual home health Medicare rate changes have made some businesses wary.[38] Private equity firms also have reportedly slowed their activity in hospitals and physician practice management in the face of heightened federal and state regulatory scrutiny—leading them to pursue acquisitions in more specialized healthcare services, such as home-based care.[39] Investors may also find home care agencies to be an enticing investment because personal care

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[35] Salcedo et al., 2025; also ibid.
[36] Bugbee, 2023; Bugbee et al., 2024.
[37] For more on large insurers buying home health companies and driving consolidation, see Salcedo et al., 2025 and Appelbaum et al., 2023.
[38] Donlan, A. (2024, June 12). *M&A With $350 Million Gentiva Deal, Addus Puts Its Money Where Its Mouth Is*. Home Health Care News. https://homehealthcarenews.com/2024/06/with-350-million-gentiva-deal-addus-puts-its-money-where-its-mouth-is/#; Martin, A. (2025, May 6). *Addus Homecare Reports 20% Service Revenue Growth in Q1 Driven by Personal Care Segment.* Home Health Care News. https://homehealthcarenews.com/2025/05/addus-homecare-reports-20-service-revenue-growth-in-q1-driven-by-personal-care-segment/.
[39] Fischer, J. R. (2024, December 19). *Home-Based Care Deals Driven by Chronic Conditions, Aging Population, Patient-Directed Care*. PE Hub. https://www.pehub.com/home-based-care-deals-driven-by-chronic-conditions-aging-population-patient-directed-care/

providers do not have to compete for skilled nursing labor with other types of healthcare providers and agencies.[40]

Another important factor that makes home care particularly attractive to private equity firms is that it is virtually unregulated relative to other health-related sectors and especially so in comparison with nursing homes.[41] Unlike nursing homes, home care is not subject to a standard federal regulatory system; it is left to states to regulate, which have various and typically weak standards. Part IV of this paper explains the regulatory and policy landscape for home care and how financial actors can exploit its weaknesses and opacity to extract profit.

III. MAPPING PRIVATE EQUITY IN NEW YORK STATE HOME CARE

While private equity has been quietly but steadily carving out a foothold in New York State home care over the past decade, its presence sharply expanded in 2025 to control around half of the state's home care delivery. In a state that spends over $20 billion on Medicaid personal care services,[42] the pressure to contain costs and confront "waste" has been growing; but less attention has been paid to the financial actors including private equity who are profiteering from this Medicaid spending.

This section traces private equity's pathway into New York State home care, outlining how it has shaped industry and ownership patterns and raised public concern about its impact on the quality of jobs and the quality of care, as well as the overall stability of the care system. As noted earlier, the private equity acquisition model—with its reliance on leveraging high amounts of debt onto portfolio companies, its relatively short timeline for investment, and its extractive financial practices—can create risk and instability within the care system.

Overview of New York State home care

New York's home care industry is substantial, with home care jobs—including home health aides and personal care aides—constituting the largest occupational category in the state. In 2023, New York State had 566,160 home health aides and personal care aides, with women of color

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[40] Bugbee, M., O'Grady, E., & Fenne, M. (2025, February 20). *Private Equity Healthcare Deals: 2024 in Review.* Private Equity Stakeholder Project. https://pestakeholder.org/reports/healthcare-deals-2024-in-review/

[41] Bugbee et al., 2025.

[42] Michael Kinnucan shared this estimate, calculated based on projected Medicaid spending reported in the "Medicaid Global Spending Cap Report: April 2025 through September 2025 Quarterly Report" (personal communication, April 30, 2026). New York State Department of Health. 2025. Medicaid Global Spending Cap Report: April 2025 through September 2025 Quarterly Report. https://www.health.ny.gov/health_care/medicaid/regulations/global_cap/monthly/sfy_2025-2026/docs/2nd_qtr_rpt.pdf

comprising the vast majority of the workforce. Among home care workers in New York, 87% were women and 81% people of color: 31% were Hispanic/Latine, 27% Black or African American, 19% white, 18% Asian or Pacific Islander, and 5% identified as an "other" race/ethnicity. Immigrants are also disproportionately represented in the workforce, with 66% of home care workers in New York being foreign-born; 35% were U.S. citizens by birth, 37% U.S. citizens by naturalization, and 29% not U.S. citizens.[43]

Medicaid beneficiaries in New York can obtain home care services through two main options: Through the agency model, where a private agency—a licensed home care services agency (LHCSA)—assigns an aide to the beneficiary from the agency's pool of home care employees, or through the Consumer Directed Personal Assistance Program (CDPAP), where the Medicaid beneficiary is responsible for selecting, hiring, and training the aide, with payroll and enrollment supported by a fiscal intermediary; through CDPAP, care recipients may select a family member or friend to be their caregiver. New York State's home care utilization trend has shifted over the past seven years, as agency-provided home care utilization declined and consumer-directed care utilization increased sharply; as of 2023, over half of Medicaid dollars spent on personal care services in New York State financed care through CDPAP.[44]

Private equity pathways into New York State home care

As noted in Part II, at the national level, private equity firms in home care have driven consolidation through a platform and add-on acquisition strategy: Private equity firms buy an initial home care business that becomes the platform for acquiring a series of additional businesses to "add on"—leading to large national chains.[45] Among the largest national home care chains that are backed by private equity (PE), many currently operate agencies in New York, including AccentCare, Aveanna Healthcare, Elara Caring, Help at Home, Interim Healthcare, and Senior Helpers. Some have ventured into New York more recently, such as Help at Home, which entered the New York market in 2022 through the acquisition of two local home care agencies, Preferred Home Care and Edison Home Health Care. Others such as AccentCare and Elara Caring have been operating in New York for more than 10 years. Other PE-backed home care chains appear to have a limited presence in New York (such as Aveanna) or are shrinking their presence or exiting entirely (such as Addus HomeCare, described below).

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[43] PHI's Workforce Data Center. (2024). PHI. https://www.phinational.org/policy-research/workforce-data-center/

[44] Kinnucan, M. (2024, December 12). *How Fast is New York's Home Care Program Really Growing?* Fiscal Policy Institute. https://fiscalpolicy.org/wp-content/uploads/2024/12/2024.12.12-How-Fast-is-Home-Care-Growing.pdf. Note that FPI's analysis is based on data that is estimated to cover 90% of all personal care in New York State.

[45] Salcedo et al., 2025; Moss and Valdes Viera, 2023.

The pattern of consolidation into national home care chains—driven by private equity firms, large insurance conglomerates, and for-profit corporations—has been a key driver in channeling private equity into the New York State home care industry. In a number of cases, New York home care agencies initially became PE-backed when a local New York agency was acquired by a PE-backed national home care chain as part of its roll-up strategy. Several PE-backed national home care chains entered the New York market in this manner. For example, Help at Home entered New York when it acquired Preferred Home Care and Edison Home Health Care (which shared the same majority owner) in 2022;[46] and HouseWorks did so through its acquisition of Elite Home Healthcare in 2023.

In other cases, a large home care chain acquired a New York–based home care agency before the chain was taken over by private equity: For example, AccentCare acquired the New York–based Alliance for Health in 2002, and then AccentCare was taken over by a private equity firm in 2010. Another pathway entails private equity firms taking over a New York home care business and using it as a platform to make acquisitions and expand it into a chain operating across different states. For example, Caring People began operating as a licensed home care agency in 2001 in New York and was acquired by private equity firm Silver Oaks Service Partners LLC in 2017. After the acquisition, the firm made a series of add-on acquisitions of home care businesses operating in New York and several other states. Unlike many of the other PE-backed agencies operating in New York, Caring People focuses on the private pay home care market.[47]

Other New York businesses such as Elara Caring and Simplura Health Group (which acquired and integrated the New York home care agency All Metro Health Care into its brand) went through various stages of private investment and private equity takeovers before being subsumed into national chains. In certain cases, New York agencies are a franchise of a PE-backed national chain (such as Interim Healthcare and Home Instead) that operates on a franchising model.

Timeline of financialization in New York State home care

Private equity activity in New York State home care has accelerated over the past decade. Among the home care businesses in New York that are currently or formerly backed by private equity, there were relatively few deals before 2012 (see Figure 1 below). There was a sizeable increase in annual dealmaking from 2015 onward, with a majority of those deals involving privately held

[46] Donlan, A. (2022, April 17). *Help at Home Enters New York, Adding 10,050 Clients, 12,000 Employees.* Home Health Care News. https://homehealthcarenews.com/2022/04/help-at-home-enters-new-york-adding-10050-clients-12000-employees/.
[47] Baxter, A. (2017, November 14). *Caring People Acquired by Private Equity Firm.* Home Health Care News. https://homehealthcarenews.com/2017/11/caring-people-acquired-by-private-equity-group/.

companies. Figure 1 includes a broad range of deal types, including leveraged buyouts, debt refinancing, and recapitalizations. The years 2015, 2021, and 2024 stand out for particularly high levels of private equity activity, a pattern that roughly matches private equity buyout trends in healthcare and more broadly. For example, 2021 was a peak year for private equity activity globally due to various factors including low interest rates and favorable debt financing terms, as well as substantial "dry powder" (committed funds from limited partners that have never been invested);[48] it was also a peak year for the number of private equity deals in healthcare overall.[49]

Figure 1. New York State home care annual deal count by ownership type, 2007–2026[50]

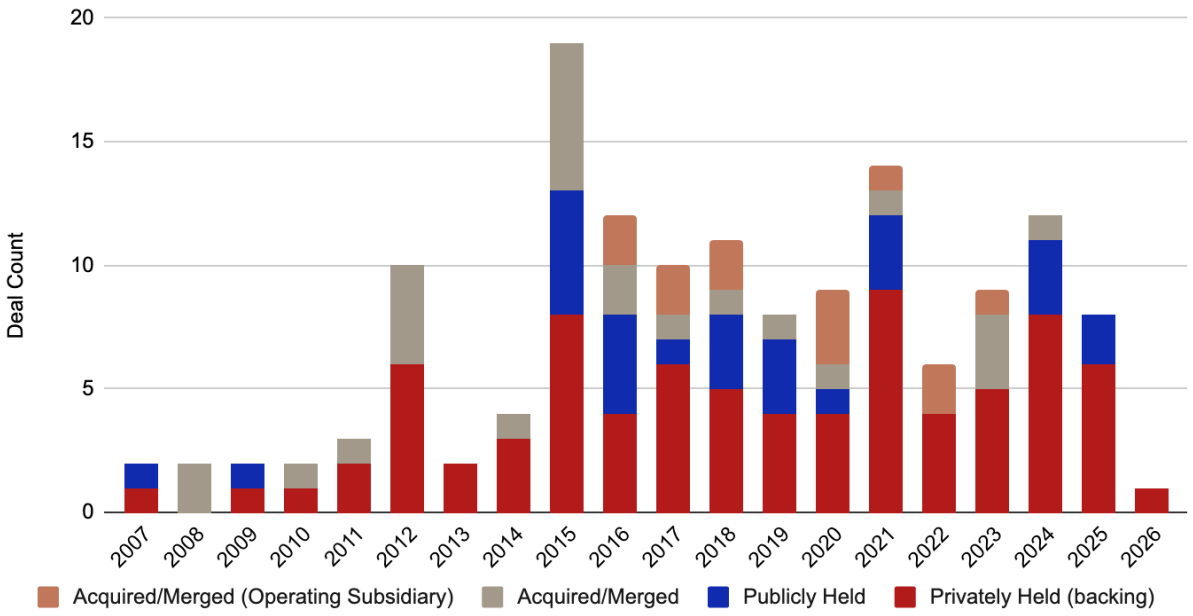

Figure 1 source: Authors' analysis of PitchBook data

Since 2017, there has been a steady clip of two to four private equity deals per year among the current or formerly PE-backed home care companies operating in New York (see Figure 2 below, which shows data through January 2026). Figure 2 shows specific deal types including private

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[48] MacArthur, H., Burack, R., De Vusser, C., & Yang, K. (2022). *The Private Equity Market in 2021: The Allure of Growth*. Bain & Company. https://www.bain.com/insights/private-equity-market-in-2021-global-private-equity-report-2022/; Cohen, S. A., Cain, K. L., & Harish, A. B. (2022, February 9). *Private Equity: 2021 Year in Review and 2022 Outlook*. Harvard Law School Forum on Corporate Governance. https://corpgov.law.harvard.edu/2022/02/09/private-equity-2021-year-in-review-and-2022-outlook/.

[49] *Global Healthcare Private Equity Report 2026*. (2026). Bain & Company. https://www.bain.com/globalassets/noindex/2026/bain_report_global-healthcare-private-equity-report-2026.pdf.

[50] Figure 1 shows data through January 2026.

equity (PE) leveraged buyouts and growth/expansion investments, venture capital (VC) investments, corporate mergers and acquisitions (M&A), and initial public offerings (IPO) for this group of home care companies between 2017 to 2026.

Figure 2. New York State home care annual deal count for PE, VC, M&A, and IPO, 2017–2026

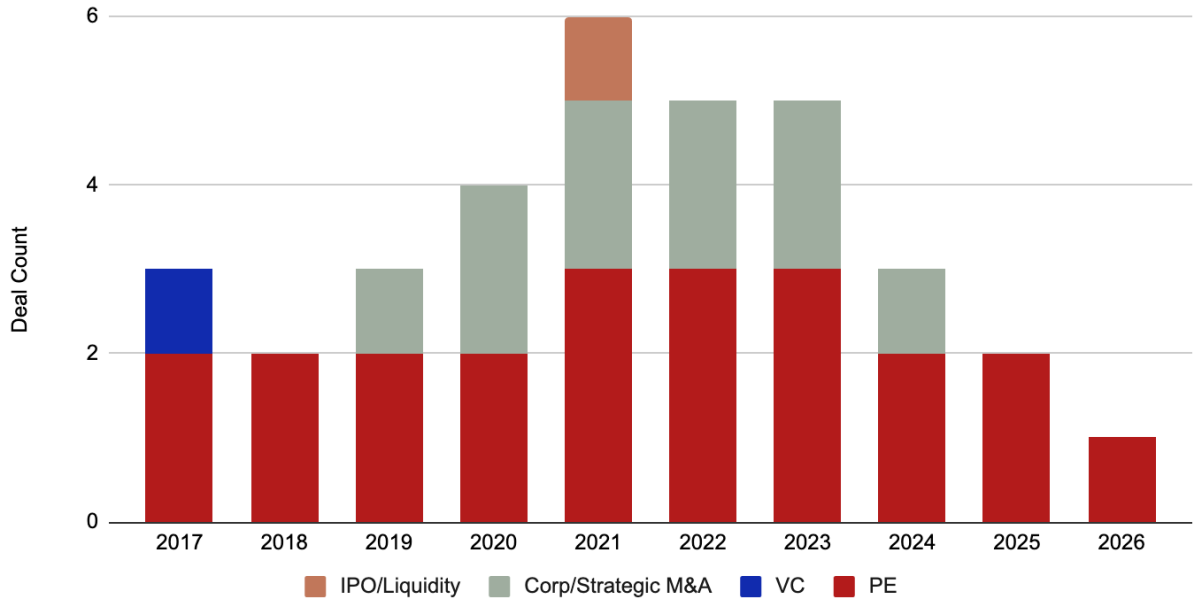

Figure 2 source: Authors' analysis of PitchBook data

Note, however, that the number of deals does not indicate how many establishments were part of the deal—which could be one or dozens. The amount of capital involved in deals provides some indication, but unfortunately, most deals do not disclose the amount of capital involved. With that caveat in mind, Figure 3 below includes only deals with reported amounts—which substantially underestimates the actual capital involved across all deals. Among the home care businesses operating in New York that are currently or formerly PE-backed (including national chains), 2021 also stood out as a year where a markedly high amount of capital was invested in deals, as demonstrated in Figure 3 below (and in line with broader private equity trends noted above).

In the record-high year of 2021, private equity firms engaged in several large buyouts and debt refinancing rounds. For example, private equity owners sold the Landmark Health home care agency for $3.5 billion to Optum, a subsidiary of the largest Medicare Advantage insurer, UnitedHealth Group (UHG). UHG has become one of the largest monopoly providers of home-

based care, as discussed below. Private equity firm Advocate Aurora Enterprises bought out Senior Helpers from another private equity firm for $187 million, while Webster Equity Partners did a leveraged buyout of Honor Health Network for $157.21. Advent International did two rounds of refinancing the debt of AccentCare for a total of $1.22 billion. Bain Capital and J.H. Whitney Capital Partners completed an IPO of Aveanna for $458.83 million, distributing returns to themselves and their investors, but remained majority owners—allowing them to continue controlling the direction of the company. Shortly after, they refinanced $1.26 billion in debt and took on additional debt of $415 million that was loaded on Aveanna. In 2024, a deal that stands out is Centerbridge Partners and the Vistria Group's $1.75 billion refinancing and dividend recapitalization of Help at Home, used to pay themselves and their investors dividends and to buy out additional agencies.

This level of dealmaking, debt refinancing, and dividend recapitalizations reveals how private equity firms have used home care agencies to extract wealth for themselves and their investors, while loading excessive debt on the agencies.

Figure 3. Capital value of private equity deals in home care agencies, by year, 2006–2025

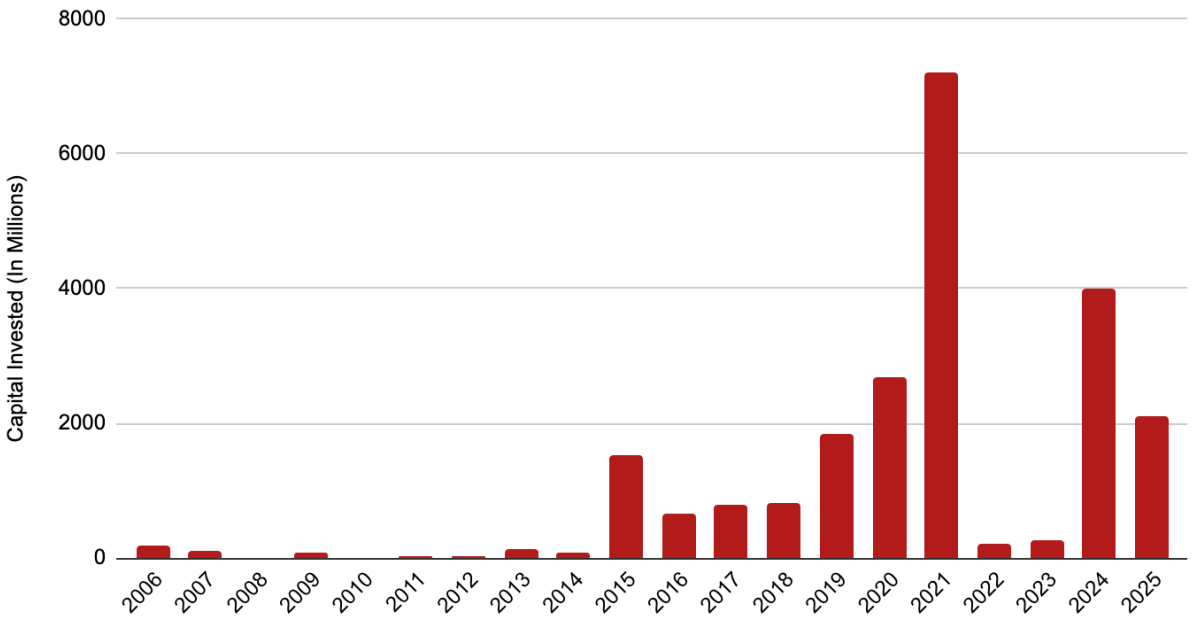

Figure 3 source: Authors' analysis of PitchBook data on capital value actually reported

The growing size of private equity's footprint

The growing proportion of New York State home care agencies owned or controlled by private equity is difficult to estimate. Of the 1,434 licensed home care services agencies (LHCSAs) in New York,[51] 23 are currently or formerly backed by private equity, which appears relatively small.[52] But their total footprint and share of Medicaid funding is much larger.[53] An analysis of 2022 cost report data for home care providers—including both LHCSAs and fiscal intermediaries that administered the Consumer Directed Personal Assistance Program (CDPAP)—indicates that PE-backed agencies in New York State received over $2.32 billion in Medicaid revenue, reflecting more than 7.6% of the Medicaid home care revenue reported by home care providers in that year. Moreover, this is a definite undercount, as it excludes some PE-backed agencies that provided incomplete cost report data or that did not provide cost report data at all.[54] It is likely that in 2023 over 10% of reported Medicaid revenue in New York State home care went to PE-backed agencies.[55]

In 2025, private equity's footprint dramatically expanded to own more than half of home care delivery in New York State, due to a significant change to New York's consumer-directed home care program (CDPAP). Public Partnerships LLC (PPL), a company owned by private equity firms Linden Capital Partners and DW Healthcare Partners, recently took over administration of CDPAP, which at the time accounted for more than 50% of home care delivery (specifically, personal care services) in New York.[56] This change was spurred by a controversial decision by

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[51] *2025 State of the Industry Report*. (2025, January 6). Home Care Association of New York State. https://hcanys.org/advocacy-and-policy/hcanys-priorities-position-papers?view=article&id=603:2025-state-of-the-industry-report&catid=33

[52] This total number of agencies does not include the fiscal intermediaries (FIs) that administered the Consumer Directed Personal Assistance Program (CDPAP) prior to the 2025 transition to a single statewide FI, described below.

[53] Our analysis here focuses primarily on agencies that provide personal care services and fiscal intermediaries that administer the Consumer Directed Personal Assistance Program (CDPAP) program—sometimes in addition to certified home health services. Our analysis of cost report data and PitchBook data indicates that there are 16 home care agencies in New York State that are currently backed by private equity firms and seven that are formerly private equity backed. Among the formerly PE-backed home care businesses, in at least two cases, the private equity firm formally exited when the company went public through an IPO but retained a significant proportion of ownership shares; for example, Aveanna's former private equity owners continue to jointly hold a majority of ownership shares in the company. Cases like this indicate the murkiness of the boundaries around formal versus de facto private equity control.

[54] Authors' analysis of 2022 Licensed Home Care Services Agency (LHCSA) Statistical Report and 2022 Fiscal Intermediary Statistical Report data, based on the Medicaid revenue reported. All licensed home care service agencies and fiscal intermediaries in New York State are required to submit annual reports to the Department of Health. 2022 is the most recent year for which we had statistical report data available for analysis. Some PE-backed agencies did not submit statistical report data or submitted incomplete data.

[55] While we did not have cost report data available for 2023 and subsequent years, this estimate is based on the inclusion of the Medicaid revenue of FreedomCare, a CDPAP fiscal intermediary that is not included in the calculations above because it was not backed by private equity until 2023. In 2022, FreedomCare received $736.67 million in Medicaid revenue, or over 2.4% of Medicaid home care revenue reported statewide.

[56] See Kinnucan, 2024, *How Fast is New York's Home Care*. "To demonstrate this shift, we rely on data provided to the State by managed care organizations participating in New York State's Partial Capitation Managed Long-Term Care program, the State's

Governor Kathy Hochul and state legislators to replace the existing CDPAP system of over 600 fiscal intermediaries administering the program with a single, statewide fiscal intermediary; PPL was selected for this role. This has greatly expanded private equity's role in New York State home care, given that CDPAP had recently displaced agency-provided care to become the leading form of personal care service delivery in the state, accounting for approximately 280,000 care recipients.[57]

It remains to be seen precisely how this major transition will affect the overall balance of home care delivery in the state and the overall footprint of private equity, given that thousands of consumers switched to the agency model of home care amid the turbulent transition.[58] Many of the former fiscal intermediaries were owned by companies that also provide personal care services through the agency model (through a licensed home care services agency, or LHCSA), and some of these agencies encouraged care recipients to switch from CDPAP to the agency-provided care model, in order to avoid losing clients in the transition; some PE-owned agencies engaged in this practice.[59] While the transition greatly expanded private equity's footprint in New York State home care, it is worth noting that administration of CDPAP was largely controlled by for-profit companies before the transition,[60] including some PE-backed companies; the largest fiscal intermediary prior to the transition was FreedomCare, a national chain that served approximately 30,000 CDPAP consumers in New York State and received private equity backing for growth and development capital in 2023.[61]

While this transition is distinct from the consolidation that results from a private equity platform and add-on strategy—since in this case the consolidation *replaced* the existing fiscal intermediaries, rather than taking them over and merging them—the result is that the entire consumer-directed home care program (CDPAP) in New York is now administered by a PE-

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largest long-term-care Medicaid program. This data is not comprehensive (other NYS Medicaid programs also provide home care), but we estimate that it covers over 90% of all personal care in New York State."

[57] New York State Department of Health. (2025, May 19). CDPAP Update: State Department of Health Provides Data on Number of Consumers and Personal Assistants Registered with Statewide Fiscal Intermediary Ahead of June 6 Deadline [Press release]. https://www.health.ny.gov/press/releases/2025/2025-05-19_cdpap_update.htm. See Kinnucan, 2024, How Fast is New York's Home Care on pattern of displacement.

[58] Early reports on the transition indicate that 75,000 care recipients transferred from CDPAP to personal care services (the agency model) during the course of the transition. See New York State Department of Health, 2025.

[59] Our forthcoming qualitative research on private-equity-owned agencies in New York indicated that some were encouraging care recipients and care workers to switch to the agency model, in order to maintain them as clients.

[60] Among fiscal intermediaries in 2022, 75.7% were proprietary (for-profit), 20.1% were voluntary (non-profit), and 4.19% were public. Among LHCSAs, 73.98% were proprietary, 21.09% were voluntary, and 4.93% were public. Authors' analysis of the 2022 Licensed Home Care Services Agency (LHCSA) Statistical Report and 2022 Fiscal Intermediary Statistical Report data.

[61] PitchBook. Number of consumers cited in: Freedom Care LLC v. The New York State Department of Health; James V. McDonald; and Public Partnerships LLC, (Supreme Court of the State of New York, County of New York 2024). https://www.mcknightshomecare.com/wp-content/uploads/sites/10/2024/12/lawsuit-freedom-care.pdf. Private equity

owned company. This follows a national trend in which private equity has increasingly taken over companies providing services in self-directed/consumer-directed care programs.[62]

The transition to a single fiscal intermediary and the selection of PPL were highly controversial, with disability rights advocates, existing fiscal intermediaries (both for-profit businesses and non-profit organizations), and some care worker advocates waging a persistent campaign aiming to stop the transition. New York legislators held a joint public hearing about the CDPAP transition in August 2025, which highlighted many serious concerns raised regarding the procurement process and the experience of CDPAP clients and caregivers during the transition itself.[63] Further problems with PPL in New York and in other states are discussed below in the "Labor, compliance, and care quality issues in private-equity-backed home care" section below.

Prior to PPL's entrance into the New York market with the CDPAP transition in 2025, the private-equity-backed home care agencies with the largest footprint in New York State were FreedomCare (2.4% of statewide reported Medicaid personal care revenue in 2022),[64] Preferred (2.09%), and Elara Caring (1.03%); the other PE-backed agencies that provided Statistical Report data each made up less than 1% of Medicaid home care revenue reported statewide. Overall, PE-owned home care agencies provided more than 7.2% of New York State's Medicaid home care hours reported in 2022.[65] Again, this represents a definite underestimate as certain PE-backed agencies did not submit this reporting data. The total amount of Medicaid revenue that PE-owned agencies receive is set to rise sharply in 2026, as private-equity-backed PPL has now taken over administration of CDPAP, which was estimated to be a $9 billion program as of 2025.[66]

Private equity expansion via diversification and consolidation

Nationally, many of the large PE-backed home care chains are consolidating multiple kinds of home-based care under one umbrella, including home health, home care (personal care services), self-directed/consumer-directed care, and hospice services.[67] This strategy diversifies their revenue streams and allows them to expand their business across related areas in the

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[62] See Salcedo et al., 2025. Such programs have grown nationally as a way for families and people with disabilities to exercise more agency in the hiring and training of caregivers, which can include paid family caregivers. Medicaid is also the dominant payer of this form of home care. States rely on different systems for determining eligibility and managing payroll for self-directed care, often contracting with organizations or firms that act as fiscal intermediaries.

[63] *Joint Public Hearing: Consumer Directed Personal Assistance Program (CDPAP)*. (2025, August 21). The New York State Senate. https://www.nysenate.gov/calendar/public-hearings/august-21-2025/joint-public-hearing-consumer-directed-personal-assistance

[64] As noted above (in footnote 55), FreedomCare did not become PE-backed until 2023, and the cost report data used for analysis is for 2022.

[65] Percentage of Medicaid hours and Medicaid revenue is based on 2022 LHCSA and Fiscal Intermediary Statistical Reports.

[66] Mellins, S. (2025, August 22). '*Complete Waste of Our Time': Lawmakers Get Few Answers on Home Care Chaos*. New York Focus. https://nysfocus.com/2025/08/22/new-york-cdpap-hearing-skoufis

[67] Salcedo et al., 2025.

continuum-of-care needs of the elderly and disabled. In the past, home care agencies tended to focus primarily on one payer (i.e., private pay, Medicare Advantage, Medicare fee-for-service, or Medicaid). This separation is still visible in the primary revenue streams of many PE-owned national chains, but patterns of consolidation have increasingly created diversified chains that benefit from multiple payers and revenue streams.

Different types of financial actors in home-based care have tended to focus their acquisitions in ways that mirror this pattern, pursuing consolidation strategies that focus on one primary payer while at times also creating diversified chains. For example, the largest Medicare Advantage insurers such as UnitedHealthcare have been a dominant force investing in and consolidating the home health and hospice industries because their Medicare Advantage plans will only cover enrollee expenses for "in-network" providers, creating a captive clientele. This has meant that, within Medicare-financed home health and hospice, private equity firms have focused on buying up agencies with traditional Medicare clients under a fee-for-service payment system.[68] In recent years, the home care industry, which provides long-term care/personal care services, has become an attractive site for such private equity ownership and consolidation. According to one executive, who moved from Humana's home health company to a PE-owned home care agency, home health and hospice had largely been "aggregated up into larger providers"; by contrast, the non-medical side had "really stayed kind of mom and pop, and franchised, and nobody's really taking up the opportunity to put those assets together. That was really our mission."[69] Private equity and large insurance conglomerates have also enabled each other's growing financial activity in home-based care by buying and selling from each other and at times combining forces to make multi-billion-dollar acquisitions.[70] The section below details examples of home care businesses that passed from private equity ownership to insurance conglomerates, as those insurance conglomerates sought to expand their home-based care business.[71]

Many PE-backed agencies in New York State reflect this multi-service model, offering services in home care, home health, and the state's Consumer Directed Personal Assistance Program (CDPAP).[72] Yet overall, most PE-backed home care agencies in New York are focused more on personal care services (where Medicaid is the primary payer) than on certified home healthcare

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[68] Moss and Valdes Viera, 2023; Appelbaum et al., 2023.
[69] Filbin, P. (2022, May 31). *Former Home Health Leaders Turning Their Attention to Non-Medical Home Care.* Home Health Care News. https://homehealthcarenews.com/2022/05/why-former-home-health-leaders-are-turning-their-eyes-to-non-medical-home-care/.
[70] For more on this at the national level, see Salcedo et al., 2025.
[71] See "Ongoing ownership changes drive profits and organizational disruption" below.
[72] These agencies can no longer offer CDPAP services, in light of the program's transition to a single statewide fiscal intermediary, described in detail above.

(where Medicare is the primary payer).[73] A number of New York agencies owned by PE-backed national chains appear to offer fewer services in New York than in other states, often offering only personal care services in New York while they provide certified home health, hospice, and/or other specialized home healthcare services in other locations. For example, AccentCare, AccordCare, and Elara Caring offer only personal care services in New York but offer home healthcare services as well in other states. While private equity has been most active in personal care services in New York, it also has been active in specialized forms of home healthcare in New York, such as infusion therapy, in-home psychological services, and home-based high-level medical care.[74] Specialized forms of home healthcare such as infusion therapy appear to be one of the new frontiers of private equity activity.[75]

The large size of New York's Medicaid long-term-care market may also drive financial actors' focus on this sector. With expanded access to Medicaid long-term care in New York, the state has higher enrollment in Medicaid long-term care and higher spending on it than most states—nearly double the number of seniors are enrolled in Medicaid compared to the national average.[76] In 2023, New York was spending more than $11.9 billion on Medicaid personal care services.[77] This can make the Medicaid-financed personal care services market in New York attractive to private equity firms. For example, after PE-backed Help at Home entered the New York market through two acquisitions, the president of the company said, "New York is the largest home- and community-based services state in the country. We love a state that has that density and providers that have that density…"[78] Yet, recent changes to the regulatory environment in New York may give certain investors pause—the example of Addus HomeCare in the box below reveals how shifting policy and regulations around CDPAP and around worker protections, such as higher minimum wages, were viewed as a business risk; and the high volume of authorized care hours in New York was not necessarily viewed as a revenue boon. Notably, the company's inability to break into the home health and hospice sectors also became a dealbreaker. While this regulatory landscape certainly has not stopped private equity investment

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[73] There are some exceptions—the large national chain Aveanna, for example, specializes in pediatric home healthcare (although it has expanded to also provide home health and hospice services for adults), but has only one location in New York State.
[74] See appendix for Table 2, which includes private equity investment in home care providers that do not provide personal care services.
[75] Fischer, J. R. (2024, December 6). *Private Equity Active in the Infusion Services Market: 6 Deals.* PE Hub. https://www.pehub.com/private-equity-active-in-the-infusion-services-market-7-deals/.
[76] Because Medicare does not fund most long-term care, older and disabled Medicare enrollees who require long-term care often need to rely on Medicaid as "dual-eligible" enrollees if they cannot afford the steep costs of long-term care. See Kinnucan, M. (2024, December 4). *Making Sense of New York's Medicaid Long-Term Care Spending,* Fiscal Policy Institute. https://fiscalpolicy.org/wp-content/uploads/2024/12/2024.12.03-Long-Term-Care.pdf.
[77] Kinnucan, 2024, How Fast is New York's Home Care.
[78] Donlan, 2022.

in New York State home care, these examples suggest that some financial actors may be better positioned to profit in this environment than others.

In this context of high enrollment and high spending on Medicaid home care, it is perhaps not surprising that our analysis suggests that PE-backed home care agencies in New York State derive most of their home care revenue from Medicaid, with private pay generally representing a much smaller proportion of revenue. While there are exceptions to this trend, most PE-backed agencies with available 2022 Licensed Home Care Services Agencies (LHCSA) Statistical Reports derived more than 90% of their home care service revenue in New York from Medicaid, and less than 4% of their revenue from private pay services.[79] This trend continues with private-equity-backed PPL's takeover of administration of the consumer-directed home care program (CDPAP), as the entire program is financed by Medicaid. This reliance on Medicaid revenue mirrors the rest of the New York State home care industry that is not backed by private equity; when aggregating the total percentage of home care revenue derived from Medicaid across all agencies in 2022, both PE-backed and non-PE-backed agencies were at just over 88%.[80]

Ongoing ownership changes drive profits and organizational disruption

In addition to the risks private equity ownership generates through excessive use of debt and extractive financial tactics, the private equity business model can drive organizational instability through frequent ownership changes. Private equity firms promise investors returns that beat the stock market within a short time frame, leading them to sell companies off within three to seven years—often by "flipping" companies to other private equity firms. Across all of the currently and formerly PE-backed home care companies operating in New York, the average hold time for private equity ownership has been five years.[81]

Most PE-owned national home care chains operating in New York have changed hands among multiple private equity firms, with a number of them being passed from one private equity owner (or joint owners) to a second and often with multiple private equity players involved. For example, Senior Helpers has had four different consortia of private equity owners since 2012—involving six private equity firms—changing hands every three to five years. Interim HealthCare has had no less than five different sets of private equity owners, with eight private equity players involved

[79] Analysis is based on 2022 LHCSA Statistical Reports.

[80] Analysis is based on 2022 LHCSA Statistical Reports. For non-PE home care agencies, 88.374% of home care service revenue was derived from Medicaid, and for PE-backed agencies it was 88.225%. Note that cost report data is incomplete, and some home care agencies, including PE-backed ones, did not submit reports for that year.

[81] Authors' calculation based on available Pitchbook data. The hold times were calculated based on the hold times for all of the previous private equity ownership (where the private equity firm(s) had exited) for all currently or formerly PE-backed home care agencies in New York State. The median hold time was 4.6 years.

in it changing hands every three to nine years. Aveanna was created in 2017 when two private equity firms (Bain Capital and J.H. Whitney) merged their respective home healthcare portfolio companies. Bain Capital acquired Epic Health from the private equity firm Webster Capital to initiate the merger with PSA Healthcare to create Aveanna as a new brand. Aveanna went public in 2021 but is still majority owned and controlled by its private equity investors.

Among the PE-owned home care businesses operating in New York, Figure 4 (below) shows 19 exits from 2016 to 2025, including original leveraged buyouts ("buyouts"), secondary buyouts (from one private equity firm to another), mergers and acquisitions (M&As) by corporations or by private equity firms, and initial public offerings ("IPO"). The largest number of exits in this time period were secondary buyouts, reflecting the pattern of private equity firms buying and selling companies to each other.

Figure 4. Private equity exits from home care agencies, by type and by year, 2016–2024

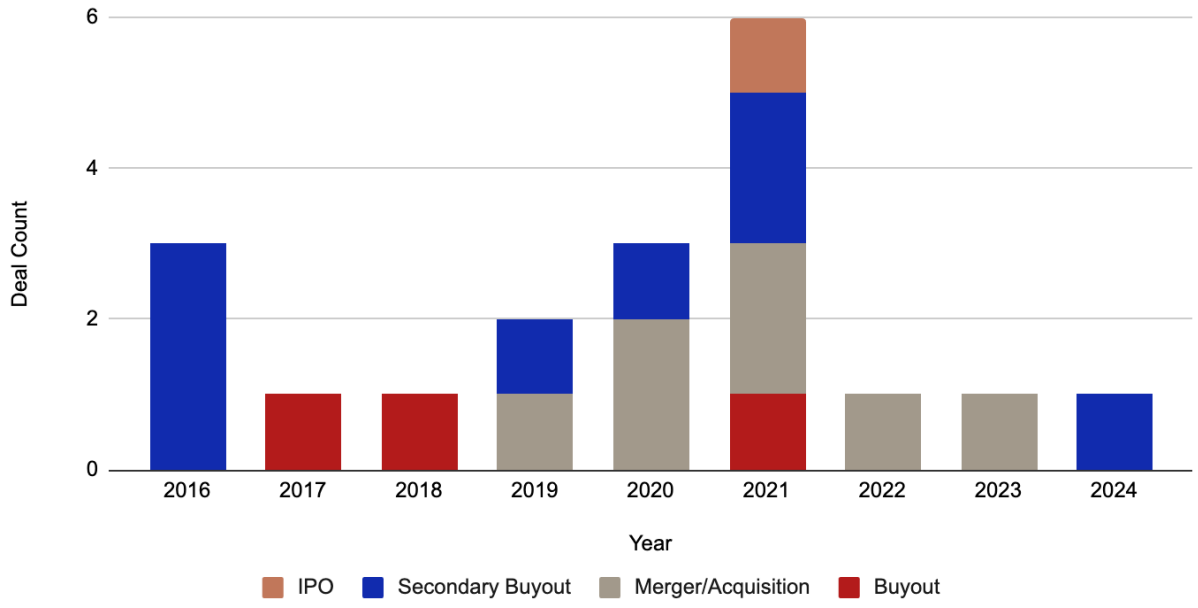

Figure 4 source: Authors' analysis of PitchBook data

Even when private equity firms don't flip their companies to other private equity firms, they often sell them to other types of financial actors, with national chains owned by large Medicare Advantage insurers such as Optum/UnitedHealth Group and Humana/CenterWell playing an important role. For example, Willcare, a home care agency originating in Buffalo, New York, was owned by a private equity firm for seven years until it was acquired in 2015 by Almost Family, a

national home care company seeking to expand its personal care services.[82] In 2018, Almost Family was then acquired by a large national home healthcare business, LHC Group (which had prior private equity backing).[83] In 2023, LHC Group was acquired by Optum, a subsidiary of UnitedHealth Group, in a $5.4 billion acquisition, as part of UnitedHealth Group's drive into home health and personal care services.[84]

Landmark Health is another New York home care agency that followed the pathway from private equity ownership to being acquired by Optum/UnitedHealth Group for $3.5 billion, in 2021.[85] Another home care agency, Simplura (which had acquired and subsumed All Metro Health Care) was passed from one private equity owner (Nautic Partners, 2014–2016) to another (One Equity Partners, 2016–2020), before being acquired by a large healthcare services holding company, Modivcare (formerly known as Providence Service Corporation) in 2020; Modivcare also formerly had private equity backing.[86]

Another New York–based home care provider, SeniorBridge, received private equity growth funding in 2008, subsequently doubled in size within a few years, and was then acquired in 2012 by Humana, another one of the largest Medicare Advantage insurers.[87] This was part of Humana's strategy to expand its home-based care business; although SeniorBridge focused on private pay customers, Humana said it intended to leverage SeniorBridge's care management system across Humana's health plan membership.[88] In 2021, Humana moved deeper into home-based care when it acquired the large home health chain Kindred at Home and rebranded it as CenterWell. Then in 2022, Humana announced it would close its SeniorBridge locations across eight states in order to "concentrate on its Medicare Advantage plans."[89] The New York SeniorBridge

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[82] Mullaney, T. (2015, February 25). Almost Family Acquires WillCare for $50 Million, Targets Personal Care Growth. Home Health Care News. https://homehealthcarenews.com/2015/02/almost-family-acquires-willcare-targets-personal-care-growth/; PitchBook.

[83] Mullaney, T. (2018, April 2). LHC Group Closes Almost Family Merger, Charts Future Course. Home Health Care News. https://homehealthcarenews.com/2018/04/lhc-group-closes-almost-family-merger-charts-future-course/

[84] Parduhn, R. P. (2023, February 22). *UnitedHealth Closes $5.4B Buy of Home Health Business LHC*. Healthcare Dive. https://www.healthcaredive.com/news/unitedhealth-lhc-group-closes-buy-home-health/643200/

[85] Donlan, A. (2021, February 21). *UnitedHealth's Optum Reportedly Strikes Deal for Landmark Health.* Home Health Care News. https://homehealthcarenews.com/2021/02/unitedhealths-optum-reportedly-strikes-deal-for-landmark-health/

[86] PitchBook; Famakinwa, J. (2021, May 10). *Simplura is First Block in ModivCare's Mission to Build $1B Personal Care Business.* Home Health Care News. https://homehealthcarenews.com/2021/05/simplura-is-first-block-in-modivcares-mission-to-build-1b-personal-care-business/.

[87] Caltius Equity Partners Exits Its Investment in SeniorBridge. (2012, August 10). *Health & Medicine Week*, 1529. https://link.gale.com/apps/doc/A299138633/HRCA?u=cornell&sid=bookmark-HRCA&xid=ec281ee1.

[88] *Humana Announces Agreement to Acquire SeniorBridge.* (2011, December 12). Managed Care Weekly Digest. https://go.gale.com/ps/ i.do?p=HRCA&u=cornell&id=GALE%7CA274622707&v=2.1&it=r&sid=sitemap&asid=4be6fb78

[89] Morse, S. (2022, November 30). *Humana Closing Most SeniorBridge Locations to Focus on Medicare Advantage Plans.* Healthcare Finance News. https://www.healthcarefinancenews.com/news/humana-closing-most-seniorbridge-locations-focus-medicare-advantage-plans

locations were closed shortly after that, in early 2023, leading to layoffs of more than 1,000 workers in New York.[90]

Box 1. Addus HomeCare case study

Spotlight on Addus HomeCare

The trajectory of the New York operations of the national chain Addus HomeCare sheds light on pathways in and out of private equity ownership, and the instability generated by profit-driven buying and selling of agencies. Before entering New York, Addus HomeCare was acquired by Eos Partners through a leveraged buyout in 2006 and then went public in 2009. After the IPO in 2009, Eos Partners maintained about 38% ownership and retained a seat on the board of directors; in 2018 and years following, Eos continued to sell off more of its ownership shares but maintained a seat on the board. While Addus was no longer private-equity-owned after 2009, the private equity firm still retained substantial ownership shares and affected strategic decisions through its board membership.

Addus entered the New York market in 2016 through its acquisition of South Shore Home Health Services, a provider primarily of personal care services.[91] That year, Addus also began to refine its business strategy of adding clinical care services to its offerings.[92] In 2024, Addus announced it would divest from New York entirely, selling its New York operations (which included personal care services and CDPAP) to HCS-Girling, a private-equity-backed home care agency based in Brooklyn that acquired the company through a leveraged buyout. In exiting the New York market, the Addus CEO Dirk Allison cited the shifting regulatory landscape in New York, noting that the New York market "no longer fits our growth strategy" and that the "start-and-stop changes in the state's approach" had "consumed a disproportionate amount of management resources for limited financial contribution."[93] Allison cited challenges that included the state's changing approach to CDPAP, minimum

[90] Eastabrook, D. (2023, January 9). *Humana to Close NY SeniorBridge Locations at the end of January, Lay off 1,000+ Workers.* McKnights Home Care. https://www.mcknightshomecare.com/news/humana-to-close-ny-seniorbridge-locations-at-the-end-of-january-lay-off-1000-workers/

[91] *Addus HomeCare Completes Acquisition of South Shore Home Health Services in New York.* (2016, February 8). PR Newswire. https://www.prnewswire.com/news-releases/addus-homecare-completes-acquisition-of-south-shore-home-health-services-in-new-york-300216358.html

[92] *About Addus: Our Story.* (n.d.). Addus HomeCare. https://addus.com/why-addus/

[93] *Addus HomeCare Announces Definitive Agreement to Divest Operations in New York.* (2024, May 21). Business Wire. https://www.businesswire.com/news/home/20240521748487/en/Addus-HomeCare-Announces-Definitive-Agreement-to-Divest-Operations-in-New-York

wage and wage parity "pressures," and problems with the state reimbursing providers. He said that New York authorized more care hours than other states where they operated, leading to it being an expensive program to run and "zero on the bottom line."[94] He also noted that Addus had been unable to expand its business into home health and hospice in New York.[95]

Recall that the leveraged buyout model allows private equity firms to take decision-making control of the companies they buy, often reflected in one way through PE firms appointing the board of directors and making decisions about hiring and firing of top executives and managers. AccordCare provides a clear example of financial actors' direct involvement in organizational leadership from founding to expansion. The CEO of AccordCare, Dave Jones, became a managing director at private equity firm Coppermine Capital in 2009, and he founded Allegiant Home Care in New York in 2010 while at Coppermine.[96] Coppermine acquired Allegiant through a leveraged buyout in 2015, and then created AccordCare as a new brand in 2019 by merging three of its portfolio companies—Allegiant and Georgia-based businesses A Hand to Hold and Accord Services.[97] When AccordCare was created, its first CEO was Brandon Ballew, who came from the home health chain Kindred at Home, owned by large Medicare Advantage insurer Humana.[98] In 2020, AccordCare announced it would expand its New York footprint by acquiring Health Force through a leveraged buyout with Coppermine Capital.[99]

In taking control of the board of directors, private equity owners take control of strategic decision-making and hiring and firing of top executives and managers. If these executives and managers don't go along with the decisions of private equity partners, they are often dismissed. Appelbaum and Batt (2014) describe how private equity firms use a "carrot and stick" approach to align the interests of portfolio companies' top managers with the private equity owners; the highly leveraged capital structure of the portfolio company becomes the "stick," while the "carrot" is the promise of substantial performance-based pay if they improve profit margins and

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[94] Famakinwa, J. (2024, June 5). Why Addus Decided to Leave the New York Market. Home Health Care News. https://homehealthcarenews.com/2024/06/why-addus-decided-to-leave-the-new-york-market/

[95] Eastabrook, D. (2024, May 21). *Addus HomeCare to Sell New York Operations*. Modern Healthcare. https://www.modernhealthcare.com/providers/addus-homecare-new-york-mcs-girling/

[96] Ibid.

[97] Eastabrook, D. (2021, July 13). *Peer-to-Peer: AccordCare, Which Dropped Anchor on East Coast, Now Has Designs on West*. McKnights Senior Living. https://www.mcknightsseniorliving.com/news/peer-to-peer-accordcare-which-dropped-anchor-on-east-coast-now-has-designs-on-west/.

[98] Filbin, 2022; Ballew, B. (n.d.). *Brandon Ballew* [LinkedIn page]. LinkedIn. Retrieved March 6, 2026, from https://www.linkedin.com/in/brandon-ballew-2a77411/

[99] PitchBook; Drury, T. (2023, April 5). *Health Force, Willcare Undergo Ownership Shifts*. Buffalo Business First. https://www.bizjournals.com/buffalo/news/2023/04/05/health-force-willcare-undergo-ownership-shifts.html

meet targets set by the private equity firm (56-57). One academic study found that 68% of private equity deals involved a change of management plan and that private equity owners replaced 38% of portfolio company CEOs in the first 100 days after the leveraged buyout.[100]

This leadership churn is exemplified in a series of leadership changes at PPL (the private-equity-owned corporation that took over New York's consumer-directed home care program). The takeover raised concerns about the direct control of private equity and the overall stability of the corporation. Some reports indicate that PPL had undergone at least seven changes in CEOs over the past four years,[101] and during the course of the rocky transition, PPL's CEO, CFO, and president were all replaced. The new CEO who took over in 2025, Miki Kapoor, is also an operating partner of one of PPL's private equity owners, Linden Capital Partners—a fact not mentioned in PPL's press release about the leadership change.[102] Kapoor had been on PPL's board of directors since Linden and DW Healthcare Partners acquired PPL in a leveraged buyout in 2022.[103] The change sparked major concerns that it would allow the private equity firm to have more direct control of PPL's operations and financial decisions.[104]

These examples highlight the ways that the strategies of financial actors can breed instability and reshape the care system, leading profiteering to drive decisions and overshadow the healthcare mission. They also raise questions about whether there are meaningful differences in how ownership by different financial actors impacts job quality and quality of care. While it is difficult to isolate the different effects for comparative study, our accompanying qualitative research report on working conditions at PE-owned home care agencies will explore specific effects of private equity ownership.

These frequent changes in ownership and increasing consolidation are rarely fully visible to consumers seeking to secure care. The national PE-backed chains have taken different approaches to branding in their New York businesses and the extent to which they preserve the local agencies' branding or foreground the national chain. Help at Home, for example, continues to operate Edison and Preferred under their respective business names, while adding additional

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[100] Acharya, V., Hahn, M., & Kehoe, C. (2009). "Corporate Governance and Value Creation: Evidence from Private Equity," p. 33 and table 10, available at: https://w4.stern.nyu.edu/sternfin/vacharya/public_html/acharya_hahn_kehoe.pdf (accessed April 11, 2026).

[101] Lisa, K. (2024, September 26). *Calls Grow for N.Y. to Bid Medicaid Program Contract with Care*. Spectrum Local News. https://spectrumlocalnews.com/nys/central-ny/politics/2024/09/27/calls-grow-for-ny-to-bid-medicaid-program-contract-with-care.

[102] *Welcoming New Leaders, Strengthening Our Mission*. (2025, August 7). PPL First. https://pplfirst.com/news/welcoming-new-leaders-strengthening-our-mission/

[103] PitchBook data; Kapoor, M. (n.d.). *Miki Kapoor* [LinkedIn page]. LinkedIn. Retrieved March 6, 2026, from https://www.linkedin.com/in/mikikapoor/

[104] Clark, D. (2025, July 14). *Lawmakers Question Leadership Swap at Company Managing CDPAP Home Care Program*. Times Union. https://www.timesunion.com/state/article/ny-lawmakers-question-leadership-swap-company-20768793.php

branding that names them each as "a Help at Home company" on their websites. AccordCare takes a similar approach with its New York businesses, Allegiant and Health Force; yet while the two businesses maintain their respective branding, clicking on each of their websites' "Leadership Team" page identifies the same AccordCare leadership.[105] In some cases, the link to PE-backed chains is even less evident. New York–based Elite Home Healthcare, for example, was acquired by HouseWorks in a leveraged buyout in 2023, but this is not apparent on their website—leading to the appearance that it continues to be a locally owned and operated home care agency. Elara Caring, by contrast, operates under its own name for its New York business, as do Interim HealthCare and Home Instead franchises in the state. This variation in how the chains are branded and organized is consistent with national patterns in PE-backed home care businesses.[106]

Box 2. Elara Caring case study

Elara Caring case study

The case of Elara Caring shows how mergers and acquisitions and changes in branding drive consolidation in the industry and make it difficult to trace changing ownership. In 2018, two private equity firms joined forces to merge three home care companies and rebrand them as Elara Caring, creating one of the largest home-based care providers nationwide. Private equity firm Blue Wolf Capital Partners had acquired two of the companies, Great Lakes Caring and National Home Health Care, in 2016, and then partnered with the firm Kelso & Company in 2018 to acquire Jordan Health Services and implement the three-way merger.[107] The merger of the three companies, which had largely operated in different regions, gave Elara Caring strategic geographic reach—part of an ongoing strategy to expand into new markets. The merger was also part of a business strategy of building a single company's ability to provide services across the care continuum—or what the company called the "caretinuum"—including personal care, skilled home health, hospice, and behavioral health. At the time of the merger, around 50% of Elara's revenue came from providing personal care services; National Home Health Care had primarily provided personal care financed by Medicaid, Great Lakes had

[105] *Meet the AccordCare and it's Family of Companies' Executive Team*. (n.d.). Allegiant Homecare. https://allegiant-homecare.com/about-us/leadership/; *Meet the AccordCare Executive Team*. (n.d.). Health Force. https://www.healthforcewny.com/about-us/leadership/

[106] Salcedo et al., 2025.

[107] Mullaney, T. (2018, April 10). Great Lakes, Jordan, National Home Health Merge to Create Powerhouse Provider. Home Health Care News. https://homehealthcarenews.com/2018/04/great-lakes-jordan-national-home-health-merge-to-create-powerhouse-provider/; Mullaney, T. (2018, July 17). *Jordan, Great Lakes, National Home Health Rebrand as Elara Caring.* Home Health Care News. https://homehealthcarenews.com/2018/07/jordan-great-lakes-national-home-health-rebrand-as-elara-caring/

focused on home health and hospice financed by Medicare, and Jordan operated across all types of care.[108]

Elara Caring's footprint in New York State began with one of the home care agencies in the three-way merger, National Home Health Care. National Home Health Care was a public company headquartered in New York that was taken private in 2007 when it was acquired by private investment firm Angelo Gordon & Company in partnership with investment bank Eureka Capital Partners.[109] In 2016, National Home Health Care was acquired by private equity firm Blue Wolf for about $103 million, in a deal that was deemed one of the highest-value transactions in the industry in recent quarters.[110] The private equity ownership of Elara Caring's New York operations thus began in 2016, prior to the three-way merger and subsequent rebranding.

Labor, compliance, and care quality issues in private-equity-backed home care

Private equity firms' drive to generate outsized profits as quickly as possible raises concerns about cost-cutting measures that may diminish care quality, job quality, and overall compliance with regulations.[111] New York's home care industry is rife with labor and compliance violations, including rampant wage theft that puts the industry among the worst violators in New York City and the state. The top 17 wage theft violators investigated by the New York State Department of Labor from 2020 to 2022 were all home care agencies, with a number of them owing employees millions of dollars in stolen wages.[112] This section reviews how PE-backed home care agencies in New York have perpetuated some of these alarming practices.

Among some of the worst offenders have been Preferred Home Care and Edison Home Health Care, which were acquired in 2022 by PE-owned national chain Help at Home. As a case study, Help at Home and its New York home care acquisitions illuminate some of the troubling labor and compliance issues perpetuated both locally and across the national chain. Recently, Preferred and Edison together were featured on the New York City Comptroller's 2024

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[108] Mullaney, 2018, Jordan, Great Lakes, National Home Health Rebrand as Elara Caring.
[109] VCJ Staff. (2007, November 26). *Angelo Gordon Buys National Home Health*. Venture Capital Journal. https://www.venturecapitaljournal.com/angelo-gordon-buys-national-home-health/
[110] Nelson, M. K. (2016, May 17). *[Updated] Private Equity Firm Buys Home Health Company for $103 Million*. Home Health Care News. https://homehealthcarenews.com/2016/05/private-equity-firm-buys-home-health-company-for-65-million/; Or, A. (2016, May 19). *Blue Wolf Buys National Home Health Care*. The Wall Street Journal. https://www.wsj.com/articles/blue-wolf-buys-national-home-health-care-1463695123
[111] For national examples of problematic cost-cutting measures enacted by private equity in home- and community-based services, see Salcedo et al., 2025.
[112] Geringer-Sameth, E. (2024, September 12). *Home Care Agencies Lead New York City in Wage Theft Violations*. Crain's New York Business. https://www.crainsnewyork.com/health-pulse/wage-theft-rampant-home-health-care-industry.

"Employer Wall of Shame" with a $7.5 million settlement—the largest wage and hour legal settlement with a prosecutorial agency that year.[113] The agencies will pay $7.5 million in unpaid wages to more than 25,000 current and former home care aides who were cheated out of their full compensation, and $9.75 million to Medicaid. The investigation found that the employers used the wage parity funds—which are legally required to be paid to aides in cash wages or in benefits such as paid vacation time—to run a scheme that involved purchasing medical "stop loss" insurance and diverting millions of dollars in dividend payments from this insurance to individuals and entities related to Edison and Preferred. This fraudulent scheme was carried out from 2012 to 2020, and the investigation was triggered by a whistleblower complaint.[114]

While the violations occurred before the Help at Home acquisition of these companies in 2022, it is worth considering the implications of private equity firms buying up home care agencies known for violating and driving down standards. Help at Home's private equity owners, Vistria Group and Centerbridge Partners, should have been aware of this fraudulent scheme: Their exceptional due diligence processes include a comprehensive review of a company's financial, operational, and management practices. Neither Help at Home nor the private equity owners are named as current owners in the coverage of this settlement. Help at Home was taken over in a leveraged buyout by private equity firm Wellspring Capital Management in 2015, with the majority of its ownership sold to its current private equity owners, Vistria Group and Centerbridge Partners, in 2020. Help at Home has pursued an "aggressive" national growth strategy in recent years, using substantial debt, which is loaded on the national platform, to continue making acquisitions across different states.[115] Yet amid these acquisitions, Help at Home closed down its services in the State of Alabama in September 2023, pointing to the state's failure to expand Medicaid coverage under the Affordable Care Act—something the private equity firm would have known at the point of acquisition.[116] The closure of its Alabama providers, which had operated in the state since 1975, led to 785 employee layoffs. Here again, the evidence shows

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[113] *Comptroller Lander Exposes Worst Employers in NYC, Updates Comprehensive Violations Dashboard* [Press release]. (2025, September 3). https://comptroller.nyc.gov/newsroom/comptroller-lander-exposes-worst-employers-in-nyc-updates-comprehensive-violations-dashboard/.

[114] Attorney General James and U.S. Attorney Peace Secure Over $17 Million From Home Health Agencies for Cheating Workers and Defrauding Medicaid in Landmark Wage Parity Agreement [Press release]. (2024, September 30). https://ag.ny.gov/press-release/2024/attorney-general-james-and-us-attorney-peace-secure-over-17-million-home-health.

[115] Donlan, A. (2021, July 22). *Help at Home Continues Executing on Growth Strategy, Acquires Community Care Systems*. Home Health Care News. https://homehealthcarenews.com/2021/07/help-at-home-continues-executing-on-growth-strategy-acquires-community-care-systems/

[116] *Help at Home to Lay Off 785 Workers and Leave Alabama, Blaming State's Medicaid Policies*. (2023, September 15). Alabama Local News. https://www.al.com/news/2023/09/help-at-home-to-lay-off-785-workers-and-leave-alabama-blaming-states-medicaid-policies.html;
Fenne, M. (2023, September 21). *PE-Owned Home Health Company Terminates Operations in Alabama*. Private Equity Stakeholder Project. https://pestakeholder.org/news/pe-owned-home-health-company-terminates-operations-in-alabama/

how private equity investors can drive loss of care services and loss of jobs through profit-driven decision-making that put wealth extraction above patients' needs.

Help at Home's private equity owners, Vistria Group and Centerbridge Partners, have been implicated in harmful practices throughout their home- and community-based services. In 2019, Vistria and Centerbridge took majority ownership of Sevita Health (formerly known as the MENTOR Network), a large provider of home- and community-based specialty healthcare for people with intellectual or development disabilities (I/DD), people with neurological injuries and other complex care needs, and children in foster care. This is part of a recent trend of private equity ownership in the array of home- and community-based services for people with I/DD.[117] Over the past decade, investigative reporting and state and federal investigations have exposed an extensive and disturbing trail of substandard care and abuse across at least seven states where Sevita was operating, including sexual abuse, neglect, and a strikingly high rate of death for children in their foster care.[118] Although Sevita ultimately exited operations in certain states when investigations were initially released, the company now operates in these states again and has expanded further, as its private equity owners have pursued a strategy of rebranding and aggressive mergers and acquisitions.[119]

Across its national chain, PE-owned Elara Caring has been penalized for other significant labor, safety, and compliance violations. In early 2025, New York officials found that Elara Caring violated worker protections in New York. As a result, the New York City Department of Consumer and Worker Protection (DCWP) required Elara Caring to pay over $913,000 in restitution to more than 2,200 workers for violating the workers' right to use their paid safe and sick leave as required by law; Elara also was fined almost $92,000 in civil penalties and costs. Furthermore, in April 2024, the Occupational Safety and Health Administration (OSHA) fined Elara over $163,000 in penalties after a client killed a licensed nurse practitioner during a home care visit at a transitional housing site in Connecticut. The OSHA investigation faulted Elara for failing to protect employees from known hazards, despite repeated incidents of clients threatening and assaulting them. Americans for Financial Reform noted that "[a]s of September 2023, Elara Caring generated $985 million in annual revenue with $92 million in cash on hand, though $43 million

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[117] O'Grady, E. (2025). Private Equity in Intellectual and Developmental Disability Services. In *Private Equity Stakeholder Project*. https://pestakeholder.org/wp-content/uploads/2025/03/PESP_Report_IDD_2025.pdf.

[118] O'Grady, E. (2022). *The Kids Are Not Alright: How Private Equity Profits Off of Behavioral Health Services for Vulnerable and At-Risk Youth*. Private Equity Stakeholder Project. https://pestakeholder.org/wp-content/uploads/2022/02/PESP_Youth_BH_Report_2022.pdf; O'Grady, 2025; Salcedo et al., 2025; Roston, A. (2015, June 24). *US Senate Committee Probes Nation's Largest For-Profit Foster Care Firm*. United States Senate Committee on Finance. https://www.finance.senate.gov/chairmans-news/us-senate-committee-probes-nations-largest-for-profit-foster-care-firm.

[119] Salcedo et al., 2025.

of that was held in escrow for acquisitions, which meant it could not go to safety upgrades, additional staffing, or any other workplace improvements."[120] Elara Caring also has been penalized for fraudulent practice. In May 2024, Elara reached a $4.2 million settlement agreement with the U.S. Department of Justice to resolve allegations that various Elara Caring locations in Texas had defrauded Medicare over the course of six years by submitting false claims and retaining overpayments for ineligible hospice patients.[121]

When private-equity-backed Public Partnerships LLC (PPL) became the sole statewide fiscal intermediary for New York's consumer-directed home care program (CDPAP) in 2025, the transition ushered in many problems for care recipients and caregivers. While the decision to transition to a single fiscal intermediary was itself highly controversial (as detailed above), the selection of PPL also proved controversial, as critics drew attention both to the corporation's history in other states and to a cascade of irregularities and problems that emerged during the transition. Concerted campaigns to halt the transition were waged by disability justice and care worker advocates and by the existing fiscal intermediaries who would lose their CDPAP business; some of these existing fiscal intermediaries filed legal actions seeking to challenge or postpone the transition and elements of the transition process. In August 2025, state lawmakers held a public hearing to examine the problems emerging from the CDPAP transition.[122] Testimony at the hearing identified a wide range of serious problems that emerged, including: extensive problems that caregivers and care recipients encountered in switching to PPL; widely reported payment problems where many caregivers went without pay or were paid incorrectly; a strikingly deficient health coverage plan and policy; and irregularities in the procurement process.[123] While it is difficult to disentangle the extent to which the problems are a result of the state's mismanagement of a complex process versus PPL's operational failures, the copious problems that arose during the transition have sparked ongoing calls for transparency and accountability in the state's contract with PPL.

Critics of the selection of PPL also pointed to its problematic track record acting as a fiscal intermediary for home care programs in other states. While these incidents occurred prior to PPL

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[120] Salcedo et al., 2025, p.21.
[121] Bugbee, M. (2024, May 10). *Private Equity-Owned Hospice Company Agrees to Pay $4.2 Million Settlement*. Private Equity Stakeholder Project. https://pestakeholder.org/news/private-equity-owned-hospice-company-agrees-to-pay-4-2-million-settlement/.
[122] Joint Public Hearing: Consumer Directed Personal Assistance Program (CDPAP), 2025.
[123] See hearing testimony transcripts here: https://www.nysenate.gov/calendar/public-hearings/august-21-2025/joint-public-hearing-consumer-directed-personal-assistance

being acquired by private equity firms, they suggest a pattern of concerning behavior that appears to have continued under private equity ownership.[124]

IV. INSTITUTIONAL CHANGE AND THE RISE OF PRIVATE EQUITY IN HOME CARE

Public policies have enabled and encouraged private equity acquisitions in home care. Prior studies of private equity's expansion across industries demonstrate that policies and institutional changes have facilitated their strategies for extracting wealth.[125] Appelbaum and Batt for example show how regulatory changes in healthcare and financial markets going back to the 1960s and 1970s gave rise to private equity, while the Affordable Care Act of 2010 spurred its expansion into hospitals and healthcare more broadly.[126] Weak federal and state regulatory frameworks and opaque public and private payment systems incentivize private equity firms and other financial actors to use financial engineering and introduce management practices of extraction. However, there has not yet been a comprehensive analysis of how the policy landscape specific to home care has shaped the conditions that facilitate private equity's move into and profiteering from investing in these services.[127] This part of the paper outlines the

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[124] For example, after PPL became the sole provider of financial management services for a Medicaid home care program in Pennsylvania, a state audit found that the procurement process through which PPL was selected was unfair; that the transition to PPL was confusing and overwhelming for care recipients and providers; and that thousands of direct care workers experienced delays in wage payments that were sometimes months long. The auditor pointed to the Department of Public Welfare's lax oversight of PPL and PPL's lack of readiness to handle the transition. https://www.paauditor.gov/wp-content/uploads/audits-archive/Media/Default/Reports/speDPWPPL111413.pdf
https://www.bangordailynews.com/2013/11/22/news/pennsylvania-lawmaker-requests-attorney-general-review-of-welfare-consultant-hired-by-lepage/?ref=comm-from.
In New Jersey, disability rights advocates criticized the state's contract with PPL, charging that PPL had caused disruptions and denials of care to Medicaid beneficiaries. They cited irregularities in the procurement process; failures to provide certain care services; and incorrect, delayed, and missing payments. https://www.abcdnj.org/wp-content/uploads/2025/01/ABCD-PPL-Operational-Failures-White-Paper.pdf
https://seiuhcpa.org/home-care-workers-and-consumers-describe-the-real-impact-of-governor-corbetts-outsourcing-of-their-fiscal-management-system-to-ppl/.

[125] See, for example, Appelbaum, E. and Batt, R. (2021, September 9). *Financialization in Health Care: The Transformation of US Hospital Systems*. CEPR. https://cepr.net/wp-content/uploads/2021/10/AB-Financialization-In-Healthcare-Spitzer-Rept-09-09-21.pdf; Morgan, J. (2022). Private Equity. In L. Seabrooke & D. Wigan (Eds.), *Global Wealth Chains: Asset Strategies in the World Economy*. Oxford University Press. https://doi.org/10.1093/oso/9780198832379.003.0006

[126] Appelbaum, E. and Batt, R. (September 9, 2021). *Financialization in Health Care: The Transformation of US Hospital Systems*. CEPR., 59, https://cepr.net/wp-content/uploads/2021/10/AB-Financialization-In-Healthcare-Spitzer-Rept-09-09-21.pdf; Appelbaum, E. and Batt, R. (2020). Private Equity Buyouts in Healthcare: Who Wins, Who Loses? Working Paper No. 118 March 15, 2020, CEPR, https://cepr.net/wp-content/uploads/2020/03/WP_118-Appelbaum-and-Batt.pdf; Appelbaum, E., & Batt, R. (2019, September). Private Equity and Surprise Medical Billing: How Investor-owned Physician Practices Are Driving up Healthcare Costs. Institute for New Economic Thinking. https://www.ineteconomics.org/perspectives/blog/private-equity-and-surprise-medical-billing

[127] A recent report by Americans for Financial Reform provides important background on changes in Medicare and Medicaid, demographic shifts, and labor regulations; and a review of state and federal policy levers that could be used to curb the damaging impacts of private equity ownership of HCBS. Section IV of this paper builds on this analysis by tracking policy changes within the historical context and specifically focusing on the central role of policy changes in Medicaid long-term care and labor protections for domestic workers in the rise of private equity in home care. See Salcedo et al., 2025.

development of Medicaid long-term-care policies and reviews the weak labor market regulations and protections for home care workers that have empowered private equity to profiteer from home care and exploit the home care workforce. It emphasizes the responsibility of interconnected health and labor policies and regulations, and the importance of reforms to this system to protect home care workers from private equity and other predatory profit-seeking financial actors.[128]

This section extends existing literature by demonstrating how policy changes to the Medicaid long-term services and supports (LTSS) system have fostered the incursion of private equity (PE) in the home care industry. As noted, Medicaid is the dominant source of financing for LTSS in the United States, including both nursing home and home care.[129] As such, it is the primary source of payment to home care agencies and an important source of steady revenue for private equity firms that purchase and consolidate smaller home care agencies into large chains. An overview of how this policy system has been structured and restructured helps illuminate some of the reasons why private equity is attracted to and able to profit from long-term care. It also underscores how a broad set of stakeholders is affected by private equity's extraction of profits from home care: home care workers, those receiving care, communities that rely on long-term-care systems, and of course, the taxpayers whose public dollars are the source of private equity's extraction. At a macro level, private equity's profit-making strategies coupled with weak healthcare and labor market regulations and protections perpetuate the exploitation of home care workers who are predominately women of color, contributing to widening inequalities structured by race, gender, and class.

This section therefore highlights important policy shifts in Medicaid long-term services and supports that have gradually restructured the entire program over several decades. These shifts have occurred in the context of continuing budgetary restrictions that have contributed to poorly executed and chronically underfunded deinstitutionalization, increased privatization, and the deregulation of long-term care. But equally important, this section will chart how the absence of oversight in home care leaves care workers potentially more vulnerable to already poor wages and working conditions. Poor wages are endemic in the home care sector. In 2024, for example, direct care worker median hourly wages adjusted for inflation in home care was $16.77, an

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[128] The following Section IV of the report draws on Rowe, R. (2026). "Variegated Social Reproduction and Strategies of Resistance to the Financialization of Care." [Paper presentation] 2026 Social Policy Association Annual Conference July 2026, Liverpool, UK; and Rowe, R. (2026). "The Policies, Politics, and Contradictions of the Financialization of Care." [Paper presentation] 2026 Society for the Study of Social Problems (SSSP) Annual Meeting, New York, NY 2026.

[129] Colello, K. and Sorenson, I. (2026, April 9). *Who Pays for Long-Term Services and Supports?* Congress.gov, Library of Congress. https://www.congress.gov/crs-product/IF10343.

increase of just $3.70 from the 2014 average hourly wage of $13.07.[130] As a point of comparison, the median hourly pay for nurse aides in nursing homes in 2024 was $19.01.[131] The section will argue that the absence of appropriate regulation, oversight, and enforcement in both healthcare and labor market policy domains compounds existing racialized and gendered inequities in the institutional framework.

Home care: fiscal 'crisis' and privatization

Fiscal restrictions and privatization represent an important starting point for understanding how health policy changes have created a home care system that puts downward pressure on home care workers' compensation and working conditions while simultaneously enabling and attracting predatory financial actors such as private equity to the industry. The shift to private vendors and "contracting out" home care began in the 1970s, when the federal government and states sought to restrict spending on social services in the wake of the 1973 and 1979 oil embargoes and the subsequent global economic downturn. Until that time, local health and social service departments had been developing programs to employ home care attendants and other care workers to provide in-home non-medical support for community members.[132] These programs sought to create jobs—albeit low-paid jobs—for people (mainly women of color) who might otherwise have been entitled to public assistance by channeling black women into jobs that paid less than cash assistance and less than minimum wage.[133] In addition to this longer-term policy of providing low-wage work instead of cash benefits, states sought strategies for shifting care workers to funding streams that reduced cost and responsibility for oversight—further solidifying racialized and gendered labor market segmentation.[134] In New York State, for example, many government-run and non-profit home care programs were increasingly contracted out to private vendors to take over home care provision, creating an agency model that cut care workers off from the benefits and protections of public sector employees.[135] Historians Boris and Klein explain that it was "by design" that workers would not have access to

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[130] PHI. "Workforce Data Center." Last modified September 2025. https://www.phinational.org/policy-research/workforce-data-center/#tab=National+Data&natvar=Wage+Trends

[131] U.S. BLS, "Occupational Employment and Wage Statistics (OEWS) Profiles – May 2024. Home care workers pay level approaches the $15-16 hourly wage of fast-food workers.

[132] It should be noted that a federal framework was briefly established through the New Deal's Works Progress Administration's (WPA) Household Service Demonstration Project (1937–1942) that trained and employed women in household services, aiming to professionalize domestic work. This included training women to work in nursery schools, school lunch programs, and provide home care services for the sick and elderly. Woodward, E. S. (n.d.). Lasting Values of the WPA (speech). National Archives, WPA Papers, Record Group 69, Series 737, Box 8. Social Welfare History Project.

[133] Boris, E., and Klein, J. (2012). *Caring for America: Home Health Workers in the Shadow of the Welfare State*. Oxford University Press, pp. 94-117. This was also a way of reducing public assistance payments to recipients by placing women in low-paying jobs.

[134] Ibid.

[135] Ibid.

benefits such as disability and unemployment insurance, and no public agency monitoring the delivery of services.[136]

'Rebalancing': the shift away from institutional care and the shadow of cost-cutting and deregulation

One of the most significant changes in long-term care in the United States has been the shift away from institutional care (e.g., nursing homes) toward home- and community-based services (HCBS). This began in the 1970s,[137] later becoming a major policy goal referred to as Medicaid "rebalancing" where the federal government pushed states to provide HCBS in their Medicaid programs as an alternative to nursing home care.[138] This transformation has been a core component of the restructuring of Medicaid. The shift away from institutional care responded to the growing struggles for the rights of people with disabilities to live in community—leading to the legal mandates of the *Olmstead* ruling—and the rising demand for the ability to "age in place," especially in the wake of horrific nursing home scandals.[139] Yet as the cost of long-term care grew through the 1970s and 1980s, federal and state policymakers also viewed "rebalancing" as a way to control Medicaid budgets. The first major federal initiative to expand HCBS came as part of the Reagan Administration's 1981 Omnibus Budget Reconciliation Act (OBRA).[140] OBRA created the 1915(c) waivers that states can use to provide HCBS instead of nursing home care so long as the state can demonstrate that costs for HCBS are no greater than costs for nursing home care.[141] Federal funding and support for HCBS has continued with the

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[136] Ibid.

[137] Since the 1970s, states were given the option to add personal care services in their state plans. See, for example, O'Keeffe, J., Saucier, P., Jackson, B., Cooper, R., McKenney, E., Crisp, S., & Moseley, C. (2010). *Understanding Medicaid Home and Community Services: A Primer*. U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/43551/primer10.pdf; Congress. (2023, December 20). *Long-Term Services and Supports: History of Federal Policy and Programs* (K. J. Colello, Author; Report No. 47881). Congressional Research Service. https://www.congress.gov/crsproduct/R47881?q=%7B%22search%22%3A%22CRS+2023+LongTerm+Services+and+Supports%3A+History+of+Federal+Policy+an d+Programs%22%7D&s=1&r=1; LeBlanc, A. J., Tonner, M. C., & Harrington, C. (2001). State Medicaid Programs Offering Personal Care Services. Health Care Financing Review, 22(4), 155-173. https://pmc.ncbi.nlm.nih.gov/articles/PMC4194739/

[138] See, for example, *Long-term Services and Supports (LTSS) Rebalancing Toolkit Fact Sheet*. (2020, November 2). Center for Medicare & Medicaid Services. https://www.cms.gov/newsroom/fact-sheets/long-term-services-and-supports-ltss-rebalancing-toolkit-fact-sheet.

[139] The 1999 Supreme Court decision in the *Olmstead v L.C.* case ruled that to support the Americans with Disabilities Act (ADA) (1990), persons with disabilities must be provided with services they need to enable them to live as independently as possible and to be integrated within the community. The Department of Health and Human Services (DHHS) plays a central role through HCBS provision. See *Community Living and Olmstead*. (n.d.). U.S. Department of Health and Human Services. https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html#:~:text=The%20U.S.%20Supreme%20Court%27s%201999,with%20Disabilities%20Act%20%28ADA%29

[140] Omnibus Budget Reconciliation Act of 1981: Titles III, VI, IX, XI, XXVI [Public Law 97–35, Enacted August 13, 1981 (95 Stat. 357)], https://www.govinfo.gov/content/pkg/COMPS-10576/pdf/COMPS-10576.pdf. OBRA was notorious for its devastating cuts to the welfare state.

[141] O'Keeffe, J. et al. (2010). Understanding Medicaid Home and Community Services: A Primer.

creation of additional waiver programs in the 1980s through to the Affordable Care Act in 2010, all with provisions for cost containment.[142] Over time, legislation to create HCBS has shifted financial responsibility and discretion of service provision and the regulation thereof to states and localities as part of the New Federalism promoted by Republicans as much as it has been part of the Democrats' emphasis on budget control and the reform of the welfare state.[143] Despite such efforts to control costs by avoiding or replacing nursing home care with HCBS, costs of Medicaid long-term services and supports (LTSS) have continued to grow due to expanding need, leading to further strategies by states, such as New York, to rein in the costs that ultimately impact care workers' compensation and care recipients' care.

Since 2013, more Medicaid money has been spent on HCBS than on institutional care, and, as of January 2026, all states have at least one Medicaid program with home care benefits.[144] Because federal policymakers and the Centers for Medicare and Medicaid Services have measured rebalancing in terms of the shift in spending and enrollment away from nursing homes and into HCBS, the initiative has generally been considered a success, despite grave problems of inequities, care quality, access, and workforce shortages—all problems tied to the requirement for cost containment and the notoriously weak system of home care regulation. This is in addition to moving care from guaranteed coverage and access (e.g., nursing homes) to care that, when provided through waivers, is rationed and capped.[145] As a result, home care is inequitable, often inaccessible,[146] and dependent on an underpaid and undervalued workforce comprised mostly

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[142] As of 2026, there are several 1915(c) waivers in addition to other authorities that enable states to use HCBS or integrate personal care into their state plan. Mohamed, M., Burns, A., & Watts, M. O. (2026, January 5). Medicaid Home Care (HCBS) in 2025. KFF. https://www.kff.org/medicaid/medicaid-home-care-hcbs-in-2025/; Congress. (2023). Long-Term Services and Supports: History of Federal Policy and Programs; Home & Community Based Services Authorities. (n.d.). Medicaid.gov.

[143] All waivers and programs to expand HCBS have included provisions for cost containment, even if they provide financial incentives up front for states to use HCBS instead of institutional care. All have been part of broader neoliberal reforms, see e.g. Boris, E., and Klein, J. (2015). *Caring for America*. See also Olson, L. K. (2010). *The Politics of Medicaid*. Columbia University Press.

[144] Ibid; Mohamed, M., Burns, A., & O'Malley Watts, M. (2025, February 18). What is Medicaid Home Care (HCBS)? KFF. https://www.kff.org/medicaid/what-is-medicaid-home-care-hcbs/

[145] Medicaid enrollees use state plan home health and personal services in slightly higher numbers than states use waivers, as shown in Figure 3 here: Chidambaram, P. and Burns, A. (2023). *How Many People Use Medicaid Long-Term Services and Supports and How Much Does Medicaid Spend on Those People?* Data Note. Kaiser Family Foundation. https://www.kff.org/medicaid/how-many-people-use-medicaid-long-term-services-and-supports-and-how-much-does-medicaid-spend-on-those-people/

[146] *Rebalancing Long-Term Supports and Services Among Older Adults Enrolled in Medicaid, 2016-2019*. (2025, January 15). Assistant Secretary for Planning and Evaluation: Office of Behavioral Health, Disability, and Aging Policy. https://aspe.hhs.gov/sites/default/files/documents/ad7cf66fb2a7ae1a0bd91b288363fc71/rebalancing-ltss-medicaid-enrolled-brief.pdf;
Report to Congress on Medicaid and CHIP. (2023, June). The Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/wp-content/uploads/2023/06/MACPAC_June-2023-WEB-508.pdf; Bernacet, A., Kordomenos, C., Karon, S., Knowles, M., Archibald, N., & Kruse, A. (2021, April). *Examining the Potential for Additional Rebalancing of Long-Term Services and Supports*. The Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/wp-content/uploads/2021/05/Examining-the-Potential-for-Additional-Rebalancing-of-Long-Term-Services-and-Supports.pdf; Rohde, K., Coe, N. B., Gonalons-Pons, P., Miller, K., Kreider, A. R., & Hoffman, A. K. (2024). Addressing Problems with Medicaid Home and Community-Based Services in the Age of Rebalancing. *Health Affairs, 43*(10). https://doi.org/10.1377/hlthaff.2023.01276

by women of color.[147] The impact of rebalancing has therefore been complex: it has enabled a critical move away from institutional care, yet the cost-cutting and deregulation that has accompanied it has compounded already long-standing racialized and gendered labor market inequities through the HCBS system.

Federal regulatory inadequacies and enforcement failures of home- and community-based services

Federal policymakers' interest in rebalancing was not accompanied by a new federal regulatory framework for Medicaid-funded home- and community-based services (HCBS), applicable across all 50 states and Washington, D.C. Instead, the federal government regulates home care only indirectly, by placing certain minimum requirements for the provision of HCBS in state Medicaid programs where the regulating "authorities" are essentially the waivers used to create HCBS.[148] Home care is directly regulated by states, which have wide discretion in their approach to licensing, certification, and oversight of agencies through state departments of health. At both the state and the federal levels, home care regulations that are part of the health system are entangled in regulations of care work through labor policies. For example, responsibility for workers' training and wages is spread across federal and state labor laws and health systems. The labor laws regulating care work and the health policies regulating home care are at times at odds, but as this section will show, together they serve to keep labor costs low to control Medicaid spending, thereby perpetuating the racialized and gendered labor market segmentation discussed above.[149]

Although the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) are not officially designated as regulatory bodies, CMS does play a small role in regulating states' Medicaid-funded home care programs at the federal level. The examples below highlight the way the federal government regulates states' home care programs. A brief review of the key components of the existing regulatory landscape reveals the many gaps in the system as well as certain ways the regulations may be incentivizing predatory profit-making practices.

To start, the 1915(c) waiver is the central mechanism through which states can contain costs by rebalancing Medicaid long-term care from institutional care to home- and community-based

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[147] See, for example, Boris, E. and Klein, J., 2015; Olson, L. K., 2010.
[148] See the explanation of the waiver authorities above and *Home & Community Based Services Authorities.* (n.d.). Medicaid.gov. For a broad overview of regulations for LTSS and HCBS see Nadash, P. (2024). Regulatory Framework and Compliance in Long-Term Care. In D. Liu & N. G. Castle (Eds.), *Managing Quality and Safety in Long-Term Care* (pp. 51-67). Springer Publishing.
[149] This is well documented, e.g., Boris and Klein, 2012.

services (HCBS). For a state to introduce low-cost HCBS as part of the state's Medicaid Long-Term Services and Supports program, CMS requires states to detail their plans of services covered, how they will address health and welfare, and the qualified providers involved, including the agencies that will receive contracts. The waiver enables the states to bypass the regulations and requirements set forth in the 1965 Medicare and Medicaid Act, thus indirectly deregulating HCBS.

As Nadash points out, the process of applying and renewing waivers acts as the primary system of federal regulation of states' HCBS.[150] The waiver approval process requires states to submit applications to CMS that explain how they will finance (ensuring costs will not exceed that of nursing home care) and meet certain standards of care. But the waiver approval process provides little ongoing oversight apart from the renewal process,[151] and again unlike nursing home regulations, does not require transparency of ownership that could make ownership (private equity or otherwise) publicly accessible. Furthermore, the waiver approval process generally does not involve state provisions for care worker compensation, working conditions, or labor protections.[152] Waivers do not require transparency about the quality and adequacy of services provided, the level of payments, or other aspects of a state's waiver plan. In effect, these waiver processes are relatively undemanding and, in their current form, offer little oversight of management practices at the agency level. Despite the relatively weak regulation waivers provide, they have raised concerns about administrative burden and restricting access to HCBS, especially the requirements for regular renewal.[153] For these reasons, the influential nonpartisan Medicaid policy advisory body, Medicaid and CHIP Payment and Access Commission (MACPAC), has recommended amending the Social Security Act to increase the renewal period

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[150] Nadash, 2024. Briefly, states require a waiver to provide HCBS instead of nursing home long-term care because when Medicaid was created it only included a benefit for nursing homes. States can use several waivers, including the Medicaid 1915(c) waiver program, to apply to the federal government for permission to use state Medicaid dollars to provide home- and community-based long-term care. In addition to the 1915(c) waiver benefit, the other two benefits through which states can provide HCBS are the mandatory home health benefits and the optional personal care benefit. LTC supply is an important predictor of community-based use and expenditures. States with greater availability of HCBS providers and more limited nursing home beds are found to have higher rates of Medicaid waiver use. See Miller, N. A., Rubin, A., Elder, K. T., Kitchener, M., & Harrington, C. (2006). Strengthening Home and Community-Based Care Through Medicaid Waivers. *Journal of Aging & Social Policy, 18*(1), 1-16. https://doi.org/10.1300/J031v18n01_01

[151] At least one onsite review is required during the three- to five-year waiver period; if states fail to satisfy provisions of its plan, CMS has the option to sanction actors or act to make changes. See Nadash, 2024.

[152] It is worth noting that states can and, to some extent, do set up their own requirements within waiver programs, including, for example, training standards.

[153] Medicaid and CHIP Payment and Access Commission (MACPAC). (October 2024). Directed Payments in Medicaid Managed Care. Issue Brief. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf; Medicaid and CHIP Payment and Access Commission (MACPAC). (March 2025). Report to Congress on Medicaid and CHIP. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2025/03/MACPAC_March-2025-WEB-Final-508.pdf

for HCBS programs operating under Section 1915(c) waivers and state plan amendments from five to ten years.[154]

In the years since the Affordable Care Act (2010), Congress and CMS have introduced other requirements for states in their provision of Medicaid home care services. The federal government introduced the Electronic Visit Verification system (EVV) in response to demands for greater transparency and oversight of home- and community-based services, quality improvement, improved access, and expansion of the workforce.[155] Mandated by the 21st Century Cures Act in 2016, EVV represents a source of data collection designed to modernize health infrastructure and prevent fraudulent practices by agencies and providers. Unless given an exemption, states are required—with threat of reduction in federal funding if they fail to do so—to provide documentation of Medicaid-funded home health care service (HHCS) and personal care service (PCS) visits including date, location, type of service, individual(s) providing and receiving services, and duration of service. EVV is designed to validate hours of work for home health employees, eliminate billing data entry mistakes, reduce costs related to paper billing and payroll, and help combat fraud, waste, and abuse.[156]

While the introduction of a data collection system, especially if it provides more transparency, is welcome, the Electronic Visit Verification (EVV) system has shown to be at once a problem for care workers and a weak oversight mechanism for tracking services provided as they correspond to assessments of needs and/or payments to agencies. In practice, EVV places responsibility on and increases administrative and technical demands of care workers without showing signs of effectively stopping owners from legally or fraudulently failing to provide services.[157] In addition to the burden it places on care workers, EVV has been criticized for its technical difficulties,

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[154] Medicaid and CHIP Payment and Access Commission (MACPAC). (March 2025). Report to Congress on Medicaid and CHIP. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2025/03/MACPAC_March-2025-WEB-Final-508.pdf. "Congress should amend Section 1915(c)(3) and Section 1915(i)(7)(C) of the Social Security Act to increase the renewal period for HCBS programs operating under Section 1915(c) waivers and Section 1915(i) state plan amendments from 5 years to 10 years" (p. 60).

[155] As home- and community-based services (HCBS) have expanded over time, calls have come from a range of stakeholders for the Centers for Medicare and Medicaid Services (CMS) to introduce new regulatory and oversight mechanisms to increase transparency, collect and publish more information and data, and establish standards for services and care. But these calls often face strong opposition to regulations from the home care industry.

[156] Section 12006(a) of the 21st Century Cures Act mandates that states implement EVV for all Medicaid personal care services (PCS) and home health services (HHCS) that require an in-home visit by a provider. All states must implement an EVV system to avoid a reduction in federal Medicaid funding. This applies to PCS provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or a waiver. See *Electronic Visit Verification*. (n.d.). Medicaid.gov. https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-guidance-additional-resources/electronic-visit-verification

[157] Miller, J., Breslin, M. L., & Chapman, S. (2021). Impact of Electronic Visit Verification (EVV) on Personal Care Services Workers and Consumers in the United States. UCSF Health Workforce Research Center on Long-Term Care. https://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/EVV_Report_210722.pdf; Mateescu, A. (2024). Working Against the Clock: Digital Surveillance in US Medicaid Homecare Services. *Journal of Sociology*, *60*(3), 560-576.

privacy breaches, and for reducing care access and quality—suggesting EVV may increase problems of access and underlying inequities based on needs or other characteristics.[158] Moreover, evidence suggests that EVV would not prevent agencies from billing for services not provided. For example, the New York State comptroller reported large discrepancies between personal care visits and Medicaid payments: only 56% of the personal care services documented by EVV matched the $82 million of personal care claims to Medicaid.[159]

The EVV system is thus relevant to understanding the ways in which financial actors may profit from home care. It demonstrates how the introduction of technology for efficiency or data collection may place greater demands on care workers and create new opportunities for wage fraud. Because EVV was created to improve documentation through technology, protect the consumer, and promote efficiency in saving money, it was not designed to help home care workers. It did not come with funding and provision for training home care workers, though they must interface with EVV to be paid, thus requiring them to learn the technology to be paid. Like much regulation in the Medicaid system and the broader realm of means-tested benefits in the United States, it is inflected by a pervasive distrust of both workers of color and low-income families.[160] Evidence suggests that some uses of such technology in home care have led to greater incidence of wage theft and Medicaid fraud.[161] Instances of wage theft (whether intended or not) ensue when the hours worked are not logged appropriately in the system, putting the responsibility on the worker to prove they were present and working at a patient's home so that they are paid. Such a system often does not support workers' ability to address wage theft and hold the agency (or private equity owners) accountable, even as they may be profiting from underpayment of wages and overbilling of services.

Though not yet implemented, the Biden-Harris Administration's "Ensuring Access to Medicaid Services" final rule included a series of provisions to improve quality and promote person-centered care that were to be phased in over several years (but are now in question as they may be overturned under the current Trump Administration). The rule's objective—whether implemented as planned or under a future administration—is to strengthen oversight of person-centered service planning in home- and community-based services by requiring states to

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[158] Ibid.

[159] Office of the New York State Comptroller. (2024, November). Department of Health. Medicaid Program: Provider Compliance with the Electronic Visit Verification Program. Report 2022-S-31. https://www.osc.ny.gov/files/state-agencies/audits/pdf/sga-2025-22s31.pdf

[160] Zhang, Y. (2024). The Care Bureaucracy. *Indiana Law Journal*, *99*(4), 4.

[161] Ming, J., Gong, D., Ngai, C. S. E., Sterling, M., Vashistha, A., & Dell, N. (2024). Wage Theft and Technology in the Home Care Context. *Association for Computing Machinery, 151*, 1-30. https://doi.org/10.1145/3637428

meet nationwide incident management system standards.[162] If funded and enforced, these provisions could shed more light on profiteering practices and their effects on care work and quality care—important steps toward holding financial actors including private equity accountable. Yet they would require large investment in technology and infrastructure needed for increasing electronic data collection in the context of years of underfunded federal and state health departments and potentially devastating cuts to both under the current Trump Administration.

Moreover, the Ensuring Access to Medicaid Services rule is best known for the arguably controversial "80/20" rule requiring agencies to ensure 80% of Medicaid payments for certain home- and community-based services (HCBS), including personal care, are applied to care workers' wages. This rule was framed as a policy to address chronic workforce shortages, thereby also expanding access for people to HCBS.[163] If funded and enforced, it would help protect workers while also minimizing the profitability of the home care industry. While the rule serves as an important milestone in seeking to secure better wages for home care workers, it has limitations that could undermine the rule's ultimate objective. In its current form, the rule allows for exclusions and exemptions, it would not go into effect until 2030, and even if implemented and enforced in its current form, it is unlikely to raise care workers' wages high enough or improve job conditions to the extent that the increase in wages would effectively address workforce shortages and high turnover. Nevertheless, the home care industry has aggressively opposed it, arguing that reimbursement rates are too low to stay in business with the rule in place, though evidence of the profits made through Medicaid reimbursement in some cases complicates this claim. The point here is that such a rule as written—whether implemented under this administration or later under a new administration—would not necessarily prevent profit extraction. Without more comprehensive policy and regulatory change, the provisions could

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[162] States must meet nationwide incident management system standards for monitoring HCBS programs, collect data, and report on the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to the direct care workers furnishing these services. The rule requires states to report on waiting lists in section 1915(c) waiver programs; and service delivery timeliness for personal care, homemaker, home health aide, and habilitation services. In addition, the rule promotes transparency related to the administration of Medicaid-covered HCBS through public reporting of standardized quality, performance, and compliance measures.

[163] CMS. (2024). Ensuring Access to Medicaid Services Final Rule (CMS-2442-F). https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-final-rule-cms-2442-f; Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Parts 431, 438, 441, 447 [CMS-2442-F] RIN 0938-AU68 Medicaid Program; Ensuring Access to Medicaid Services, https://public-inspection.federalregister.gov/2024-08363.pdf
Gonzalez, M. (2025). Trump Administration's Anti-Competitive Efforts Could Implicate 80/20 Rule, *Home Healthcare News*, https://homehealthcarenews.com/2025/05/trump-administrations-anti-competitive-efforts-could-implicate-80-20-rule/; Healy, A. (2025). Lawmakers push Trump to block Medicaid 80/20 rule. McKnights Home Care, https://www.mcknightshomecare.com/news/lawmakers-push-trump-to-block-medicaid-80-20-rule/; Goodman, G. (2024). Final Medicaid Access Rule Includes Controversial 80% Compensation Pass-Through. *LeadingAge*. https://leadingage.org/final-medicaid-access-rule-includes-controversial-80-compensation-pass-through/

encourage financial actors to engage in overbilling, billing for exempt services, failing to provide services, or shifting to different services. It could prompt job cuts or cutting care workers' working hours. The rule could prompt private equity to "tunnel" profits through different parts of its vertically integrated portfolio or further consolidate ownership of interconnected components of the health services industries.

New York State regulation of home care: weaknesses and failures of enforcement

The absence of a uniform federal regulatory framework has left home care regulation almost completely at the discretion of states, making state regulations especially important in protecting workers from profiteering.[164] This section provides a brief overview of some of the ways that New York State's regulations leave gaps or lack enforcement, thus providing openings for financial actors to extract wealth. Outlining this landscape also helps point to how financial actors and management leverage regulatory gaps at the state level that contribute to worsening working conditions for care workers.

New York State does have more regulation in place to cover home care workers than many states. However, as this section will outline, New York State still falls short of regulating the industry sufficiently to safeguard workers and improve financial transparency and accountability. New York State's Department of Health (NYSDOH) is responsible for regulating and organizing home care in the state, with the focus on ensuring agencies uphold standards of care required to receive Medicaid funding from beneficiaries.[165, 166] This role includes certification, licensing, training, and oversight. New York State Public Health Law requires agencies providing care services to be certified or licensed to receive payment from Medicaid.[167] To become a licensed home care services agency (LHCSA) or certified home health agency (CHHA) that provides care services, agencies go through an application process and an initial survey or inspection; they are then listed in online registries maintained by NYSDOH. Although agency listings provide information about services offered, regions served, inspections, and licensing details, transparency relevant to private equity is minimal. The type of ownership included here, for example—limited liability corporation (LLC)—tells nothing of the role of parent companies or other entities such as private equity firms. Without any requirements for disclosure from the

[164] Agencies and care workers are also subject to labor regulations at federal and state level, discussed below.
[165] *New York State Home Care Registry.* (n.d.). New York State Department of Health. https://apps.health.ny.gov/professionals/home_care/registry/home.action.
[166] *New York State Home Care Agency Profiles.* (n.d.). New York State Department of Health. https://profiles.health.ny.gov/home_care/; *About Licensed Home Care Services Agencies.* (n.d.). New York State Department of Health. https://preview-nysprofiles.ipro.org/home_care/pages/LHCSA; *Home Care Agencies by Provider Type and Region/County.* (n.d.). New York State Department of Health. https://profiles.health.ny.gov/home_care/counties_served?type=LHCSA
[167] To receive payment from other forms of insurance and payment out of pocket as well.

agencies, no information is kept on rates of services or even types of insurance accepted. The lists are only online and do not appear to be updated. The NYSDOH also keeps a searchable online registry of care workers trained by an approved state program, though it acknowledges that the list may be incomplete and/or out of date.

Currently, oversight of home care agencies in New York State involves "periodic" inspections and investigations of complaints by the New York State Department of Health (NYSDOH).[168] The NYSDOH conducts inspections focused on patient care and safety and assesses whether agencies are meeting program requirements. But critically, this does not involve oversight of working conditions, home care agencies' compensation of workers, practices regarding scheduling, or provisions to ensure workers' safety—all oversight roles for the New York State Department of Labor (NYSDOL). In the current context, there is no regular reporting, no observational and qualitative approaches to overseeing implementation of policies or working conditions, and no oversight of management practices or the use of apps and technology by the NYSDOL. As rebalancing moved care from nursing homes to the home, a worker's labor became highly dispersed and almost completely unregulated—out of sight and subject to the whims of clients at home. Agencies, especially smaller agencies, tend to avoid oversight by state officials. This stands in contrast to at least some oversight of nursing homes—though oversight and enforcement of nursing homes remain poor, resulting in poor care and staffing conditions.[169]

New York State has one of the largest and fastest-growing home care workforces in the country.[170] In New York City, the comptroller reported that home care work is one of the city's largest and fastest-growing parts of its economy.[171] And yet, home care work in New York State is precarious, despite having won important rights and protections at the state level. New York

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[168] *State Inspection Process*. (n.d.). New York State Department of Health. https://profiles.health.ny.gov/home_health/pages/inspections#:~:text=A%20standard%20level%20deficiency%20identifies,all%20findings%20within%2090%20days; *Home Care—Information for Consumers*. (n.d.). New York State Department of Health. https://www.health.ny.gov/facilities/home_care/consumer.htm.

[169] All nursing homes are subject to a standard federal regulatory framework to be certified, a condition imposed by the Federal Nursing Home Reform Act (FNHRA) (1987). Specifically, 42 C.F.R. Part 48 Subpart B Requirements for Long Term Care Facilities, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483. See also Bos, A. and Harrington, C. (2017). What Happens to a Nursing Home Chain When Private Equity Takes Over? A Longitudinal Case Study. *Inquiry: A Journal of Medical Care Organization, Provision and Financing,* 54. https://doi.org/10.1177/0046958017742761; Harrington, C. A. (2025). Wealth Extraction from a Nursing Home Chain with Individual, Private Equity, and Real Estate Owners. *International Journal of Social Determinants of Health and Health Services*, 55(4), 441–454. https://doi.org/10.1177/27551938251335565

[170] PHI Workforce Data Center compares 10-year employment trend data across states: https://www.phinational.org/policy-research/workforce-data-center/#tab=State+Data&natvar=Wage+Trends&states=36 (which shows a few states that have similar or even higher growth trends).

[171] *Spotlight: Care Workers and the New York City Economy*. (2023, March 21). New York City Comptroller Mark Levine. https://comptroller.nyc.gov/reports/spotlight-care-workers-and-the-new-york-city-economy/.

home care workers generally experience more economic hardship than in other states, as PHI ranks it 31 out of 51 on its economic index of direct care workers.[172]

New York State, like much of the country, is experiencing severe workforce shortages in home care.[173] Partly because of these workforce shortages, growing attention has been given to improving the wages and working conditions of home care workers to expand supply by adding to, and strengthening, decades-old campaigns by home care workers and advocates to raise compensation, obtain and expand rights and protections, and develop training and other job supports.[174] The New York State care workforce has benefitted from being relatively well organized and represented by a powerful union, 1199SEIU United Healthcare Workers East, and other organizations, including New York Caring Majority, the National Domestic Workers Alliance, and local domestic worker organizations. But limitations and weaknesses in New York State labor policies, laws, and regulations to protect home care workers nevertheless still exist and thus create a pathway for new financial actors to exploit home care workers' labor.

For example, the Wage Parity Act illustrates how existing policy objectives are undermined by contradictions within this broader framework of Medicaid cost control. For home health aides and personal care aides reimbursed through New York's Medicaid program, New York State mandated a higher minimum wage and wage parity through the 2012 Home Care Worker Wage Parity Act. In addition to the Act raising the state's minimum wage and creating wage parity among workers, it included requirements for agencies and managed care organizations to certify compliance with the law.[175] Yet Medicaid cost containment meant that it was inevitable that higher minimum wages for home health aides and personal care aides would not be tied to adequate funding from the beginning, thus undermining the core objective of the Act.[176]

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[172] *Direct Care Workforce State Index*. (n.d.). PHI. https://www.phinational.org/state/new-york/; *New York State's Direct Care Workforce*. (2023, January 10). PHI. https://www.phinational.org/resource/new-york-states-direct-care-workforce-2/. In PHI's ranking of supportive labor market policies for direct care workers, New York ranks 7 out of 51, and for its combination of policies and the economic status of direct care workers, 10 of 51.

[173] A problem intensified by growing demand for home health aides (HHAs) and personal care aides (PCAs) since the COVID-19 pandemic.

[174] In 2010, a coalition of domestic worker organizations won a years-long campaign that made New York the first state to enact a Domestic Workers' Bill of Rights, entitling domestic workers to paid days off, wage and overtime protection, recognition of human rights, and special protections from harassment and retaliation (this includes privately hired home care workers, but critically, overtime pay and a day of rest do not apply to home care workers who work for an agency). Workers in the state gained these rights before they were guaranteed protection by the Fair Labor Standards Act (FLSA) at the federal level. Now, as the Trump administration is overturning the FLSA rule and many home care workers are faced with losing hard-won rights, the New York State Bill of Rights will help fill the gaps in federal protection for state home care workers.

[175] In addition, New York's expanded Medicaid program helps to boost workers' healthcare coverage. New York City has gone further, with a special Paid Care Division of the Office for Consumer and Worker Protections that provides a designated ombudsman among other benefits.

[176] Although New York State has one of the nation's largest Medicaid programs, it has suffered from inadequate funding for decades owing to the global Medicaid spending cap. But advocates' emphasis on adequate funding for Medicaid is clearly crucial

Similarly, a PHI report explains that a recent policy to increase the minimum wage for home care workers was beset by several problems: changes in the law during its implementation, lack of funding that left agencies without increased reimbursements to pay the higher minimum wage, lack of transparency, and an overemphasis on cost control.[177] While these policy efforts do go further than many other states have gone, they are simply still not enough. Even if it had been implemented as planned, the higher wage rate schedule would not have provided a living wage, and a "benefits cliff" would have left many workers worse off because of the interaction between the increase in wages with benefits and taxes.[178]

Home care agencies, managed care organizations, and financial actors have also found ways to manipulate the 2012 Wage Parity Act to their advantage. One example is the well-documented abuse of the provision that allowed home care agencies to pay part of the required wage increase for home care workers in benefits rather than cash, without workers having a choice to opt out.[179] This created a new source of wage theft as certain agencies took advantage of the law by withholding benefits that were supposed to replace wages. The highly publicized case involving Edison Home Health Care and Preferred Home Care (purchased together by private-equity-owned Help at Home in early 2022), described above in Section III, is a prime example of how companies exploited the Wage Parity Act to perpetuate wage theft schemes.[180] And yet, these companies have been allowed to continue to provide services with Medicaid contracts across New York State.

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to support improvements for home care workers: a 2023 report found that around 87% of home care workers are paid through Medicaid. See Eisner, E. (2023, March). *Workforce Report: Labor Shortage Mitigation in New York's Home Care Sector.* Fiscal Policy Institute. https://fiscalpolicy.org/wp-content/uploads/2023/03/Fiscal-Policy-Institute-March-2023-Workforce-Report-Labor-Shortage-Mitigation-in-New-Yorks-Home-Care- Sector-1.pdf

[177] *New York State's Direct Care Workforce.* (2023). PHI; See also summary: Scales, K. (2024, July 23). *Investing in New York's Home Care Workforce: Progress and Challenges in Raising Wages.* PHI. https://www.phinational.org/investing-in-new-yorks-home-care-workforce-progress-and-challenges-in-raising-wages/

[178] Dawson, S. L., and Rodat, C. A. (2014, June). *The Impact of Wage Parity on Home Care Aides: How Better Wages Affect Public Benefits, Tax Credits, and Family Income.* PHI. https://www.phinational.org/wp-content/uploads/legacy/research-report/phi-benefitcliffs-20140623.pdf

[179] Attorney General James and U.S. Attorney Peace Secure Over $17 Million From Home Health Agencies for Cheating Workers and Defrauding Medicaid in Landmark Wage Parity Agreement [Press release]. (2024, September 30). https://ag.ny.gov/press-release/2024/attorney-general-james-and-us-attorney-peace-secure-over-17-million-home-health. See also: Mellins, S. (2025, March 20). Fraudster-Linked Company Set to Begin Massive Insurance Contract for Home Health Workers. New York Focus. https://nysfocus.com/2025/03/20/home-care-insurance-leading-edge; Mellins, S. (2025, July 21). New York's Health Companies Could Pocket Millions Meant for Low-Wage Care Aides. The City. https://www.thecity.nyc/2025/07/21/leading-edge-home-care-wage-parity/

[180] Attorney General James and U.S. Attorney Peace Secure Over $17 Million From Home Health Agencies for Cheating Workers and Defrauding Medicaid in Landmark Wage Parity Agreement [Press release]. (2024, September 30). https://ag.ny.gov/press-release/2024/attorney-general-james-and-us-attorney-peace-secure-over-17-million-home-health

Some agencies have also used a "company union" to manipulate such policies and mislead home care workers.[181] The failure to regulate the use of company unions has resulted in wages being garnished without worker's knowledge or consent. One such example includes Preferred having been found to use a "company union" to offer benefits to workers that were difficult or impossible to access. This also appears to be a strategy employers use to avoid workers unionizing with 1199SEIU United Healthcare Workers East, a prominent union for healthcare and home care workers. The company union, Home Healthcare Workers of America (HHWA), does not disclose that it represents the companies, and workers often do not know that they have been made members and are paying dues.[182] At the end of 2024, *The City* reported that HHWA had collected $13 million in dues and risen to 43,000 members "without holding elections, locking employees into boss-friendly contracts while amassing political clout and millions in union dues."[183] Not only does HHWA have a record of working with home care companies guilty of labor violations—including Preferred, before it was bought by private-equity-owned Help at Home—the company union has also gained significant political power by joining powerful lobbyists to prevent increased regulation of the industry.[184]

Another example of a labor policy that undermines home care workers' quality work and compensation is New York State's "13-hour rule." The controversial rule is a decades-old New York State Department of Labor policy that allows home care agencies to pay home care workers for 13 hours of 24-hour shifts, as long as home care workers can ostensibly sleep for eight hours and take unpaid meal breaks. The rule allows home care agencies to take advantage of wage and hour regulations by manipulating the hours worked and services provided by home care workers, resulting in wage fraud and over-exhaustion of workers. This situation is enabled by Medicaid and managed long-term-care plans, which play a major role in shaping whether and how agencies can pay for 24-hour shifts.[185] Recently, the 13-hour rule has been at the center of highly publicized wage violations by agencies and managed care organizations. Workers testified that agencies often ignored the rule that allocated eight hours for sleep and the appropriate conditions needed to do so. Instead, it was found that home care workers worked extremely

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[181] A company union is a worker organization which is dominated or unduly influenced by an employer and is therefore not an independent, democratically elected union. Company unions are contrary to international labor law (see ILO Convention 98, Article 2).[1] They were outlawed in the United States by the 1935 National Labor Relations Act §8(a)(2),[2] due to their use as agents for interference with independent unions. However, company unions persist.

[182] Aponte, C. I. and Katz, A. (2024, December 19). *New York's Fastest-Growing Union Is Management's Best Friend—and Some Workers Don't Even Know They're Members*. The City. https://www.thecity.nyc/2024/12/19/home-healthcare-workers-america-union/.

[183] Ibid.

[184] Ibid.

[185] Scales, K. (2018). *The 24-Hour Home Care Shift: Why This Debate Matters,* PHI. https://www.phinational.org/24-hour-home-care-shift-debate-matters/

long hours without compensation. They became so exhausted that some developed chronic illnesses.[186] Even when compensation is recovered, it is often only a fraction of what companies owe workers in lost wages. It has also been difficult to reform the 13-hour rule to address companies' abuse of the provisions. In 2018, for example, the rule was upheld by the New York Court of Appeals.[187] Since then, bills were introduced in New York State in 2023 and in New York City in 2024 to replace the 24-hour shift with two 12-hour shifts; neither passed into law.[188] Despite Governor Hochul's Wage Theft Task Force created in 2022,[189] her administration has not sought to tighten regulations and to hold providers accountable.[190] The rule is also highly illustrative of the extent to which workers' low pay is maintained and labor rights are overridden to contain labor costs for home care agencies while controlling state Medicaid budgets. Fundamentally, the reticence to overturn this rule points to policy decisions made to ensure that home- and community-based services are designed to be less expensive than nursing home care. Paying overtime for 16 hours of a 24-hour shift could become as costly as institutional care.

Home care payment and delivery through Medicaid managed long-term care

As noted above, the incursion of private equity into home care has happened in the context of Medicaid rebalancing that increased the provision of home- and community-based services (HCBS), but also and equally important, as states have increasingly shifted to Medicaid managed long-term care. The trend toward Medicaid managed long-term care is becoming an especially vital component of the Medicaid home care policy landscape. Available data from 2021 shows that 24 states have adopted Managed Long-Term Services and Supports (MLTSS) plans—the delivery of long-term-care services, such as nursing home care, personal care, and home-

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[186]Chen, S. (2024, March 7). *Home Care Aides Fight to End 24-Hour Shifts: 'This Work Is Killing Them'*. The New York Times. https://www.nytimes.com/2024/03/07/nyregion/home-care-aides-city-council-bill-end-24-hour-shifts.html; see also Sainato, M. (2023, April 23). *New York City Home Care Aides Push to End 24-Hour Shifts: 'Destroyed My Body'*. The Guardian. https://www.theguardian.com/us-news/2023/apr/23/new-york-city-home-care-workers-end-24-hour-shifts.

[187] *NYS Court of Appeals Upholds "13-Hour" Rule*. (n.d.). Leading Age New York. https://www.leadingageny.org/providers/home-and-community-based-services/lhcsa/nys-court-of-appeals-upholds-13-hour-rule2/; *NYSDOL Issues Notice on 24-Hour/Live-in Aide Regulation*. (n.d.). Leading Age New York. https://www.leadingageny.org/providers/home-and-community-based-services/lhcsa/nysdol-issues-notice-on-24-hourlive-in-aide-regulation/.

[188] State of New York, April 26, 2023. In Senate, 2023-2024 Regular Session, Senate Bill Number S6561, Places limits on the maximum amount of hours a home care aide may be required to work without voluntarily consenting to such an assignment. https://www.nysenate.gov/legislation/bills/2023/S6561#:~:text=2023%2DS6561%20(ACTIVE)%20%2D%20Sponsor%20Memo,with%20activities%20of%20daily%20living. And, The New York City Council, March 7, 2024. File # nt 0615-2024, Maximum working hours for home care aides. https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=6566011&GUID=CAD8F84C-35B8-434C-9923DA1147B3BEBA&Options=Advanced&Search=

[189] *Governor Hochul Announces Major Crackdown to Combat Wage Theft*. (2022, July 19). New York State Governor Kathy Hochul. https://www.governor.ny.gov/news/governor-hochul-announces-major-crackdown-combat-wage-theft.

[190] As the campaign for policy change continues, it remains a divisive issue.

delivered meals, through state managed care organizations—up from only eight in 2004.[191] The most recent report shows that in 2022, 60% of MLTSS had managed care plans, and 62% of managed long-term-care plans cover HCBS, where home care is one of the dominant benefits.[192]

The relationship between Medicaid MLTSS and financial actors such as private equity is not well understood, nor has it been widely researched, and thus remains one of the complex areas of the "black box."[193] MLTSS aims to improve care coordination and increase efficiency by moving away from traditional fee-for-service (FFS) models. Federal and state policymakers have sought to link Medicaid MLTSS to the expansion of home- and community-based services (HCBS), notably through the Affordable Care Act where states can use the same federal waivers to introduce HCBS and MLTSS simultaneously. They can also use MLTSS plans to create financial incentives to provide HCBS over institutional care for beneficiaries.[194] As in managed care more generally, the basic goal of Medicaid MLTSS is to reduce but also control Medicaid expenditure through contracts with managed care organizations.[195] One important component of MLTSS for

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[191] *Managed long-term services and supports*. (2022, March 22). Medicaid and CHIP Payment and Access Commission (MACPAC). https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/.

[192] Though more spending was on fee-for-service payments, 62.6% FFS versus 37.4% managed LTSS (CMS/Stockdale et al., 2024). Stepanczuk, C., Carpenter, A., Murray, C., & Wysocki, A. (2024, August 29). *Medicaid Long-Term Services and Supports Users and Expenditures by Service Category, 2022*. Centers for Medicare and Medicaid Services. https://www.mathematica.org/publications/medicaid-long-term-services-and-supports-users-and-expenditures-by-service-category-2022.

[193] For example, in home healthcare, Appelbaum and Batt (2023) explain that PE focuses on acquiring home health agencies with Medicare fee-for-service rather than Medicare Advantage (managed care).

[194] At the same time, states may find that greater use of HCBS makes costs less predictable, encouraging them to adopt MLTSS for its prospective payment system. Medicaid and CHIP Payment and Access Commission (MACPAC). (June 2018). Chapter 3: Managed Long-Term Services and Supports: Status of State Adoption and Areas of Program Evolution. *Report to Congress on Medicaid and CHIP.* Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf; Dobson, C., Gibbs, S., Mosey, A., & Smith, L. (2017). Demonstrating the Value of Medicaid MLTSS Programs. Washington, DC: National Association of States United for Aging and Disabilities and Center for Health Care Strategies. http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17_0.pdf; Archibald, N. D., Kruse, A. M., & Somers, S. A. (2018). The Emerging Role of Managed Care in Long-Term Services and Supports. *Public Policy and Aging Report*, 28(2), 64–70. https://doi.org/10.1093/ppar/pry011; Bernacet, A., Kordomenos, C., Karon, S. L., Knowles, M., Archibald, N., & Kruse, A. (April 2021). Examining the Potential for Additional Rebalancing of Long-Term Services and Supports. Final report. RTI International. https://www.macpac.gov/wp-content/uploads/2021/05/Examining-the-Potential-for-Additional-Rebalancing-of-Long-Term-Services-and-Supports.pdf

[195] Like the basic model of Medicaid managed care, Medicaid managed long-term supports and services (MLTSS) involves states making capitated prospective payments to managed care organizations (MCOs). Instead of paying providers directly as in the traditional fee-for-service (FFS) system, MCOs that are for-profit companies become mediators that pay providers for services at negotiated prices. In addition to capitated payments, MLTSS also offers the flexibility to use other payment systems, including value-based payments (VBP) and directed payments to encourage specific goals such as increasing the use of home- and community-based services. See *Medicaid Managed Care Capitation Rate Setting*. (2022, March). The Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/wp-content/uploads/2022/03/Managed-care-capitation-issue-brief.pdf; Centers for Medicare & Medicaid Settings. (n.d.). *Capitated Rate Setting for MLTSS Programs* [PowerPoint Slides]. Medicaid.gov. https://www.medicaid.gov/medicaid/home-community-based-services/downloads/rate-setting-mltss-prgrms.pdf; *2024-2025 Medicaid Managed Care Rate Development Guide for Rating Periods Starting between July 1, 2024 and June 30, 2025*. (2024,

home care agencies is that in transitioning to MLTSS, home care providers no longer simply bill their state Medicaid program as they had under FFS systems; they are instead required to negotiate contracts for plans and prices with managed care organizations (MCOs), often resulting in substantial reductions in payments.[196] Because MCOs profit from the savings they make from state payments,[197] policies introducing Medicaid MLTSS provide strong incentives to reduce service prices paid to providers of MLTSS, cut services, and use other often fraudulent strategies to extract more from Medicaid and pay less to home care providers—all behaviours MCOs currently engage in.[198] The problems of MLTSS are well documented, recognized by both advocates and critics who have long demanded requirements for, and public access to, regular and comparable reports on Medicaid payments to MCOs, service prices, care quality, beneficiary outcomes, and MCOs' profit-oriented practices.[199]

January). Centers for Medicare & Medicaid Services.https://www.medicaid.gov/medicaid/managed-care/downloads/2024-2025-medicaid-rate-guide-01222024.pdf; Libersky & Lipson, 2016.

[196] See, for example, Medicaid and CHIP Payment and Access Commission (MACPAC) 2018. *Report to Congress.* Ch. 3. Managed Long-Term Services and Supports: Status of State Adoption and Areas of Program Evolution, https://www.macpac.gov/publication/managed-long-term-services-and-supports-status-of-state-adoption-and-areas-of-program-evolution/; MACPAC, 2022. Managed long-term services and supports https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/; MACPAC, March 2022. Issue Brief: Medicaid Managed Care Capitation Rate Setting, https://www.macpac.gov/wp-content/uploads/2022/03/Managed-care-capitation-issue-brief.pdf

[197] MCOs make sizeable profits notwithstanding the regulations regarding medical loss ratios, including regulations such as the "80/20 rule" regarding HCBS access. See, e.g., Arguello, A. and Murphy, N. (2025). Medical Loss Ratio Reform Can Help Curb Corporate Power and Lower Health Care Costs, CAP, https://www.americanprogress.org/article/medical-loss-ratio-reform-can-help-curb-corporate-power-and-lower-health-care-costs/; Rigney, G. (2025). Gaming the Medical Loss Ratio: How Health Insurers Turn Consumer Protections into Corporate Windfalls, Foundation for Research on Equal Opportunity. https://freopp.org/oppblog/gaming-the-medical-loss-ratio-how-health-insurers-turn-consumer-protections-into-corporate-windfalls/#:~:text=This%20double%2Dsided%20capture%20undermines,and%20even%20clinical%20data%20systems MACPAC, 2022. Issue Brief: Medical Loss Ratios in Medicaid Managed Care, https://www.macpac.gov/publication/medical-loss-ratios-in-medicaid-managed-care/

On Medicaid Managed Care profits, see, e.g., Schneider and Kaneb, (2025). Medicaid Managed Care: The Big Five in Q4 2025, Georgetown University McCourt School of Public Policy, https://ccf.georgetown.edu/2026/02/20/medicaid-managed-care-the-big-five-in-q4-2025/; Ortaliza, J. et al. (2026). Health Insurer Financial Performance in 2024, KFF, https://www.kff.org/medicare/health-insurer-financial-performance/#fd69ae5c-8132-44fc-9fec-372c3f580b48

For the federal rule, see 81 Fed. Reg. 27498-27901 (May 6, 2016), available at https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. The proposed rule was published at 80 Fed. Reg. 31098-31297 (June 1, 2015), available at https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. For Medicaid managed care contracts beginning on or after July 1, 2019, CMS required states to develop capitation rates ensuring managed care plans (MCOs) achieve a medical loss ratio (MLR) of at least 85%. This means 85% of state payments must be spent on covered services, rather than administrative costs, which was a key 2016/2019 regulatory update. See also the 80/20 rule and the updated Medicaid access rule of 2024, now under threat by the Trump Administration, as discussed below.

[198] Archibald, 2018; GAO (2017, August 14). Medicaid Long-Term Services and Supports. Access and Quality Problems in Managed Care Demand Improved Oversight. GAO-17-632, Washington DC. https://www.gao.gov/assets/gao-21-49.pdf;

[199] Archibald, 2018; Gonzalez et al., 2021; Dobson et al., 2023; MACPAC, 2018; MACPAC, 2023; Nadash, 2024; Polivka et al., 2019. Federal regulation of MLTSS, even though stricter than that of Medicaid managed care in general, is process focused, as it is for HCBS. Here too, the waiver implementation stage is most closely watched. Thereafter, the Centers for Medicare and Medicaid Services (CMS) requires minimal reporting from states.

States' shift to Medicaid MLTSS is especially relevant to understand the context for the rise of private equity and other financial actors' ownership of home care agencies because, like managed care more generally, MLTSS is notoriously opaque and less well-regulated than traditional fee-for-service Medicaid LTSS.[200] This lack of transparency and oversight not only enables and encourages MCOs' manipulation of rules and fraudulent profit-maximizing practices,[201] it also empowers financial actors to do the same. At the same time, however, the lack of transparency also makes it difficult to identify any patterns in the way that private equity operates within the context of MLTSS or interacts with MCOs responsible for MLTSS. This is especially uncertain because MLTSS creates both opportunities and challenges for private-equity-owned home care agencies to extract profit. On the one hand, agencies (and private equity owners) may face a challenge to their profits where MCOs seek to push down their reimbursement rates for services provided by home care agencies. On the other hand, MLTSS may create an incentive for agencies and private equity owners to accept low reimbursement rates from MCOs in order to increase their client volume while cutting their spending on labor and/or administrative costs. It is possible that private equity agencies and MCOs collude to improve profits for both entities and their shareholders. It may also be that MLTSS creates an incentive for private equity firms to consolidate agencies to gain market power to negotiate better prices. Instead of home care agencies simply billing their state Medicaid program as they had under fee for service, transitioning to MLTSS requires home care providers to negotiate contracts for plans and prices with MCOs, often resulting in substantial reductions in payments.[202]

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[200] Archibald 2018; GAO (2017, August 14). Medicaid Long-Term Services and Supports. Access and Quality Problems in Managed Care Demand Improved Oversight. GAO-17-632, Washington DC. https://www.gao.gov/assets/gao-21-49.pdf; Gonzalez, L., Polivka-West, L.M., & Polivka, L. (2021). Failures of Regulation and Policy in Medicaid-Managed Long-Term Care and Medicare Advantage, *Public Policy & Aging Report*, 31(2), Pages 57–61, https://doi.org/10.1093/ppar/prab002; Dobson, C., Barnett, P., & Chaise, L. F. (2023, February). Advancing Equity through MLTSS Programs. MLTSS Institute. https://www.advancingstates.org/sites/default/files/Advancing%20Equity%20MLTSS%20Feb.%2023.pdf; Medicaid and CHIP Payment and Access Commission (MACPAC). (2023, June). Report to Congress on Medicaid and CHIP. Washington, DC: MACPAC. https://www.macpac.gov/publication/june-2023-report-to-congress-on-medicaid-and-chip/; Polivka L. and Luo B. (2019). Neoliberal Long-Term Care: From Community to Corporate Control. *Gerontologist.* 14;59(2):222-229.

[201] Archibald, 2018; GAO (2017, August 14). Medicaid Long-Term Services and Supports. Access and Quality Problems in Managed Care Demand Improved Oversight. GAO-17-632, Washington DC. https://www.gao.gov/assets/gao-21-49.pdf; Gonzalez, L., Polivka-West, L.M., & Polivka, L. (2021). Failures of Regulation and Policy in Medicaid-Managed Long-Term Care and Medicare Advantage, *Public Policy & Aging Report*, 31(2), Pages 57–61, https://doi.org/10.1093/ppar/prab002; Dobson, C., Barnett, P., & Chaise, L. F. (2023, February). Advancing Equity through MLTSS Programs. MLTSS Institute. https://www.advancingstates.org/sites/default/files/Advancing%20Equity%20MLTSS%20Feb.%2023.pdf; Medicaid and CHIP Payment and Access Commission (MACPAC). (2023, June). Report to Congress on Medicaid and CHIP. Washington, DC: MACPAC. https://www.macpac.gov/publication/june-2023-report-to-congress-on-medicaid-and-chip/; Polivka L. and Luo B. (2019). Neoliberal Long-Term Care: From Community to Corporate Control. *Gerontologist.* 14;59(2):222-229.

[202] See, for example, Medicaid and CHIP Payment and Access Commission (MACPAC) 2018. *Report to Congress.* Ch. 3. Managed Long-Term Services and Supports: Status of State Adoption and Areas of Program Evolution, https://www.macpac.gov/publication/managed-long-term-services-and-supports-status-of-state-adoption-and-areas-of-program-evolution/; MACPAC, 2022. Managed long-term services and supports

Managed care organizations, like private equity firms, have been actively driving, and participating in, the rapid consolidation of the healthcare industry,[203] where small(er) independent agencies may have little bargaining power to increase prices. In this context, private equity buyouts may appear to offer benefits for smaller agencies.

New York State's mandatory Medicaid Managed Long-Term Services and Supports (MLTSS) system has been an ongoing source of criticism, with lack of transparency being one of the reasons.[204] Advocates for improving and expanding Medicaid in New York State have pressed for reforms to Medicaid Managed Care in particular, emphasizing that financial transactions using public funds are shrouded in darkness, such that valuating, monitoring, and sanctioning managed care organizations is impossible.[205] Neither officials, nor policymakers, nor citizens have information to identify specific issues that may be maintaining low pay or poor working conditions, whether they are legal or illegal, or enabling abuse of workers as shown by rampant wage fraud. Such opacity obscures understanding of and the ability to evaluate the effects of MLTSS and any changes that will come from managed care organizations' interactions with other financial actors such as private equity.[206]

Criticism of New York MLTSS also points to how it is yet another intermediary squeezing profits from an already underfunded Medicaid program responsible for home care. Advocates, such as

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https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/; MACPAC, March 2022. Issue Brief: Medicaid Managed Care Capitation Rate Setting, https://www.macpac.gov/wp-content/uploads/2022/03/Managed-care-capitation-issue-brief.pdf

[203] Dranove D., Simon C. J., White, W. D. (2002). Is Managed Care Leading to Consolidation in Health-care Markets? *Health Serv Res*. 37(3):573-94.

[204] See, for example, Gonzalez, L., Polivka-West, L., & Polivka, L. (2021). Failures of Regulation and Policy in Medicaid-Managed Long-Term Care and Medicare Advantage, *Public Policy & Aging Report*, Volume 31, Issue 2, 2021, Pages 57–61, https://doi.org/10.1093/ppar/prab002; Nadash, 2024; MACPAC, 2018; Government Accountability Office (GAO) (2017). *Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs*. GAO-17-632. Washington, D.C.: August 14, 2017. https://www.gao.gov/assets/690/687211.pdf; GAO (2017). Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports, GAO-17-145, Washington, D.C.: Jan 9, 2017, https://www.gao.gov/products/gao-17-145#:~:text=Fast%20Facts,on%20care%20and%20other%20outcomes.&text=Graphic%20showing%20how%20states%20may,to%20encourage%20community%2Dbased%20care; GAO (2018). Medicaid: CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services GAO-18-103, Published: Dec 14, 2017. Publicly Released: Jan 16, 2018; GAO (2020). Medicaid Long-Term Services and Supports: Access and Quality Problems in Managed Care Demand Improved Oversight; Flynn, M., (2020). GAO: Managed Medicaid Programs for LTC Services Need National Oversight, *Skilled Nursing News*, December 21, 2020, https://skillednursingnews.com/2020/12/gao-managed-medicaid-programs-for-ltc-services-need-national-oversight/
GAO-21-49, Published: Nov 16, 2020. Publicly Released: Dec 16, 2020, https://www.gao.gov/products/gao-21-49

[205] See, for example, New York Legal Assistance Group (NYLAG) 2026. Testimony: NYLAG Advocates for Medicaid Funding, Home Care, and More in State Budget, https://nylag.org/testimony-nylag-advocates-for-medicaid-funding-home-care-and-more-in-state-budget/; New York Legal Assistance Group (NYLAG) MLTC Data Transparency Project, https://nylag.org/mltcdatatransparency/

[206] It should be noted that states can (and some do) put relevant requirements into their MLTSS contracts; for example, they can set base rates that must be paid to agencies, set requirements around workforce development, or require reporting on certain quality measures.

1199SEIU and New York Caring Majority, have called for home- and community-based services (HCBS) to be carved out of managed care in New York State.[207] Such underfunding has been institutionalized from the beginning. In the wake of the Affordable Care Act, Governor Andrew Cuomo's administration introduced New York's MLTSS alongside a global cap on Medicaid, creating a system of permanent austerity in New York State's Medicaid program. This has been maintained by Governor Kathy Hochul's administration despite strong and sustained calls for its abolition. Rebalancing to HCBS and home care provision via MLTSS has been instrumental to meeting the cost containment objectives reflected in the global cap on Medicaid spending. These same cost containment strategies have undermined efforts to increase home care workers' wages and lift standards in the industry—to meet the workforce needs of a growing number of beneficiaries who otherwise might have been cared for at nursing homes. Although the Centers for Medicare and Medicaid Services (CMS) leave MLTSS largely unregulated, CMS leaves it to the states to create their own regulatory framework. CMS has introduced rules that aim to ensure that the managed care organizations (MCOs) pass state payments to care workers. However, evidence suggests that New York State has not created oversight and enforcement mechanisms to ensure that payments are passed on to the workforce.[208] As has been shown, policy changes have largely not deterred the profit-making strategies of home care agencies, MCOs, and financial actors such as private equity.[209]

While it is difficult to identify patterns in how private equity (PE) interacts with MCOs, the expansion of private equity acquisitions in home care in New York State, where Medicaid MLTSS is mandatory for nearly all users of HCBS, provides evidence that private equity is not altogether deterred from buying out home care agencies (or nursing homes) that receive payments through Medicaid MLTSS. Here again, lack of transparency conceals processes and mechanisms for profit-making from officials and the public, while it may boost opportunities for private equity and other financial actors. Financial transactions, including private equity buyouts, how PE-owned agencies negotiate MLTSS payments and handle MLTSS payers, and how these

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[207] *1199SEIU Home Care Workers & Legislators Urge State to Cut Out For-Profit Insurance Middlemen to Save $3.5 Billion Annually* (March 10, 2026). 1199SEIU. https://www.1199seiu.org/media-center/1199seiu-home-care-workers-legislators-urge-state-cut-out-profit-insurance-middlemen-save-35-billion-annually; *New York Caring Majority Testimony to the New York State Legislature Joint Hearing of the Senate Finance and Assembly Ways and Means Committees* (February 10, 2026). Ilana Berger. https://www.nysenate.gov/sites/default/files/admin/structure/media/manage/filefile/a/2026-02/ny-caring-majority-budget-testimony_0.pdf

[208] KFF. (July 8, 2028). Health Provisions in the 2025 Federal Budget Reconciliation Bill. https://www.kff.org/medicaid/tracking-the-medicaid-provisions-in-the-2025-budget-bill/ Such profits will not be subject to the managed care organizations (MCO) tax created under the Biden Administration since the Trump Administration repealed it. Moreover, MCOs will not have to comply with "80/20 rule" requiring MCOs to pass through payments for home care workers until 2030.

[209] Ibid.

circumstances are reshaping care work and care quality, are unknown simply because of the absence of information.

Private equity may simply be attracted to home care in New York for the opportunities offered by the state for growth and consolidation.[210] Moreover, whether private equity increases prices or simply achieves a steady flow of Medicaid funds in negotiations with managed care organizations, private equity firms have other sources of potential profits: financial and operational engineering and growth may simply be pursued more aggressively, while vertical consolidation may ensure profits whatever managed care organizations pay for services.

V. CONCLUSION

This paper has examined the growing footprint of private equity in New York State's home care sector and the policy and regulatory conditions that have enabled it. The broader expansion and commercialization of healthcare have made the sector an increasingly attractive site for financial actors (such as private equity) seeking to extract profit. Over the past 15 years, private equity has expanded its reach across the continuum of care, following the growing share of public dollars being directed toward home- and community-based services for aging people and people with disabilities. As a central component of the United States' fragmented care system, home care has become a vital source of care amid rising demand to age in place and live in community. Yet this growth has unfolded within an increasingly privatized and fragmented "care economy," shaped over decades by policy choices that have paved the way for financialization. The weak regulatory frameworks that mark the health and labor policy landscape have enabled such profiteering while undermining both job quality and quality of care.

While the incursion of private equity into hospitals and nursing homes and the subsequent harms to quality of care and quality of jobs have been well documented, the relatively recent presence of private equity in home care has been less examined. With New York as a case study, this paper has shown how the strategies of private equity and other financial actors can destabilize care provision and lead profiteering—instead of the healthcare mission—to drive decision-making. Indeed, these financial actors are beholden to their shareholders and investors—not to the public who are employed by and depend on the care services provided, despite the profits they reap

[210] See, for example, explanation from one PE agency investing in NY home care in 2014: Oliva, J. (2014). Private Equity Group Acquires New York Home Care Agency, *Home Health Care News.* https://homehealthcarenews.com/2014/09/private-equity-group-acquires-new-york-home-care-agency/; and see Gonzalez, M. (2025). At-Home Care's New M&A Strategy: From Scale to Density, *Home Health Care News.* https://homehealthcarenews.com/2025/06/at-home-cares-new-ma-strategy-from-scale-to-density/

depending on a steady stream of public dollars such as Medicaid. New York State proves an interesting case study to examine the policy landscape that has enabled this incursion because, compared to other states, New York has relatively strong labor market protections and one of the highest total Medicaid budgets, even under the auspice of austerity. And yet, weak and poorly conceived regulation, oversight, and enforcement persist, compounded by opaque public and private payment systems. This paper has shown how the persistent drive to cut Medicaid spending often constrains or undermines potentially beneficial policies, while systems such as managed care reduce transparency and accountability, channel public dollars toward financial intermediaries, and create incentives for bad actors.

Wealth extraction in home-based care depends on the exploitation of a workforce with historically poor wages and working conditions, thereby perpetuating the long-standing effects of structural racism and sexism on a workforce predominantly comprised of women of color. As private equity extends its reach into home care, it is imperative to examine to what extent it perpetuates, leverages, or exacerbates these conditions. What happens to the wages and working conditions of this workforce when private equity takes over care providers? What are the implications for quality of care in a system incentivized primarily by profit? Our forthcoming qualitative research will explore these questions through an examination of the conditions home care workers face in private-equity-owned home care agencies and how this impacts the subsequent care provided.

As private equity's footprint has dramatically expanded to cover over half of home care delivery in New York State, it has become increasingly urgent to assess the implications for our broader care system and to advance comprehensive, multi-system reforms. Such reforms are necessary to curb profiteering and to bring greater transparency and accountability to the home care system. Addressing these challenges will require not only stronger financial regulation, but also reform of the fragmented regulatory landscape—including inadequate federal Medicaid regulations and state health regulations and insufficient federal and state labor protections—that have enabled financial actors to extract wealth from our care system. Access to care must be upheld as a fundamental human right and an essential public good—not as a site for private profiteering from public resources.

APPENDIX

Home care agencies in New York State with current or previous private equity backing, as of September 2025[211]

Parent company	Name of company in NYS	Ownership of Parent Company
AccentCare	AccentCare	Advent International (2019 - present) Oak Hill Capital (2010-2019)
HCS-Girling	HCS-Girling	Received development capital from Guggenheim Partners (2022) for acquisitions and company was recapitalized.
HCS-Girling (formerly Addus HomeCare)	Addus HomeCare – New York Operations	(See above.) HCS-Girling (a private-equity-backed home care agency) acquired the New York operations of Addus HomeCare through a leveraged buyout in 2024, when Addus decided to divest from New York entirely (see p.28 for details). Addus HomeCare (former parent company): IPO (2009) Eos Partners (2006-2009)
AccordCare	(see below)	Coppermine Capital (2019 – present). AccordCare was created as a new brand by Coppermine Capital in 2019. See p.29 for details.
AccordCare	Allegiant	(See above.) Coppermine Capital (2015 - present). Allegiant was acquired by Coppermine Capital prior to being merged into new brand AccordCare in 2019.
AccordCare	Health Force	(See above.) Health Force was acquired by AccordCare/Coppermine Capital in 2020.

[211] This list includes home care agencies operating in New York State that currently or previously had private equity backing, as of September 2025. The list was compiled based on data from PitchBook and information from other sources cited in the relevant sections of this report. Given the lack of transparency in private equity deals, the list reflects the information available.

Aveanna	Aveanna	Post-IPO: Bain Capital Investors LLC and J.H. Whitney Equity Partners VII, LLC own majority of all shares. Bain Capital, Ergo Partners, J.H. Whitney Capital Partners (2017 - 2021) J.H. Whitney Capital Partners, Penfund (2015 - 2017)
n/a	Caring People	Silver Oak Services Partners (2017 - present)
Help at Home	(see below)	Ascension Ventures (PE development capital received in 2025) Vistria Group, Centerbridge Partners (2020 - present; 100% ownership) Wellspring Capital Management (2015 - 2020; 100% ownership)
Help at Home	Edison Home Health Care	(See above.) Acquired by Help at Home/Vistria Group and Centerbridge Partners in 2022.
Help at Home	Preferred Home Care of New York	(See above.) Acquired by Help at Home/Vistria Group and Centerbridge Partners in 2022.
Honor	Home Instead	Parent company Honor has received over $900m in venture funding from a number of venture capital firms, including Andreessen Horowitz and Thrive Capital. Honor acquired Home Instead in 2021.
Elara Caring	Elara Caring	Blue Wolf Capital Partners and Kelso & Company (2016 - present) Elara Caring was created as a brand in 2018 when Blue Wolf Capital Partners and Kelso & Company merged three portfolio companies. See pp.31-32 for details.
n/a	Elder Care Homecare	Undisclosed amount of PE Growth/Expansion capital from Rallyday Partners and Stellus Capital Management on August 12, 2025

HouseWorks	Elite Home Health Care	BPEA Private Equity, HouseWorks, InTandem Capital Partners (2023 - present)
n/a	FreedomCare	PE Growth/Expansion from Fidelity Investments received in 2023.
n/a	Honor Health Network	Webster Equity Partners (2021 - present) Walnut Court Capital (unknown - 2021)
Interim HealthCare, owned by global brand Caring Brands International (CBI)	Interim HealthCare *(operates as franchise)*	Wellspring Capital Management (2021 - present; 100% ownership) Levine Leichtman Capital Partners (2015 - 2021; 100% ownership) AEA Investors, The Halifax Group (2012 - 2015; 100% ownership New Canaan Funding; Sentinel Capital Partners (2006 - 2012;100% ownership) Bank of America, Cornerstone Equity Investors, Ridgemont Equity Partners (1997 - 2006; 100% ownership)
Optum	Landmark Health	Acquired by Optum, a subsidiary of UnitedHealth Group in 2021 <u>Landmark Health previous ownership:</u> General Atlantic (2018 - 2021; 100% ownership)
n/a	Mavencare	Received an unknown amount of PE growth/expansion development capital from DeltaCap on an undisclosed date. Has also received capital from a number of venture capital firms.
Humana	SeniorBridge	Acquired by Humana (one of the largest Medicare Advantage insurers) in 2012; Humana shut down SeniorBridge's New York locations were shut down in early 2023.

		SeniorBridge received PE Growth/Expansion capital from Caltius Equity Partners in 2008.
Senior Helpers	Senior Helpers *(operates partially as franchise)*	Waud Capital Partners (2024 - present; 100% ownership) Advocate Aurora Enterprises (2021 - 2024; 100% ownership) Altaris, Audax Private Equity (2016 - 2021; 100% ownership) Levine Leichtman Capital Partners (2012 - 2016; 100% ownership)
ModivCare	Simplura Health Group (formerly known as All Metro)	Acquired by ModivCare (formerly known as Providence Service Corporation) in Nov 2020 Simplura Health Group: One Equity Partners (2016 - 2020; 100% ownership) Nautic Partners (2014 - 2016; 100% ownership)
Optum	Willcare	Acquired by Almost Family in 2015, and Almost Family was acquired by LHC Group in 2018. LHC Group was then acquired by Optum, a subsidiary of UnitedHealth Group, in 2023. Willcare previous ownership: Summer Street Capital Partners (2008 - 2015)
PPL (Public Partnerships, LLC)	PPL (Public Partnerships, LLC)	DW Healthcare Partners, Linden (Chicago) (2022 - present; 100% ownership)