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NEW YORK

**HOME CARE
MARKET ASSESSMENT**



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KEY TAKEAWAYS

- **Public Program:** New York is a managed care state. Most Medicaid Home and Community Based Service (HCBS) recipients receive care under Managed Long-Term Care (MLTC) plans. New York allocates 42% of Medicaid Long Term Services and Supports (LTSS) funding to home and community based (HCBS) programs, versus 53% nationally, indicating a continuing preference for institutional based long-term care. Spending on HCBS LTSS, however, has trended upwards, with a 4.21% increase recorded between 2010 and 2015¹, indicating a shift in preference towards home based care.
- **Consumer Demand:** The subset of individuals potentially needing home care in New York is almost 1.1 million; by 2025, we estimate that this group will grow by another 100,000 residents. Additionally, by 2030 New York's 60+ population will reach 5.2 million residents. Despite this sizable population of potential clients, home care costs total 132% of median income for individuals 64+ in the state, making home care services too expensive for many New York residents.
- **Labor Supply:** New York has a ratio of 3.3 clients to every 1 caregiver in the state, significantly better than the national average of 8 to 1. This ratio, however, varies significantly from rural to urban areas, and many rural markets in the state face severe labor shortages.
- **Home Care Agency Market:** New York has an estimated 686 home care agencies, providing both home health and non-medical home care (excluding skilled nursing, hospice, dialysis). The five largest home care firms in the state control 35.6% of the market, signaling moderate consolidation, but still opportunity for competition. Of the estimated 686 home care operators in the state, 46% have revenue of less than \$250,000 per year, presenting significant barriers to sustainability in the industry without scale economies².
- **Existing Home Care Cooperatives:** New York is home to Cooperative Home Care Associates (CHCA), the largest worker-owned cooperative in the country, employing over 2000 home care workers.
- **Cooperative Opportunity:** New York offers a promising market for home care cooperative development and growth. At a high level, New York spends much more per Medicaid enrollee compared to the national average, and median household income about equals the U.S. average. Additionally, New York has a much less severe caregiver shortage than in other areas of the country, placing the state in a more promising category of markets in the country.

¹ <https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf>

² U.S. Census Bureau (2016). *Monthly Population Estimates for the United States: April 1, 2010 to December 1, 2017 2016 Population Estimates*. Retrieved from www.census.gov.

About this Report:

This report is part of the Cooperative Development Foundation's Socially Disadvantaged Group Grant. The ICA Group and Margaret Lund wrote this report to assist CDF in its efforts to bring home care worker cooperatives to scale across the country and to support the scale and sustainability efforts of the numerous home care cooperatives already operating. This state specific report is an in-depth market analysis for a number of areas where either existing home care coops operate or community groups are working to start new firms. For more information visit: www.cdf.coop or www.ica-group.org.

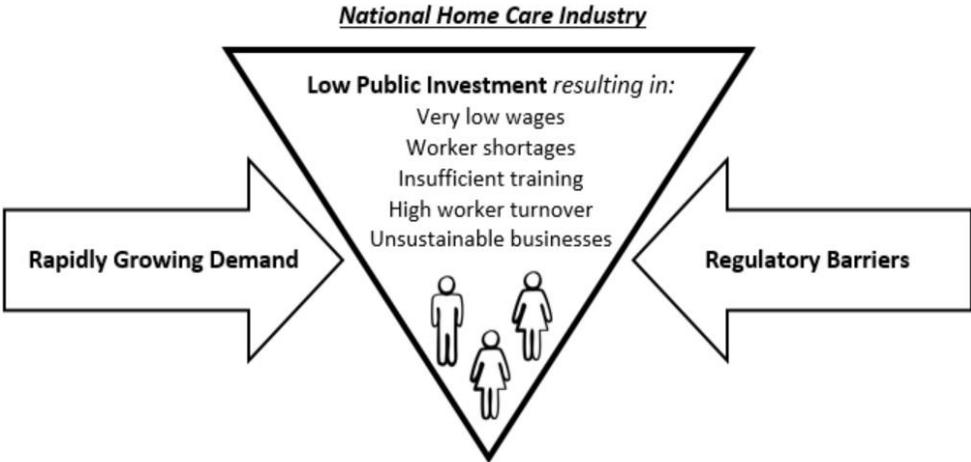
NATIONAL OVERVIEW

Unprecedented growth in the nation's elderly population, paired with a cultural shift towards aging in place, is driving historical growth in the home care sector. In the United States, the population of citizens age 65 and over will almost double by 2050. Nine in ten seniors want to “age in place” in their current home and community, and an estimated 70 percent will need help with basic daily living activities to do so. Accordingly, millions of new home care workers will need to be hired and trained over the next few decades to meet this growing demand. Today, more than two million workers are employed by the home care industry in the U.S, a workforce that has already more than doubled in the last decade.

Despite unprecedented job growth, the work is low paid, benefits are limited, hours are inconsistent, training is insufficient, career advancement is nearly non-existent, and the job is emotionally and physically taxing. Eighteen percent of home care workers are uninsured, and of those insured 40% rely on public health care coverage (primarily Medicaid). Consequently, turnover rates within the home care sector are at an all-time high of 60% nationally, and the nation struggles with a growing caregiver shortage. Nationally there are eight clients who need home care for every one caregiver in the workforce, though many states experience significantly higher shortages. The industry wide cost of caregiver turnover is over \$6.5 billion per year, a number equivalent to 10 percent of the \$61.8 billion in Medicaid dollars spent on home care in 2016.

Nationally, home care is a \$5B+ quickly expanding, national market, expected to grow at a rate of nearly 7% year-over-year for next five years.³ Yet, as a direct result of underinvestment and complex state regulations, the home care industry remains highly fragmented and dominated primarily by small, independent providers. The three largest companies in the industry have a market share of only 8.7%. Industry consolidation through merger and acquisition activity has, however, accelerated in recent years as a response to low reimbursement rates driving down profits. While local, independent providers can arguably be more responsive to consumer needs, small agencies lack the profit margins necessary to increase salaries or invest in internal growth generally.

Public reimbursement rates for home care services are low, driving down wages across the industry. Unlike many other sectors in healthcare, the homecare industry does not have strong political representation and thus has been an easy

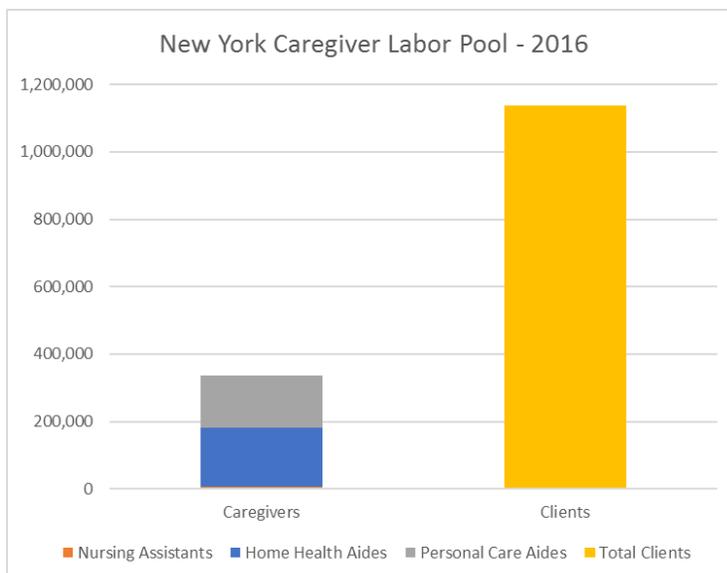


³ IBISWorld Industry Reports: 62161 Home Care Providers in the US

target for federal cuts. Across the U.S., the hourly median wage for workers in the direct care workforce is \$10.49 per hour, only 25 cents more than the median wage for retail and food service workers. Even though homecare is increasingly promoted by healthcare professionals and offers a superior value for clients, this recognition has not yet resulted in increased payments for services. With deep public underinvestment in home care, small and large home care cooperatives alike struggle to remain financially sustainable, let alone carve out the financial resources necessary to invest in the worker-focused benefits that differentiate a home care cooperative job from a standard home care job. Worker cooperatives have the potential to raise wages and job quality for caregivers and provide better outcomes for patients, but the business model must be first strengthened, scaled, and unified in order to sufficiently influence and transform the industry today.

INTRODUCTION

With the fourth largest senior population in the nation, demand for home care in New York is strong and growing. New York City in particular, will see a massive boom in its senior population, but New York’s rural aging population will grow significantly as well. Today, over one million individuals receive home health and personal assistance services through state-licensed agencies in New York. As the states’ elderly population booms—with 60+ residents making up a *quarter* of the population in 51 of New York’s 62 counties—demand for home care, particularly Medicaid funded care, will increase dramatically. While distribution of caregivers across the state is uneven, with rural areas facing greater worker shortage, for every one caregiver in New York, there are currently 3.3 people needing home care, significantly better ratio than the national average of 8 to 1.



While home care is challenging in all states, by most measures, New York is a better market than many for home care agencies and workers. This is in large part to increased public investment in the home care industry. In New York, due to a historically higher-than-average minimum wage, caregivers are currently paid \$11.44 per hour on average, about 6.7% more than their counterparts in retail and food service, and 2.2% more than the national average. The 2016 minimum wage ruling will further increase wages to \$15 per hour in New

York City and surrounding areas, and to \$12.50 in the rest of the state, by 2021. As a direct result, turnover in the Northeast region is seven points lower than the national average (53% vs. 60%)⁴. Strong training requirements also lead to reduced turnover in New York, where 40 hours of state-approved training and a competency evaluation are required to provide personal care services under the state’s

⁴ The 2017 Home Care Benchmarking Study, 2017. Retrieved from www.homecarepulse.com/benchmarking-study.

Medicaid waivers. While a rate of turnover where more than one in two caregivers leaves their job in a year is still unsustainably high for the industry, New York's policy decisions have nevertheless led to a more favorable market for workers than the national average.

In New York, as is true in all states across the nation, Medicaid is the largest payer for home care services. Low Medicaid reimbursement rates prevent agencies reliant on public pay from paying workers adequate wages to remain in the job, and negatively affect private pay agencies by setting a low rate standard. While few, if any, small agencies can remain financially viable operating in the public pay market, Medicaid offers the greatest opportunity for growth and scale. At the same time, despite significant financial investments in Medicaid and Medicare reform in the state, Medicaid services are still being significantly underfunded, resulting in major losses and home care service agencies due to underpayments that force many agencies to borrow operating capital.

Even though New York will continue to have challenges funding its Medicaid program, improved wages for workers, lower turnover, and a very strong caregiver dependency ratio make New York a favorable market for development in home care today.

This report will analyze the home care market across a few key dimensions including market size, labor supply, the regulatory environment, and other state specific findings. We will then use this analysis to drive conclusions on the state of home care in New York, how this effects current and start-up home care cooperatives in the state, and explore potential strategies for nurturing and growing home care cooperatives.

MARKET OVERVIEW

To understand the market for home care services in New York, we use three separate lenses of analysis: Customers, Competition, and Payers. This section provides a view into the number of potential home care customers in the New York market, how home care clients pay for home care in the state, and who is competing for these customers. Finally, we explore key stakeholders in the state focused on the home care and cooperative industries.

Customers

While New York's aging population is growing at a slower rate than the national average, at 6.81% vs. 9.7%, the state boasts the fourth-largest elderly population in the nation with 3.7 million state residents over the age of 60, nearly half of which live in New York City⁵. By 2030, the State Office for the Aging estimates that New York's 60+ population will reach 5.2 million, and that 82% New York's counties will be home to populations where a quarter or more of county residents will be aged 60+. Also included within the population needing home care are New York's self-care (SC) and independent living (IL) disabled population, accounting for 8% of the state total, or 1.3 million people (2015 data)⁶.

Despite large populations of both elderly and SC and IL disabled individuals, the total number of individuals in these groups potentially requiring home care services, defined as the "home care subset", is slightly lower in New York at 5.78% than 6.19% nationally. As of 2016, 1,096,142 New York residents were categorized as "frail elderly", "self-care disabled", or "independent living disabled" and likely needing home care services. By 2025, we estimate that this group will grow by over 16% to over 1.2 million. The primary source of growth in home care demand is New York's "frail elderly" population, rather than individuals with disabilities.

Competition

New York State's Department of Health defines three *non-medical* home care roles: personal care (provided by a personal care aide), housekeeper, and homemaker. Medical home care roles include, but are not limited to, home health (provided by home health aides) and nursing services (provided by a registered nurse or under the supervision of a registered nurse)⁷. New York has an estimated 686 home care agencies, providing both home health and non-medical home care (excluding skilled nursing, hospice, and dialysis). The five largest home care firms in the state control 35.6% of the market, meaning New York is still a relatively competitive market.⁸ The top-five largest agencies are:⁹

1. **Visiting Nurse Service of New York (VNSNY)** is the largest home care company in the state, with annual sales of nearly \$542 million annually. VNSNY is the largest not-for-profit home and community based health care organization in the United States, serving the five boroughs of

⁵ New York City Comptroller, Aging with Dignity: A Blueprint for Serving NYC's Growing Senior Population. Retrieved from www.comptroller.nyc.gov

⁶ Erickson, W., Lee, C., & von Schrader, S., 2016. 2015 Disability Status Report: New York. Ithaca, NY: Cornell University Yang Tan Institute on Employment and Disability(YTI). Retrieved from www.disabilitystatistics.org.

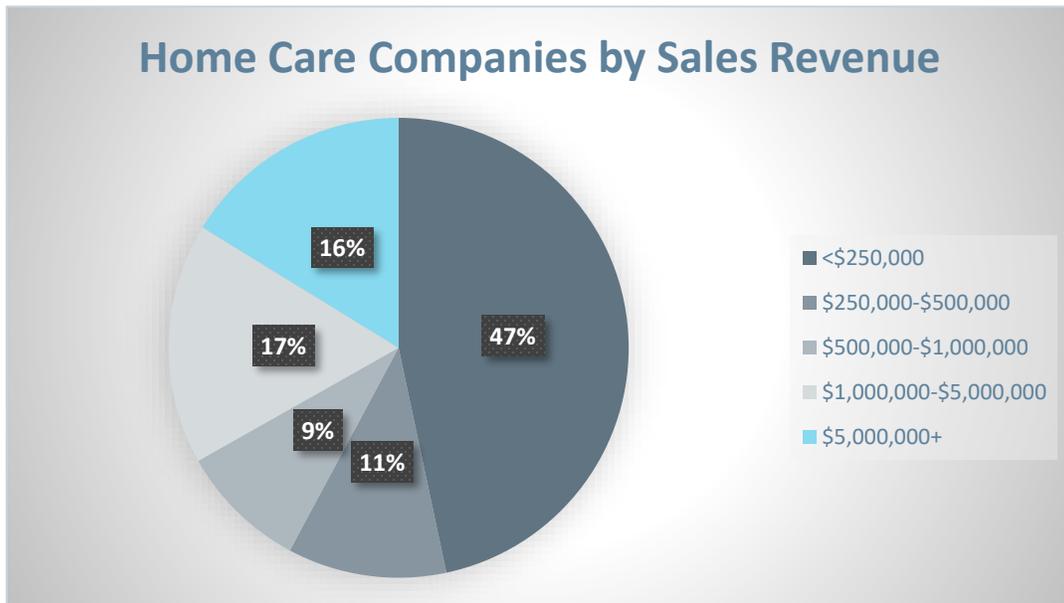
⁷ New York State, Department of Health, Home Care. Retrieved from www.profiles.health.ny.gov.

⁸ Industries in which the top five firms control 60% or more of the market are generally considered non-competitive.

⁹ Mergent Intellect Dun and Bradstreet. (n.d.). Loblaws Inc. Retrieved from www.mergent.com.

New York City, and Nassau, Suffolk, and Westchester Counties. *VNSNY focuses solely on medical home care* and does not provide non-medical homemaker, companion or personal care aide services.

2. **Personal Touch Home Care**, a national chain offering a range of services from non-medical homemaker services to skilled nursing
3. **NYSARC** New York’s largest non-profit organization serving individuals with intellectual, development or other disabilities
4. **Metropolitan Jewish Home Care, Inc.**, a certified home health agency serving the needs of patients across all of New York City, Westchester and Nassau County
5. **Best Care** providing both medical and non-medical services across New York.



New York state currently has one home care cooperative in operation—Cooperative Health Care Associates (CHCA), the largest worker owned cooperative in the country, employing over 2000 home care workers. See Appendix A for additional information on CHCA.

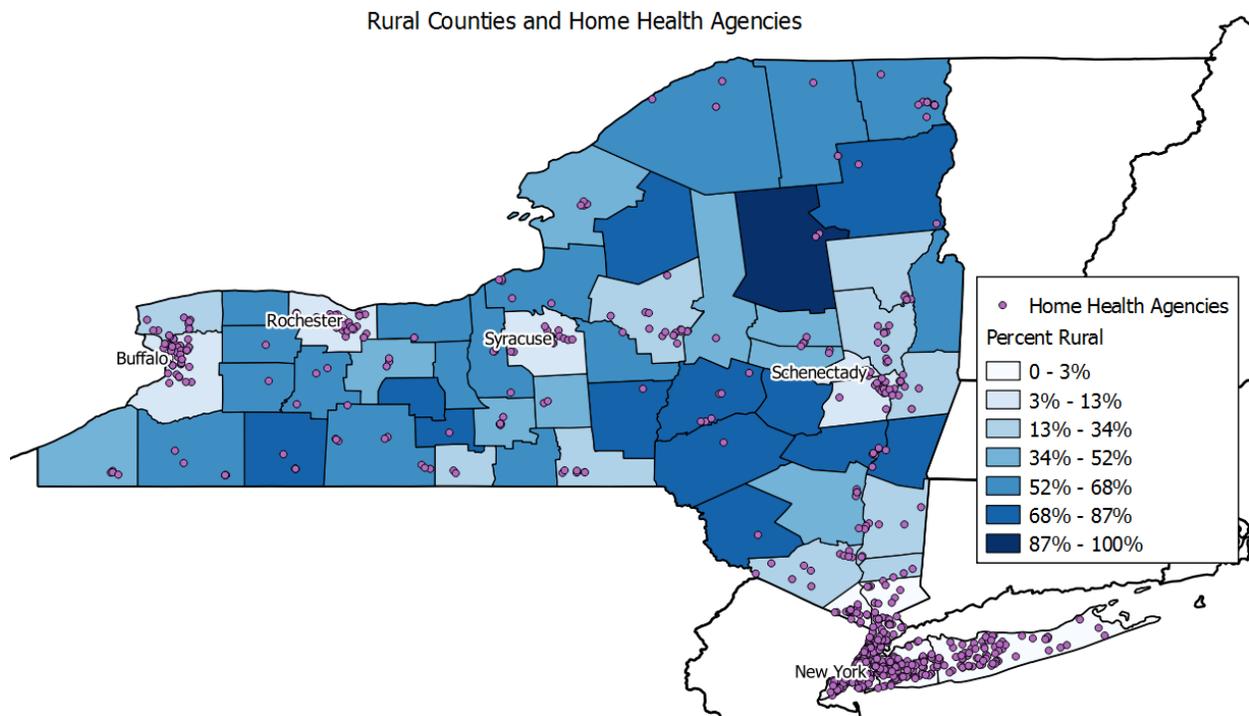
Like the national home care market, home care in New York has relatively few large companies, and primarily consists of small local operators. An estimated 35.6% of sales revenue for home care in the state goes to the top five largest operators, leaving just under 65% of sales revenue going to the remaining 681 companies. The median sales revenue for New York home care companies is \$303,233, higher than the national median of \$216,243. The average sales revenue is \$5,857,521, suggesting that the larger home care companies are of a significant order of magnitude larger than the state’s small operators. Of the estimated 686 home care operators in the state in the state, 46% have revenue of less than \$250,000 per year¹⁰. While low barriers to entry allow many small firms to enter the market, scaling to a sustainable size is much more difficult, especially because of the low Medicaid rates that depress margins and require even greater scale economies and operational efficiencies to cover costs.

¹⁰ Mergent Intellect Dun and Bradstreet. (n.d.). Loblaws Inc. Retrieved from www.mergent.com.

Rural vs. Urban Conditions

Population density in New York’s rural and suburban areas is only slightly higher than the national average. New York’s urban population density, however, is significantly higher than the national average at over 5,063 people per square mile compared to 1,015 nationally. Unsurprisingly, the largest density of provider agencies is clustered in New York’s major urban areas, with the strongest presence in New York City, Yonkers, Albany, Rochester, and Buffalo.

Rurally located home health companies in New York have median sales revenue of \$771,100 as compared to urban home health companies that have median sales revenue of only \$575,000, suggesting higher costs to operate in rural locations, possibly due to travel requirements and heightened administrative needs, leading to lower margins that must be overcome by generating higher sales revenue. Nationally, rural homecare companies have 15% higher sales revenue than urban companies. In addition to higher travel costs, due to greater distances between clients, one of the primary challenges of operating a home care agency in a rural area is recruiting an adequate number of caregivers to provide care. This is particularly true in New York where many of the state’s rural counties face significant worker shortages, leaving many patients without care despite being eligible and funded for care¹¹.



Payers

As is true nationally, the primary public payer for home care in New York is Medicaid. In New York, 32.5% of the state’s residents receive Medicaid benefits, well above the national average of 18%. The percentage of Medicaid enrollees that are categorized as “aged” (age 65+) and “disabled” is 11% for

¹¹ Advocates for Aging Call Homecare Worker Shortage a ‘Crisis’, Gronewold, A., Feb. 2017. Retrieved from www.usnews.com.

both groups¹². In total, 375,000 Medicaid beneficiaries in New York receive long-term in-home care, double the 180,000 Medicare recipients that are provided with home care services each year during the post-operative period¹³.

In 2015, New York allocated 41% of Medicaid funding to Long Term Services and Supports (LTSS) programs, higher than the national average of 32%. At the same time, New York allocated a lower proportion of LTSS spending to Home and Community Based Services (HCBS) programs (42%) than the national average (53%), with HCBS spending totaling nearly \$13B in the state¹⁴. While the proportion signals a continuing preference for institution-based long-term care in the state, HCBS spending has trended upwards, increasing by 4.21% from 2010 to 2015¹⁵.

While there is a significant amount of data available on the size of the public pay market, it is much more difficult to estimate the size of the private pay market. Our own analysis of available data indicates a potential private pay potential pool of approximately 191,700 clients.¹⁶ Given that home care costs in New York are high relative to the state's median income of \$38,929 for residents aged 65+,¹⁷ this is likely an overestimate of the potential market as many private pay customers may not actually be able to afford out-of-pocket home care costs over the long term. Home care costs as a percentage of median income for individuals 64+ in New York is 132%, 13% above the national average. Research by Genworth finds that full-time non-medical home care or homemaker services average \$4,195 per month, and home health aide services average \$4,385 per month in New York, or each over \$50,000 annually and unsustainably high. Unfortunately, these averages are expected to rise well above \$5,000 per month by 2026, further putting a private-pay option beyond the reach of many clients.¹⁸

Taken together, the number of individuals eligible for Medicaid in-home care services (180,000) and those that have private insurance or can pay out-of-pocket for home care services (191,700) is just a third of the total number of individuals who need care, or 1,141,278. Accordingly, we find that there is significant client pool that is not eligible for Medicaid, and also cannot afford private-pay services. These conditions likely lead to a large 'gray market' of informal caregivers, as well as a largely unpaid family members, friends, and neighbors providing caregiver assistance. Nationally, over 44 million Americans provide 37 billion hours of unpaid care each year to assist adult family members and friends with activities of daily living to remain at home¹⁹.

¹² Kaiser Family Foundation, Distribution of Medicaid Enrollees by Enrollment, FY 2014. Retrieved from www.kff.org.

¹³ 2017-2018 State Budget Testimony HCA Concerns and Recommendations, Cardillo, A., February 16, 2017. Retrieved from www.nyassembly.gov

¹⁴ Medicaid Expenditures for Section 1915 (C) Waiver Programs in FY2014. Eiken, S., Burwell, B., Sredl, K., Saucier, P., Sept. 2016. Retrieved from www.medicaid.gov.

¹⁵ <https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf>

¹⁶ Using data available from the November 2016 IBIS world report on the national home care provider industry, and our estimate of the size of the home care client population we can approximate the number of potential private pay home clients. First, our estimate of the combined frail elderly, independent disabled, and self-care disabled population in New York is 1,141,278. This number is then multiplied by the private pay market's (out-of-pocket and private insurance) percent of the national home care industry estimated to be 16.8 percent by IBIS World. Using this method, we estimate that the size of the New York private pay home care potential client pool to be 191,700.

¹⁷ Department of Numbers. Retrieved from www.deptofnumbers.com/income/new-york.

¹⁸ Genworth 2016, Cost of Care. Retrieved from www.genworth.com.

¹⁹ Family Caregiver Alliance, National Center on Caregiving, Introduction. Retrieved from <https://www.caregiver.org/caregiving>.

Medicaid home care beneficiaries can elect to receive home care through the traditional agency model or through New York's Consumer Directed Personal Assistance Program (CDPAP), which allows chronically ill or physically disabled individuals to contract directly with caregivers, including family members, for home care services including hiring, training, supervising and terminating. Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse. Participation in the program requires the engagement of a fiscal intermediary called a case manager. Many agencies specialize in case management or offer case management among a suite of home care services.

Key Stakeholders

New York, and New York City specifically, are home to a large number of advocacy, research, and technical support organizations focused on the home care industry, and relevant issues here like cooperative business development, and scaling the cooperative movement:

Home Care Association of New York State: New York advocacy organization for community based care organizations including home care agencies and managed long-term care plans. Provide educational resources, professional development, training and networking opportunities and advocacy on the state and national level.

Paraprofessional Healthcare Institute (PHI): PHI is the nation's leading authority on the direct care workforce, promoting quality direct-care jobs as the foundation for quality care through research, policy advocacy, training development and more.

1199 SEIU United Healthcare Workers East: A labor union representing hundreds of thousands of healthcare workers across New York, with an emphasis on New York City/Long Island, Capital/Hudson Valley, and Upstate New York.

Democracy at Work Institute (DAWI): While DAWI is not located in New York, they are a national organization with a presence in New York City. DAWI provides technical assistance for conversions of traditional businesses to worker ownership through the "Workers to Owners" program. DAWI also specifically supports the development and growth of immigrant cooperatives.

New York City Network of Worker Cooperatives: The New York City Network of Worker Cooperatives (NYC NOWC) is the trade association for worker cooperative businesses in the NYC metropolitan region. NYC NOWC aims to increase public awareness of workplace democracy and improve business conditions for democratic, employee-owned enterprises.

REGULATORY & PUBLIC POLICY OVERVIEW

Whether private pay or public pay, agencies wishing to operate in New York must have a basic understanding of the regulatory and policy environment in the state. This section provides an overview of Medicaid generally as well as New York specifically, discusses New York's commitment to home and community based services for long term service and support needs, offers an overview of specific service programs in the state, and describes licensing and worker training requirements for operators in the state.

Medicaid Overview

Dually funded by the federal government and individual states, Medicaid provides financial support for health care services for low-income individuals, including elderly and disabled individuals requiring long term care (accounting for over 60% of Medicaid spending). Under Medicaid, the federal government provides a base match of 50% for approved Medicaid provided services, with low income states eligible for higher reimbursement rates. To be eligible for Medicaid benefits, individuals must meet federally mandated financial and asset criteria.

Beginning in 2014, the Affordable Care Act allowed states the option to expand Medicaid eligibility to all non-elderly adults with income below 138% of the federal poverty line. Under "Medicaid Expansion", the federal government absorbs a larger share of Medicaid costs for new enrollees, covering 100% of costs from 2014 to 2017 and gradually reducing that percentage to 90% from 2017 to 2020. To date 32 states and the District of Columbia have expanded Medicaid²⁰.

Medicaid requires that states provide specific services at a minimum, to participate in the program. Required programs include inpatient and outpatient hospital services, physician and laboratory services, nursing home care and more recently, home health care. Above the minimum required programs, states may elect to cover additional services and/or expand services to individuals outside of the standard eligibility limits set by the Center for Medicaid and Medicare Services (CMS), the federal governing body. Typically, these additional services are provided under approved "waivers".²¹ The number and type of waivers in each state varies widely, however common waivers include 1915 waivers, Aged and Disabled Waivers (ADW), and Intellectual Disability Waivers (ID). Home care relevant 1915 waivers include:

- 1915(c) Home and Community-Based Waivers (offered in 47 states and DC)
- 1915(i) State Plan Home and Community Based Waivers
- 1915(j) Self-Directed Personal Assistance Services Under State Plan Waivers
- 1915(k) Community First Choice Waivers²²

See Appendix B for Waiver Details

1915 (c) HCBS waivers were first introduced in 1983 as a way for states to transition beneficiaries out of costly institutional care settings, and in 2005, became formal Medicaid State plan options.²³ States can

²⁰ A 50-State Look at Medicaid Expansion, April 2017. Retrieved from www.familiesusa.org.

²¹ Congressional Budget Office, Overview of Medicaid. Retrieved from www.cbo.gov/publication/44588.

²² Medicaid, Authorities. Retrieved from www.medicaid.gov.

²³ Medicaid, Authorities. Retrieved from www.medicaid.gov.

offer as many 1915(c) Home and Community-Based Waivers as they elect, provided they meet the requirements set forth by CMS, and can elect what services to cover under the waivers, however home health aide, personal care aide, and homemaker services are almost always covered under these programs.²⁴ Understanding where states fall on the spectrum of HCBS spending for their long term services and supports (LTSS) programs is an important metric for states overall preference for institutional versus home based care.

From Medicaid's founding in 1965 until the early 1990's, Medicaid operated under a system of "fee-for-service", where providers were directly reimbursed for services provided, based on rates set by individual states. In the early 1990's however, Medicaid began a transition towards a system known as "managed care" to better manage costs, utilization, and quality. Under Medicaid managed care, state Medicaid agencies contract with independent for profit or non-profit Managed Care Organizations (MCOs) that accept per member per month payments for health care services, known as "capitated payments". Because payments are "capitated" MCO's are driven to balance the needs of high-need/high-cost beneficiaries with low-need/low-cost beneficiaries and provide care in the most cost effective manner possible to avoid cost overruns. Early on, managed care was implemented under 1115 Waivers, but in 1997 the Balanced Budget Act gave states more authority to implement managed care programs without waivers²⁵. As of March 2017, only 12 states did not have Managed Care programs in place²⁶. States that have begun transitions to managed care programs are in varying states of transition. Several states including Tennessee, Hawaii, New Hampshire, New Jersey, Rhode Island, Kentucky, Iowa, Delaware, Florida and Arizona operate almost exclusively under managed care programs (over 90% transitioned)²⁷, including home and community based services, while others are just beginning this transition. Understanding where specific states fall on this transition is important, as it is directly correlated to how service rates are set, how money flows, and the importance of strategic partnerships, scale and other factors to home care agency success in a state.

In addition to the transition to managed care, states are increasingly transitioning Medicaid to "value-based" care models by implementing Accountable Care Organizations (ACO's). To date, ten states (MA, VT, NY, OR, UT, CO, MN, NJ, and RI) have implemented ACO programs²⁸. The goal of ACO's is to "(1) enhance the patient experience of care; (2) improve the health of the population; and (3) reduce the per capita cost of health care". What differentiates an ACO from an MCO is innovative values-based payment structures and carefully defined and tracked data and quality metrics to assess and confirm established value outcomes. The transition to value based care via the ACO model is an important one for cooperative home care agencies and developers to watch, as higher quality care is a hallmark of cooperative homecare agencies, and could be an important market differentiator.²⁹

²⁴ Medicaid.gov, Home and Community Based Services, 1915 (c) Waiver. Retrieved from www.medicaid.gov.

²⁵ Kaiser Family Foundation, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011. Retrieved from <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf>.

²⁶ Kaiser Family Foundation, Total MCO's, March 2017. Retrieved from www.kff.org.

²⁷ Kaiser Family Foundation, Share of Medicaid Population Covered Under Different Delivery Models, July 2016. Retrieved from www.kff.org.

²⁸ Center for Health Care Strategy, Inc. Medicaid ACO's: Status Update, June 2017. Retrieved from www.chcs.org.

²⁹ Center for Health Care Strategy, Inc. Medicaid Accountable Care Organization Programs: State Profiles Brief: October 2015. Retrieved from www.chcs.org.

New York Medicaid Overview

New York is far along in the transition from traditional fee-for-service Medicaid to a system of managed care. Demonstrating its commitment to reforming Medicaid, the state created a special “Medicaid Redesign Team” in 2011. Today, New York State contracts with 23 Managed Care Organizations (MCOs) to provide coordinated care to the state’s Medicaid beneficiaries³⁰. As part of this transition, the MRT proposed the transition of long term care services (LTSS) to Medicaid managed care. As of June 2013, most Medicaid beneficiaries requiring more than 120 days of community-based long term care access home care services including personal care, consumer-directed personal assistance, certified home health care, and private duty nursing services through Managed Long Term Care (MLTC). MLTC helps chronically ill or disabled individuals eligible for nursing home level care to coordinate and pay for a variety of home based health and supportive services. Nearly 150,000 people have successfully transitioned into MLTC to date³¹. Only a small percentage of Medicaid recipients continue to receive HCBS under the prior Medicaid Waivers program. MLTC is coordinated under Managed Long Term Care Plans and Programs for All-Inclusive Care for the Elderly (PACE) (both Medicaid and Medicare).

In addition, New York is one of ten states nationally that is pursuing a transition to “value-based” care and “value-based payments” (VBP) through the accountable care organization (ACO) model. As of May 2017, five New York provider groups were granted ACO Certificates of Authority to operate in New York, outside of Medicare. Fifteen additional ACO’s were granted Certificates of Authority as “Medicare-Only ACO’s,”³² and the state invested \$1.08B in savings from the Delivery System Reform Incentive Program (DSRIP) to support investments in long term care, among other focus areas³³.

Medicaid Home and Community Based Services

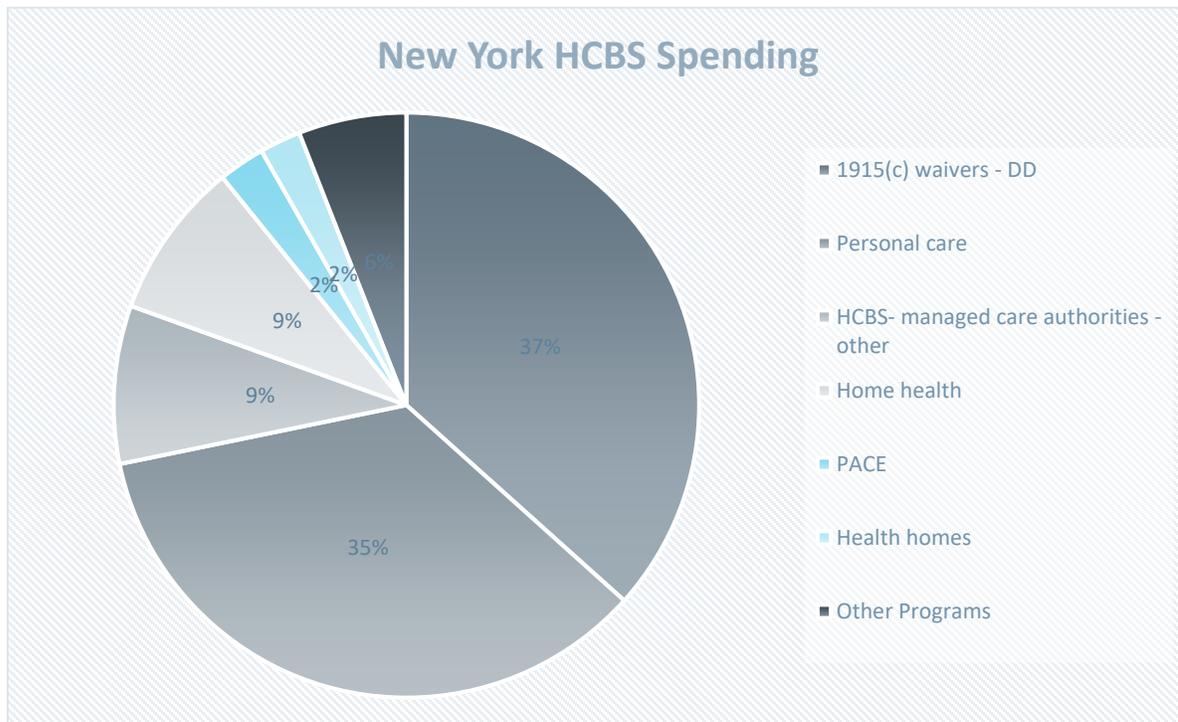
Medicaid home and community based service programs allow Medicaid recipients who are age 65+ and those living with physical disabilities to receive support with activities of daily living (ADL’s) and instrumental activities of daily living (IADL’s) at home or in their community, rather than in institutional settings. Traditionally, HCBS are offered under state waivers, approved by CMS. In New York, most Medicaid recipients requiring long term support services at home or in the community are enrolled in Managed Long-Term Care plans, but a few waiver programs remain active.

³⁰ Kaiser Family Foundation, Total MCO’s, March 2017. Retrieved from www.kff.org.

³¹ New York Department of Health, Building for the Future Managed Long Term Care Programs in New York. Retrieved from www.health.ny.gov.

³² New York State, Department of Health. Accountable Care Organization (ACO). Retrieved from www.health.ny.gov.

³³ New York State, Department of Health. DSRIP Overview. Retrieved from www.health.ny.gov.



New York State’s Department of Health (DOH) operates one 1115 demonstration waiver, five 1915(c) waivers, and one 1915(k) Community First Choice Option (CFCO) state plan amendment to provide home and community based services to individuals with physical, behavioral, mental, developmental, or intellectual disabilities. New York’s HCBS programs and waivers are:

- Long Term Home Health Care Program Waiver
- Nursing Home Transition and Diversion (NHTD) Waiver
- Traumatic Brain Injury (TBI) Waiver
- Care at Home Waivers I and II

Additionally, in 2015, CMS approved New York’s Medicaid State Plan Amendment to add a "Community First Choice Option" (CFCO), which allows states to expand access and availability of LTSS-HCBS to eligible Medicaid enrollees under their State Plan, rather than through a waiver. This option provides a 6% increase in Federal matching payments for CFCO service expenditures³⁴. CFCO services are covered under managed care and fee-for-service.

For Medicaid HCBS Waiver recipients, New York offers both traditional agency options and a self-directed services option under the Consumer Directed Personal Assistance Program (CDPAP), allowing individuals to contract directly with caregivers, including family members, for home care services.

³⁴ Section 1915 (k) Community First Choice State Plan Option. Retrieved from www.kff.org.

Non-Medicaid State Programs

In addition to New York's Medicaid home care services, New York's Expanded In-Home Services for the Elderly (EISEP) program assists state residents that are aged 60 and older, and non-Medicaid eligible, who want to remain at home and need help with activities of daily living including dressing, bathing, personal care, shopping, and cooking. EISEP services include non-medical in-home services such as housekeeping, personal care, respite, case management, and related services. EISEP is a sliding-scale, cost-sharing program based on income that is coordinated through New York's 58 local Offices for Aging.³⁵

Regulatory & Political Barriers

Despite significant financial investments in Medicaid and Medicare reform, investments in the new and revised systems has not followed suit. A financial condition report prepared by the Home Care Association of New York found that state Medicaid services are being significantly underfunded resulting in major losses to managed long term care (MLTC) plans and home care service agencies. The report found that 61% of MLTC plans had negative premium incomes in 2015, and that 31% of all home care agencies had to use a line of credit or borrow money in order to pay for operating expenses due to state underpayment. Agencies looking to enter the New York public pay market should proceed with caution and ensure adequate operating income from other sources to offset likely shortfalls. Further, the report explores unintended consequences of policy changes stemming from rising pressure on health plans to reduce hospitalizations and provide integrated services under DSRIP and other novel programs, which have inadvertently caused growth in the unregulated home care services market³⁶.

Licensing Requirements

New York State Public Health Law requires that an organization be licensed or certified as a home care agency by the New York State Department of Health to provide or arrange for home care services in New York State:

Certified Home Health Agencies (CHHAs) or, *from health.ny.gov*, long Term Health Care Programs that (LTHCPs) provide A.) Part-time, intermittent, skilled services, which are of a preventative, therapeutic, rehabilitative, health guidance, and/or supportive nature to persons at home, and B.) Part-time, intermittent health care and support services to people who need intermediate and skilled health care. Home health services under the CHHA category include: nursing services; home health aide services; medical supplies, equipment and appliances, suitable for use in the home; and at least one additional service that may include physical therapy; occupational therapy; speech pathology; nutritional services; and medical social services. Services provided by CHHAs may be reimbursed by Medicare, Medicaid, private payment, and commercial health insurers. The NYS Department of Health is responsible for

³⁵ New York Department of Health, Home Care, Information for Consumers. Retrieved from www.health.ny.gov.

³⁶ 2017-2018 State Budget Testimony HCA Concerns and Recommendations, February 16, 2017. Retrieved from nyassembly.gov.

monitoring care provided by CHHAs³⁷. Additionally, the Department certifies specific home health agencies as Special Needs CHHA's to serve identified special needs populations.

Licensed Home Care Services Agencies (LHCSAs) offer home care services to clients who pay privately or have private insurance coverage. These agencies may also contract to provide services to Medicare/Medicaid beneficiaries whose cases are managed by another provider or entity (e.g., providing home health aide services to a certified home health agency patient, or providing a licensed practical nurse for a Medicaid prior-approved private duty nursing shift.) The NYS Department of Health is responsible for monitoring the care provided by licensed care services agencies³⁸.

Certification as a CHHA or LTHCP is significantly more involved, including requirement of Certificate of Need (CON) approval by the Department of Health. The CON guarantees that the proposed facility and/or service “meets a public need, is financially feasible and is to be offered by owners and operators who are of sound character and professional competence”³⁹. The application fee for LHCSA is \$2000, and instructions can be found at: Approval and Licensure of Home Care Services Agencies – Part 765 of 10 NYCRR⁴⁰.

Training

Personal Care Aides must complete 40 hours of state-approved training and pass a competency evaluation to provide personal care services under the state's Medicaid waivers, a higher-than-average set of requirements compared to the industry nationally. Successful PCA candidates are certified and entered into the state's home care registry, which was launched in September, 2009⁴¹.

State training requirements for Home Health Aides are in-line with federal requirements. Home Health aides must complete 75 hours of training, including 16 hours of clinical training. Nursing Aides must complete 25 more training hours and 24 more clinical hours than federal standards.

The majority of home care workers in New York, as well as nationally, are trained and certified by their employing agency, and online programs are common. In partnership with the Paraprofessional Healthcare Institute (PHI), Cooperative Home Care Associates (CHCA) developed a national model for a hands-on, four-week training program that covers basic state required curriculum, but also advanced topics such as preventive health, meal preparation, active listening, nonjudgmental communication, collaborative problem-solving, and participative leadership. Caregivers who complete CHCA's four-week training program receive dual certification as a Certified Home Health Aide and Personal Care Assistant and are guaranteed employment in CHCA.

In New York City, NYC's Small Business Services Department in partnership with Workforce 1 and the New York Alliance for Careers in Healthcare (NYACH) offer free training for home health aides, including

³⁷ New York State Department of Health, NYS Health Profiles, About Certified Home Health Agencies. Retrieved from https://profiles.health.ny.gov/home_care/pages/chha.

³⁸ New York State Department of Health, NYS Health Profiles, About Licensed Home Care Services Agencies. Retrieved from https://profiles.health.ny.gov/home_care/pages/lhcsa.

³⁹ New York City Business Department, Certified Home Health Agency (CHHA), Operating Certificate. Retrieved from <https://www1.nyc.gov/nycbusiness/description/certified-home-health-agency-chha-operating-certificate>

⁴⁰ http://www.health.ny.gov/regulations/nycrr/title_10/

⁴¹ PHI Quality Care through Quality Jobs, Personal Care Aide Training Requirements. Retrieved from www.phinational.org.

an ESOL-bridge to the training for those that have language barriers to employment. Additionally, most of the state's community colleges offer tuition-based home care training programs, including personal care assistant, home health aide, and certified nursing assistant training programs for those looking to enter the field.

Labor Overview

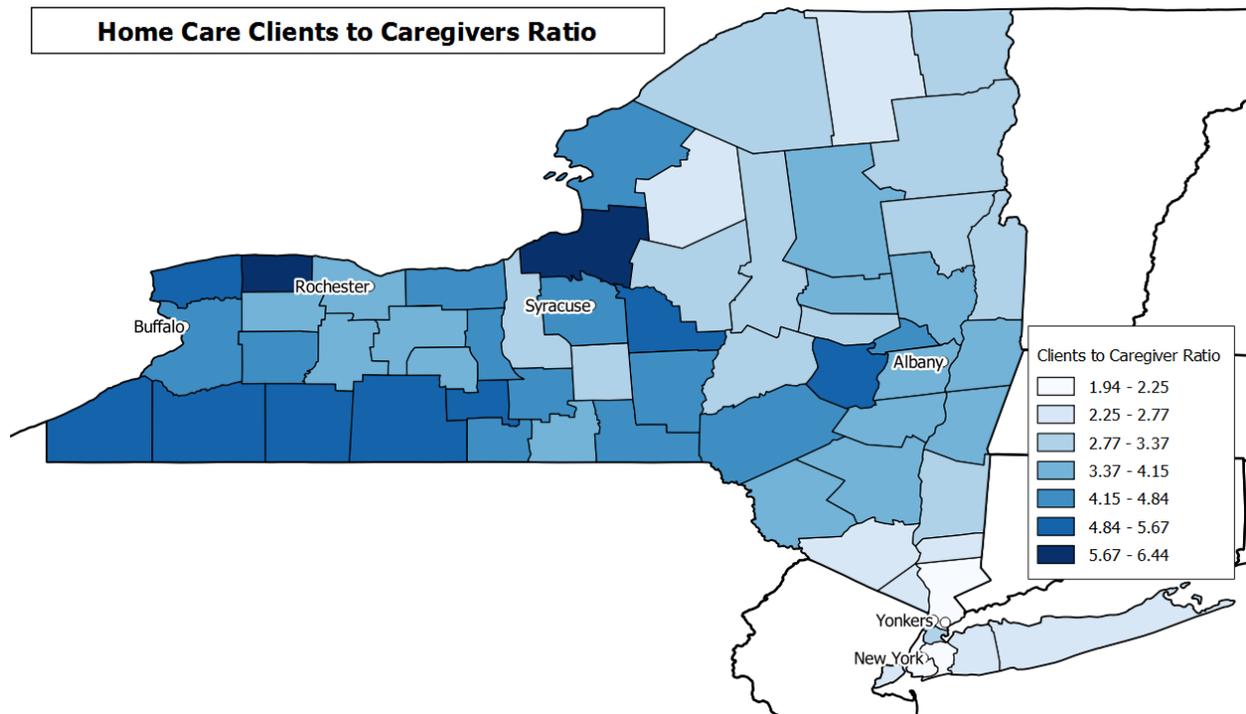
As a human centered business, recruitment and retention of enough quality home care workers is the biggest factor in the sustainability and success of any home care agency. In this section, we analyze current labor conditions as well as future trends to identify both challenges and potential opportunities to recruiting and retaining home care workers, and consider training requirements and their potential impact on entry to the field.

Current Labor Conditions

The macro employment environment in New York is relatively average with unemployment comparable to national unemployment. The prime age (25-55) labor force participation rate is also just 4.7% below the national average, indicating the potential, albeit small, for some staffing through untapped labor markets. According to research by the Paraprofessional Healthcare Institute (PHI), nearly 9 in 10 home care workers are women, with a median age of 45⁴². As is true nationally, a greater diversity of caregivers will still need to be recruited into the state's home care workforce, including notably, more men and both younger and older workers.

For every one caregiver in New York, there are currently 3.3 people categorized as frail elderly, independent living disabled, or self-care disabled needing care. While this is a significantly better ratio than the national caregiver dependency ratio of 8 to 1, distribution of caregivers across the state is uneven, with rural areas facing greater worker shortages. Further, New York's elderly population boom will necessitate significant growth in the direct care workforce over the coming years to meet demand. Notably, New York allocated \$242 million in the recent Medicaid budget to support recruitment and retention efforts for personal care aides.

⁴² Paraprofessionals Healthcare Institute, U.S. Home Care Workers: Key Facts, 2017. Retrieved from www.phinational.org.



Recruitment of new workers into the home care field depends in large part on how wages compare to similar entry-level service-sector occupations in the state. In the United States, the average caregiver is paid over 4.5% more than the average food service or retail worker. In New York, due to a historically higher than average minimum wage, and a recent 2016 increase, caregivers are currently paid \$11.44 per hour on average, about 6.7% more than worker counterparts in retail and food service, well above the national average.

Caregiver and Retail/Food Service Wage Comparison			
	Direct Care	Retail/Food	Difference
National Average	\$ 10.70	\$ 10.24	\$ 0.46
New York	\$ 11.44	\$ 10.72	\$ 0.72

Further, the 2016 minimum wage ruling will further increase wages to \$15 per hour in New York City and surrounding areas, and to \$12.50 in the rest of the state, by 2021. Additionally, in 2010, New York passed a ‘wage parity’ law establishing a minimum rate of home care aide *total compensation* for certain home care workers in New York City, Westchester and Long Island. The law applies to Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCs), Managed Care Organizations, including Managed Long Term Care plans, and Licensed Home Care Services Agencies (LHCSAs) that employ home health aides, personal care aides, home attendants or other

licensed/unlicensed staff whose primary responsibility includes the provision of in-home assistance with activities of daily living, instrumental activities of daily living or health-related tasks that are Medicaid-reimbursed. Excluded are relatives hired to care for a family member and personal assistants under the Consumer Directed Personal Assistance Program (CDPAP).⁴³

Under the wage parity requirement, agencies operating in New York City, Westchester, Nassau and Suffolk counties must pay both the minimum living wage set by the state plus benefits, or compensation in lieu of benefits. In New York City for example, "large" employers (those with 11 or more total employees) must pay a cash "base wage" of \$11.00 per hour, plus benefits or 'Additional Wages and Supplemental Wages' totaling \$4.09 per hour in place of benefits. These wages can be cash or other direct benefits, including paid leave and premiums above base pay for certain shifts or assignments. For smaller employers with 10 or fewer total employees, the cash portion of the minimum salary rate is \$10.50 per hour plus benefits, or an additional \$4.09 per hour in lieu of benefits. Both base rates and benefit wages are slightly lower in Westchester, Nassau and Suffolk Counties, with current rates are set through December 31, 2017.⁴⁴ While New York's minimum-wage increase and wage parity rulings offer significant and important pay raises to the state's home care workers, state funding has not kept pace in terms of investment or roll out, causing a trickle down of unintended negative consequences for managed care organizations, agencies, workers and clients, alike. As agencies struggle to absorb the increased costs, they have had to lay off workers, reduce hours, and schedule to avoid overtime. Even Cooperative Home Care Associates has been unable to pay dividends for three years.

Future Labor Trends

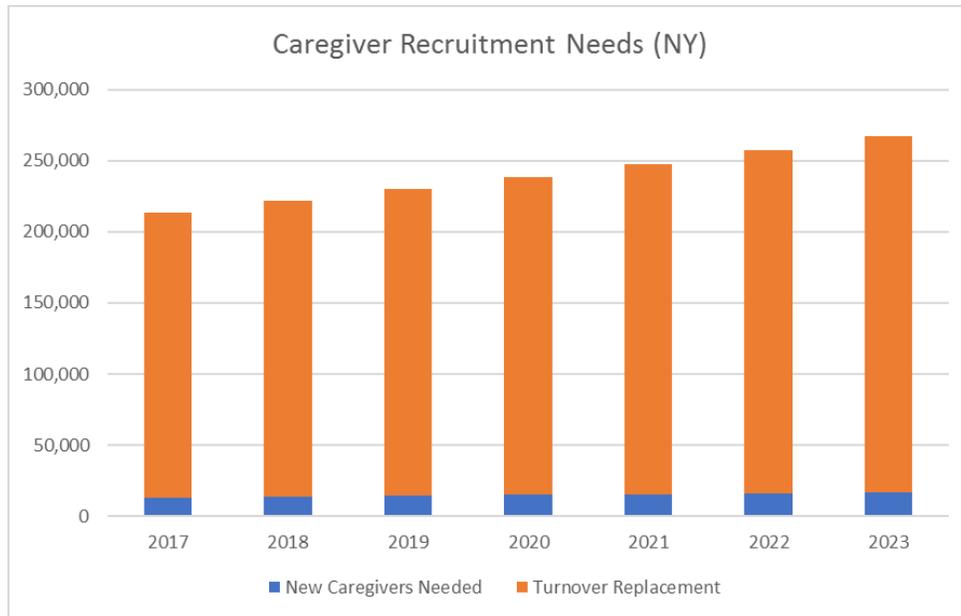
The caregiving workforce is expected to experience incredible and rapid growth over the next ten years. The national workforce of personal care aides is expected to grow 25.9% by 2024, home health aides by 38.1%, and nursing assistants by 17.6%.

Across the country, the direct care workforce has experienced a tripling in the rate of employee turnover since 2009. Currently, the national average for annual turnover is over 60%, with states in the Northeast region experiencing a lower, but still staggeringly high, 53%⁴⁵. Should current rates of employee turnover persist, we estimate that the state of New York will need to recruit and train an additional 1,028,021 caregivers into the workforce by 2024 in order to meet demand.

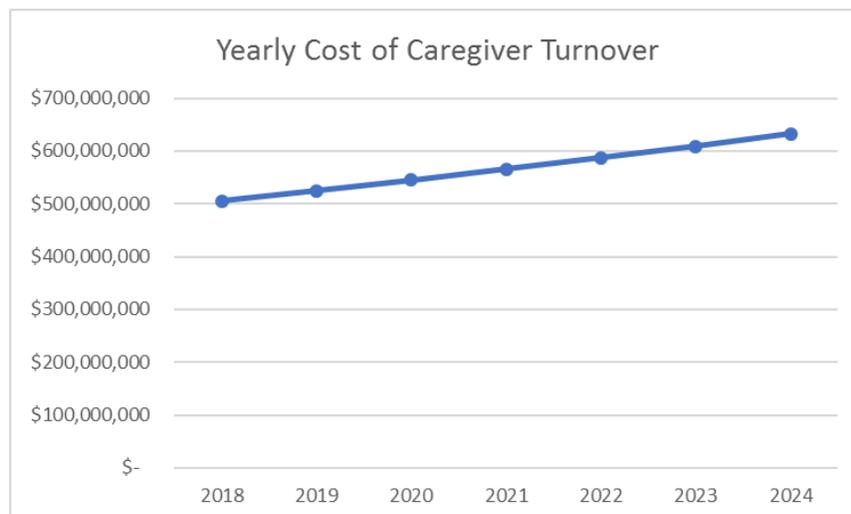
⁴³ Home Care Worker Wage Party Guidebook, 2013. Retrieved from www.HCA-NYS.org.

⁴⁴ Wage Parity 2017 Rates for CDPAS. Retrieved from www.health.ny.gov.

⁴⁵ The 2017 Home Care Benchmarking Study, 2017. Retrieved from www.homecarepulse.com/benchmarking-study.



In fact, we estimate the current turnover rate to result in annual costs exceeding \$500M and rising for the state if current conditions are not further addressed.



Even if the turnover rate was halved over the same period, over 514,000 new caregivers would be needed in order to meet current growth rates. Strategies will need to be employed to support the retention of workers in the home care field and attract others into the field.

Home care cooperatives should be particularly well positioned to leverage the benefits of worker ownership to help retain more workers, but financial stability and success, as well as the translation of this success into higher wages and benefits, will both be necessary to truly reap the benefits of the cooperative advantage. Note the darker-colored counties on the map below indicating areas where both demand *and* potential labor supply opportunity is the greatest, and revealing potentially strong areas for home care cooperative development.

COOPERATIVE OPPORTUNITY

Cooperative Law

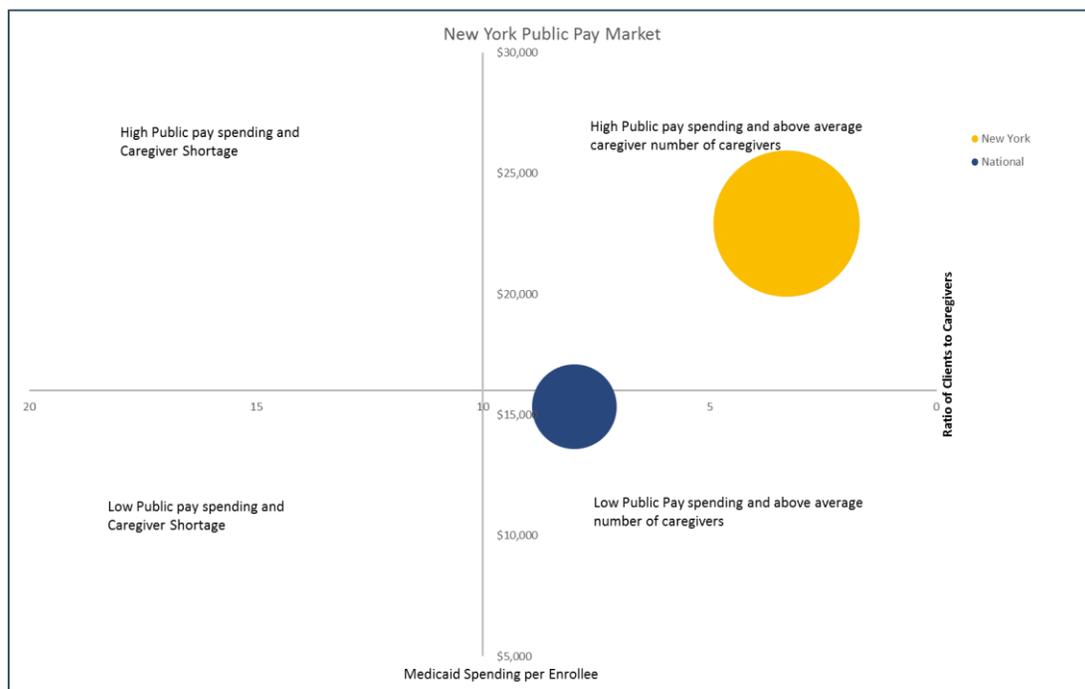
New York Article 5-A, section 82 states that “corporations organized under the business corporation law; election to be governed as worker cooperative. Any corporation organized under the business corporation law may elect to be governed as a worker cooperative under the provisions of this article, by so stating in its certificate of incorporation filed in accordance with article four of the business corporation law or amendments to its certificate of incorporation filed in accordance with article eight of the business corporation law.”⁴⁶

Cooperative Strategy

Cooperative developers and others interested in supporting home care cooperatives in New York have an exciting opportunity to improve the quality of jobs, the quality of care, and access to care in the state. However, while the potential for impact is high, the road is difficult. Nationwide, independent home care agencies are struggling to survive because of the small private market, low margins on Medicaid clients, difficulty in recruitment and retention, and high training costs.

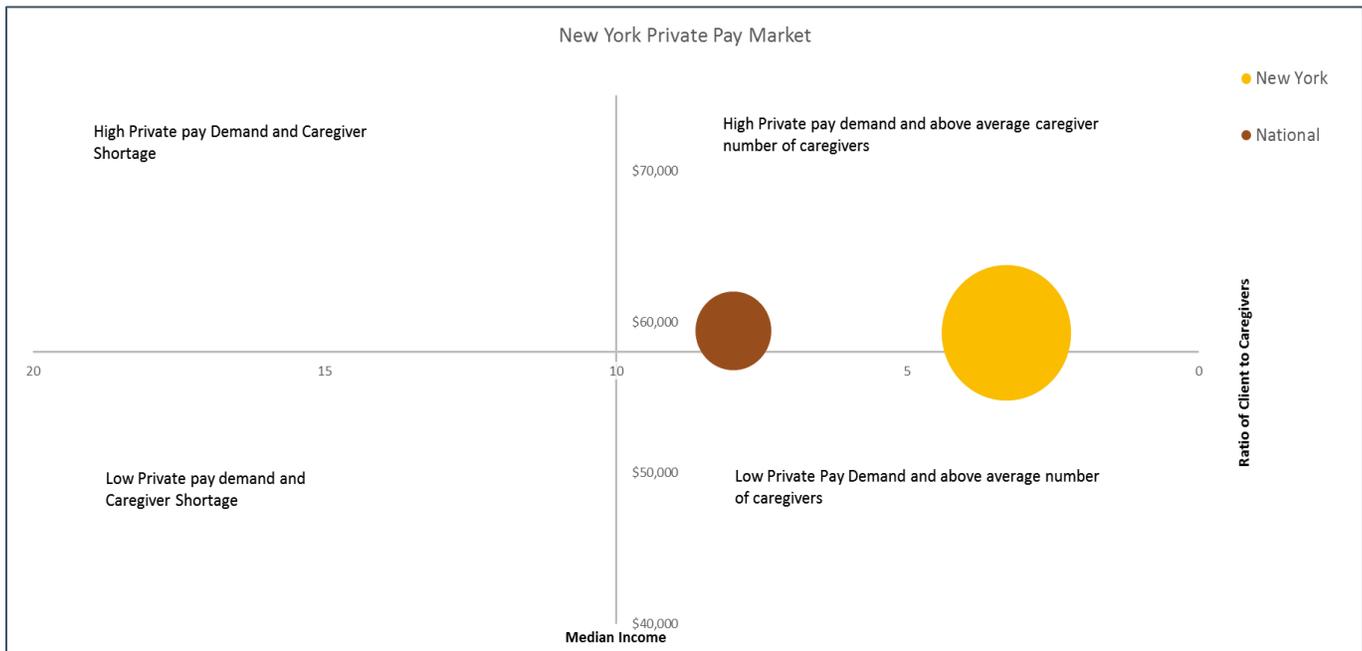
New York offers a promising market for home care cooperative development and growth. At a high level, New York spends much more per Medicaid enrollee compared the national average, and median household income about equals the U.S. average. Additionally, New York has a much less severe caregiver shortage than in other areas of the country, placing the state in a more promising category of markets for home care in the country (see public and private-pay graphics below)

New York Public Market 2x2



⁴⁶ The New York State Senate Legislature Article 5-A, Section 82. Retrieved from www.nysenate.gov/legislation/laws/CCO/82.

New York Private Market 2x2



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There are significant advantages to working in New York. New York is generally supportive of cooperative businesses and New York City in particular, has invested significant funds into cooperative development. Finally, New York boasts a wealth of strong home care and cooperative development institutions that can provide support to agencies wishing to launch or grow, providing the infrastructure to nurture the growing model.

To meet the incredible growth in New York's aging population, a large number of workers will need to enter the sector to meet demand and the quality of those workers will be paramount as the state continues its transition towards value-based, accountable care. Home care cooperatives that can leverage the "cooperative difference" of better trained, more committed, better quality workers should be well positioned to secure advantage in the market. This is evidenced by the success of Cooperative Home Care Associates (CHCA), the nation's largest worker-owned company.

Furthermore, national home care cooperative development strategies can support the successful start-up and growth of local cooperatives. One potential strategy for operatives and partners to assist local home care cooperatives is through the development of a shared services cooperative. It can be difficult

⁴⁷ The two graphics above analyze both the private pay market and the public pay market by integrating the labor supply, the number of clients needing home care services, and the pool of money available for those services. In both charts the size of the bubble indicates the total number of potential home care clients in the state. Along the x-axis, we have the ratio of home care clients to caregivers in the state. For example, nationally, there are about eight home care clients for every one working caregiver. States to the right of the national bubble have a relatively strong supply of caregivers in the state in comparison to the national average. Finally, on the y-axis we have two different data points depending on whether we are assessing the private pay market or the public pay market. In the private pay assessment, we use the state's median income to determine the potential pool of private money available to pay for home care. In the public pay assessment, we use the State's per enrollee Medicaid spending on aged and disabled beneficiaries.

for smaller scale organizations to manage back office operations, training, and regulatory paperwork while also managing a home care business and generating new sales. A membership organization for cooperatives that provides more efficient payroll and scheduling solutions and access to high quality training can create the benefits of scale while also allowing for local control of the cooperative. An organization that can provide a pool of well-trained caregivers can significantly reduce recruitment costs and increase quality of care for cooperative members. and a membership organization is one strategy that may provide that advantage.

In New York and nationwide, effecting the potential impact of cooperatives in the home care industry will require sufficient capital investment, collaboration, ingenuity, and a willingness to take risks and learn from failure. If done right, home care cooperatives can be a powerful, market-based approach creating access to dignified employment for low-wage workers in a difficult industry that has suffered from systemic underinvestment – an approach that is working for, but not waiting for, the policy solutions that are needed for larger-scale change.

Appendix

Appendix A: Cooperative Home Care Associates

Cooperative Home Care Associates (CHCA) is a worker-owned NYSDOH licensed home care agency affiliated with 1199SEIU and Independence Care System. With a stable, competent workforce, CHCA provides essential home care services for elders and individuals living with physical disabilities so that they may remain in their homes and community. CHCA has provided quality home care services for more than 30 years with a particular focus on Bronx-based residents. As the nation's largest worker cooperative, CHCA empowers its home health aides as shareholders in the company. Widely known as a pioneer in workforce training, support and supervision, CHCA is also a leader in ensuring fair compensation for its staff. Taking pride in Cooperative's mission--Quality Care Through Quality Jobs--CHCA's home care workforce delivers reliable, personalized, skillful personal care services.

CHCA's affiliated managed long term care plan, Independence Care System (ICS) is dedicated to keeping seniors and adults with physical disabilities as independent as possible, providing the home care, health care and social services they need to live at home and participate in community life. Founded by the same group of leaders, CHCA and ICS have a long history of working together to keep people healthy in the communities they love.

Appendix B: Medicaid Waivers Overview

1915(c) Home and Community-Based Waiversⁱ

This waiver enables States to tailor services to meet the needs of a particular target group. Within these target groups, States are also permitted to establish additional criteria to further target the population to be served on a HCBS waiver (e.g. target by age or diagnosis such as autism, epilepsy, cerebral palsy, traumatic brain injury, HIV/AIDS; etc.). Eligible individuals must demonstrate the need for a Level of Care that would meet the State's eligibility requirements for services in an institutional setting. States choose the maximum number of people that will be served under a HCBS Waiver program. States can offer a variety of unlimited services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

1915(i) State Plan Home and Community Based Waiversⁱⁱ

States can offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit. People must meet state-defined criteria based on need and typically get a combination of acute-care medical services (like dental services, skilled nursing services) and long-term services (like respite, case management, supported employment and environmental modifications) in home and community-based settings.

1915(j) Self-Directed Personal Assistance Services Under State Plan Waiversⁱⁱⁱ

Self-directed personal assistance services (PAS) are personal care and related services provided under the Medicaid State plan and/or section 1915(c) waivers the State already has in place.

- Participation in self-directed PAS is voluntary. Participants set their own provider qualifications, train their PAS providers and determine how much they pay for a service, support or item.

The plan must include an assessment of contingencies that pose a risk of harm to participants and an "individualized backup plan" to address those contingencies, as well as a "risk management plan" that outlines risks participants are willing to assume.

1915(k) Community First Choice Waivers^{iv}

The "Community First Choice Option" allows States to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their State Plan. This State plan option was established under the Affordable Care Act of 2010.

Appendix C: State Opportunity Assessment:

Key Metrics - Labor Supply:	US Average	New York
<i>Assesses ease or difficulty of recruitment and retention for direct-care workforce.</i>		
Prime-Age Labor Force Participation Rate (25-55 Years of Age)	81.70%	77%
Other Entry-Level Pay Comparison (Retail and Food Service)	10.83%	6.70%
Caregiver Dependency Ratio (direct care workforce over home care subset-frail elderly/dependent)	7.98	3.30
Unemployment Rate	4.40%	4.30%
Key Metrics - Firm Barriers to Entry:		
<i>Assesses ease or difficulty of entering the home care market as a new provider</i>		
Scale Barriers	\$216,243	\$303,233
Average Sales of Home Care Companies Rural	Rural: \$431,300	Rural: \$777,100
Average Sales of Home Care Companies Urban	Urban: \$373,800	Urban: \$575,000
Scale of Service Area (as Population Density)	91.39	418.99
Rural Population Density	Rural: 19.17	Rural: 34.8
Suburban Population Density	Suburban: 57.83	Suburban: 76.7
Urban Population Density	Urban: 1015.17	Urban: 5063.4
Key Metrics - Market Competitiveness		
<i>Assesses the state of market consolidation/fragmentation, and dominance of any major firms.</i>		
Total % Market Share of Top 5 Firms	8.7% (Top Three)	35.06%
Largest Provider Operating in State (Annual Sales)	Kindred	Visiting Nurse Service of New York
Key Metrics - Client/Customer Demographics		
<i>Describes composition of population in state likely needing home care services.</i>		
Total % in Home Care Subset (Frail Elderly & Ind'l with Disabilities, IL & SC)	6.19%	5.78%
Growth in Aging Population	9.70%	6.81%
Total % Population Age 65+	14.10%	14.30%
Total % Population Individuals with Disabilities	6.81%	11.30%
Total % Population on Medicaid	18.00%	32.50%
Home Care Costs as % of Median Income of 65+ Population	119%	132%
Key Metrics - Payer Composition		
<i>Describes key customers/payers in the state, how money flows, ability of providers to negotiate for better rates, etc.</i>		
Percentage Total State Medicaid Spending on LTSS	32%	41%
Share Medicaid LTSS Spending for Devoted to HCBS	53%	42%
Self-Directed Care Program	N/A	Yes
Rate Flexibility	N/A	Fee for Services and Managed Care
Per Capita HCBS	\$18,870	\$33,603

Appendix D: State Opportunity Assessment Methodology

To better understand the opportunities and challenges of creating or expanding a home care cooperative we assessed the state on five dimensions: labor supply, barriers to entry, market competitiveness, customer demographics, and payer composition. We used multiple data points and measures to assess each category, and the sources and calculation methods for each data point are outlined in the tables below.

Labor Supply: To evaluate the state's labor supply, we wanted to understand how difficult it is to recruit, attract, and retain homecare workers. The caregiver dependency ratio is the ratio of the number of direct care workers to the number of potential homecare customers which paints a picture of how much demand there is for homecare workers in the state. We also compare wages for homecare workers to wages for other service sector jobs to determine how easy it is to recruit homecare workers away from other entry-level work. Finally, the state labor force participation rate and unemployment rate are used to determine whether there is an available pool of workers to recruit from.

Barriers to Entry: Barriers to entering the homecare market were assessed using the National Establishment Time Series (NETS) database and the Mergent Intellect online database. These two databases were used to calculate the average size of homecare companies for rural counties, urban counties, and for the entire state. This data is useful in understanding how large a homecare company must be to successfully operate in a state. Additionally, we calculated the population density of rural, urban, and suburban counties to understand how travel time and costs may affect homecare companies operating in those counties.

Competitiveness: The market competitiveness category is an evaluation of the business environment for the home care industry in the state. We assessed the competitiveness of the homecare industry by calculating what percentage of the industry's sales revenue was captured by the five largest firms in the state. Since many of the larger homecare companies simultaneously operate personal care, home health, and nursing facility lines of business in multiple states, this measure does not have a high level of precision but does give an accurate assessment of the general level of homecare industry competitiveness in the state.

Client Demographics: This category is an assessment of the current and future demand for homecare services in a state based upon the size and growth of the customer base. Primarily using US census data, we determined the size of the state's elderly population, the growth rate of the elderly population, the size of the adult disabled population, and the size of the homecare subset (frail elderly plus individuals with disability). Additionally, we determined the client base's ability to pay for homecare services by comparing the current per capita homecare costs to the states per capita median wage. Finally, the potential size of the public pay market is estimated using the total percentage of the state's population currently on Medicaid.

Payer Composition: The payer composition category uses both qualitative and quantitative data to assess the regulatory environment, the amount of public money allocated towards homecare, and the funding streams for homecare in the state. The total amount of money available for homecare is measured using the percent of Medicaid spending dedicated to Long-term Support and Services (LTSS)

and Home and Community Based Care (HCBS). Per capita spending on HCBS is used to determine how much public money is dedicated to each homecare customer.

Labor Supply		
Data Point	Source	Calculation/Notes
Prime-Age Labor Force Participation Rate (25-55 Years of Age)	BLS	Direct from source
Other Entry-Level Pay Comparison (Retail and Food Service)	OES wage data	Average of retail and food service wages divided by average of personal care and home health aide wages
Caregiver Dependency Ratio	OES wage data and US Census (2015 American Community Survey 5-year Estimates)	Sum of nursing assistants in home care (7.9% of all nursing assistants nationally), personal care aides, and home health aides divided by sum of adults with disabilities and seniors designated as frail or dependent
Unemployment	BLS	Direct from source
Firms Barriers to Entry		
Data Point	Source	Calculation/Notes
Scale Barriers	Mergent Intellect	Median revenue of homecare companies in D&B database
Average Sales Revenue Rural Home Care Companies	NETS Data	Rural designation based county in which the company's headquarters is located
Average Sales Revenue Urban Home Care Companies	NETS Data	Urban designation based county in which the company's headquarters is located
Scale of Service Area	US Census	Direct from source
Rural Population Density	US Census	Direct from source
Suburban Population Density	US Census	Direct from source
Urban Population Density	US Census	Direct from source
Market Competitiveness		
Data Point	Source	Calculation/Notes
Total % Market Share of Top 5 Firms	Mergent Intellect cross checked with state list	Revenue of five largest homecare firms in state divided by total state homecare market revenue
Largest Provider is state by sales revenue	Mergent Intellect cross checked with state list	Direct from Source
Client Demographics		
Data Point	Source	Calculation/Notes
Total Percent in Home Care subset	US Census (2015 American Community Survey 5-year Estimates)	Sum of adults with disabilities and frail elderly population
Growth in Aging Population	US Census (2015 American Community Survey 5-year Estimates)	
Total Percent Population 65+	US Census (2015 American Community Survey 5-year Estimates)	

Total Percent Population Individuals with Disabilities	US Census (2015 American Community Survey 5-year Estimates)	
Total Percent Population on Medicaid	Kaiser State Health Facts	
Home Care Costs as Percent of Median Income of 65+ Population	US Census (2015 American Community Survey 5-year Estimates) and...	
Payer Composition		
Data Point	Source	Calculation/Notes
Percent Total Medicaid Spending on LTSS	CMS and Truven Health Analytics report	Direct from Source
Share Medicaid LTSS Spending dedicated to HCBS	CMS and Truven Health Analytics report	Direct from Source
Per Capita HCBS	Kaiser Health Foundation from 2013 based off KCMU and UCSF analysis	Total number of state Medicaid HCBS spending divides by number of participants.

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