REVENUE GROWTH & DIVERSIFICATION OPPORTUNITIES FOR HOME CARE COOPERATIVES

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Introduction

All companies whether for-profit or not-for-profit operate with an organizational mission. For home care cooperatives, small or large, private pay or public pay, that mission is typically to provide quality jobs for caregivers and quality care for individuals. How exactly that mission is achieved, what business strategies need to be pursued to achieve that mission, and what scale a cooperative finds satisfactory varies. As a home care cooperative considers revenue growth and diversification strategies, management and the board of directors must first ask why the co-op should pursue such a strategy. Some of the questions they may consider are:

- ✓ Are regulatory changes and industry pressures forcing a need for growth?
- ✓ Does the cooperative seek to grow caregiver wages or to offer more benefits?
- ✓ Does the cooperative hope to grow its impact by providing quality jobs to more caregivers via the cooperative model?
- ✓ Does the cooperative seek to provide quality care to more clients regardless of ability to pay?

Growth for the sake of growth is not reason enough to pursue diversification. There must be a rational driver for growth, which will clarify whether pursuing revenue growth and diversification makes sense at all, and if so, what the right strategy and pathways to success will be.

Once a home care cooperative has decided that pursing new revenue opportunities aligns with the organization's mission and business strategy, it must determine the best path forward. In a complex, fragmented, and highly regulated home care industry, choosing the right path can be difficult. This report aims to lay out a framework that will assist home care cooperative leadership in making informed, strategic decisions about revenue diversification opportunities and the paths forward to pursuing those strategies.

This report aims to assist home care cooperative leadership in making informed, strategic decisions about revenue growth and diversification opportunities and the paths to pursue those strategies. In this report you will find:

- Background on the broader home care industry
- An analysis of the typical business life cycle of a home care cooperative
- A framework for assessing revenue growth and diversification options
- A summary of some of the most fruitful expansion options available to home care co-ops today
- In-depth reports on each of the four most viable market expansion options
- A summary report on the additional nine opportunities reviewed

Industry Context

When considering market expansion and revenue diversification, it is important to consider the industry context in which a cooperative operates. In a regulated industry such as home care, it is also important to keep track of policy changes, both at the state and federal levels. Major industry trends that will continue to change the industry include:

- ➢ **Consolidation:** Over the last few years there has been significant merger activity including the merger of two of the largest home care companies, LHC and Almost Family. Other large home care agencies are pursuing growth through acquisitions of small- to medium-sized agencies. For the larger agencies, the focus of their expansion is to offer services across the continuum of care from personal care to home health care to other specialized in-home services.

- **Franchise Growth:** The industry has seen aggressive growth of home care franchises in nearly every major geographic market. Franchises are becoming more sophisticated and are beginning to look at acquisitions of small-and medium-sized agencies as a growth strategy[1]. Franchises typically operate in the private-pay market and have been gaining increased market share in that space.
- **Venture Backed Technology:** In 2016 alone, venture capital firms invested $60 million into developing technology platforms with the hope of disrupting the home care industry. Home care, however, is an industry based upon strong relationships between agencies, clients, and caregivers. While technology platforms can facilitate these relationships, they cannot replace them. This fundamental reality of the industry has ultimately forced successful venture backed home care companies to work with on the ground partners and agencies.
- **Policy Changes:** The emphasis on home-based care is growing across all publicly funded long-term care programs. In the upcoming months and years, Medicare Advantage will expand public payments for home care outside of Medicaid, but the exact impact of these changes is uncertain. As home-based programs expand, so does regulation and oversight. At the state level, moratoriums on new home care agencies have been imposed in several states to try to control unwieldy growth of new agencies.

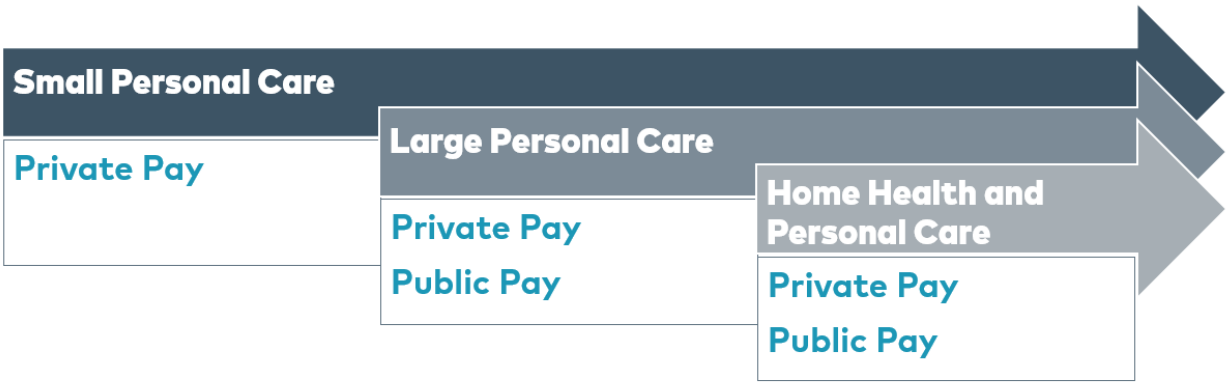
Takeaways: As the home care industry moves towards consolidation, mergers, and internal organizational growth, it will be imperative for smaller home care agencies, including co-ops, to grow and expand service offerings to remain competitive. Diversification of revenue sources will grow in importance as policy changes create risk for agencies that earn revenue from only one or two sources.

Home Care Cooperative Lifecycle

Due to current regulations and market restrictions, there is a typical lifecycle that home care cooperatives progress through from start-up to mature company; most new entrants into the home care cooperative space today start as small private pay companies. With fewer regulatory and licensing barriers to entry and often significantly higher rates, this is the most logical point in which to enter the market.

As a cooperative grows and looks to acquire more customers, it is logical to eventually consider branching out into the public pay (Medicaid and Medicare) market. In general, with lower margins and higher regulatory requirements, a cooperative must reach a certain size to make serving public pay clients financially feasible. This can be a difficult transition for many organizations, local factors such as the state Medicaid environment and whether there is capital available to fund the expansion of a cooperative will determine whether this is the right choice. With public pay representing over 65% of the market and increasing competition for private pay dollars, agencies looking to reach significant scale will eventually need to look to the public pay market for growth.

[1] Holly, Robert. November 18, 2018. Right at Home Pushing Conversion Strategy for 2019 Growth. Home Health Care News. Accessed online.



The three oldest home care cooperatives started in the public pay space (Medicaid) between 1985 and 2001. Several decades ago it was possible to start a new home care agency this way. Over time, however, regulatory pressures and low margins have incentivized most public pay home care cooperatives to grow in the hopes of gaining operational efficiencies and seek out private pay clients to increase revenue. Transitioning from public pay to private pay is an easier transition, as there are no regulatory or size barriers to taking on private pay clients. This is not without challenges however, as public pay cooperatives must develop new marketing and sales strategies to reach clients directly.

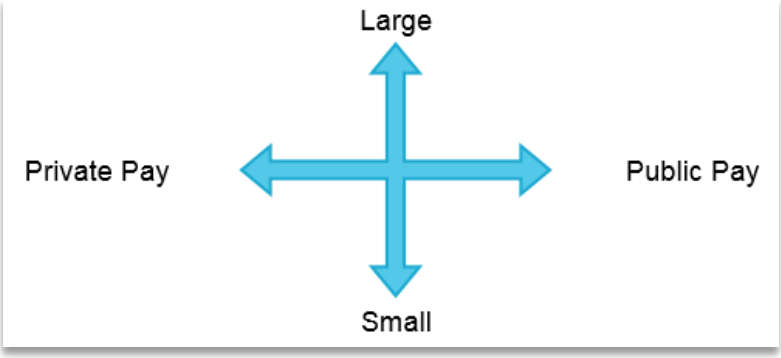
No matter how it launched, if a cooperative seeks significant growth it will likely begin to serve both public pay and private pay clients. Once an agency has entered the public pay market, a host of additional options for growth and diversification become possible including home health, hospice as a direct service offering, Fiscal Management Services (FMS), and more. This is a trajectory many large, national home care companies have followed and continue to follow today.

Framework

In assessing revenue growth and diversification strategies, the key questions a cooperative must ask are whether the cooperative **wishes** to pursue such an approach, whether a cooperative **must** pursue such an approach to be sustainable, and whether the right conditions are in place to make an approach feasible. What follows is a framework to determine how such an assessment should be made.

When and Where to Grow

The current home care cooperative industry can be divided into two dimensions, small versus large cooperatives and private pay versus public pay cooperatives[2]. Home care cooperatives with less than 100 caregivers can be categorized as small, and any cooperative



[2] All home care cooperatives that accept public pay also accept private (out-of-pocket) pay. However private pay typically represents a much smaller proportion of these agencies revenue.

with more than 100 caregivers as large. Currently, only two home care cooperatives have more than 100 caregivers and they both earn revenue primarily from public dollars. While the public pay cooperatives have begun to branch out into the private pay market, private pay revenue continues to be a small part of their overall earnings.

As a cooperative grows and changes over its life cycle, different revenue growth and diversification opportunities will be more or less viable, and it is important to begin exploration of options with a clear understanding of where the cooperative agency sits within the broader industry context.

Assessing Revenue Diversification Options

As a cooperative considers the viability of potential revenue growth and diversification options, there are five key questions that must be asked of each strategy:

1. Demand	Is there a significant need for this service?
2. Payers	Do clients or institutions have the ability and willingness to pay for the service?
3. Capabilities	Does the cooperative have the expertise, operational ability, and staff capacity to launch this type of service?
4. Financial Feasibility	Is this a financially feasible strategy for the home care cooperative?
5. Barriers to Entry	Are there obstacles, beyond operational and financial feasibility, standing in the way of pursuing such an opportunity?

The first two questions—demand and payers—focus on whether there is a critical mass of clients in the market. In the home care space, differentiating between *users* of a service (e.g. home care clients) and *payers* for the service (e.g. Medicaid) is necessary to determine whether or not a strategy is viable. For example, while there is compelling evidence for the efficacy of community health workers improving health outcomes at a low cost to the health care system (demand), the funding available for this type of service is currently relegated to small, grant funded pilot projects that do not lead to ongoing funding streams (payers).

To find a viable market, a cooperative must both identify significant demand for the service *and* payers for the service. Markets are not static, however, so regular assessment of the market and assessment of new or changing opportunities is advisable for all healthy businesses. In the case of community health workers, as pilot projects continue to show positive results, managed care organizations may decide to formally integrate this role into their service offerings, creating a viable market opportunity for agencies to pursue.

Once a market opportunity is identified, questions three and four—capabilities and financial feasibility—define whether a revenue expansion strategy is feasible for a cooperative to pursue. The purpose of question three is to determine if there is a fit between a growth or diversification strategy and a home care cooperative's current operating capacity. For example, while a new revenue stream may show great promise for a large public pay cooperative, it may prove very difficult, if not impossible, for a small private pay cooperative to pursue due to administrative or staff skills and/or capacity. Similarly, for a large co-op with a focus on public pay, staff may not have the knowledge or systems in place to effectively reach or serve private pay clientel.

Therefore, an opportunity must match a co-op's size and operational capacity, or adequate resources to develop and increase operational capacity must be available to warrant examination of a new opportunity.

The fourth question of the framework addresses whether starting a new business line would be financially feasible. A thorough assessment of a revenue growth and diversification strategy will at minimum outline the costs of starting a new business line, the ongoing expenses of operating that service, and the number of new client hours needed to make that service financially feasible at a break-even rate. Finally, the fifth question asks what other non-operational and non-financial barriers might stand in the way of launching such an endeavor, including potential opportunity costs. For example, an agency that launches its own home health business line could lose referrals from partner home health agencies. It is always important for leadership to take a holistic view when conducting an opportunity analysis and preemptively consider all potential risks, challenges, and opportunity costs.

Primary Options

When considering potential revenue growth and diversification options, there are three primary categories of opportunities that a company can pursue:

1) Offer the same service to a new customer group
2) Offer a new service to the same customer group
3) Offer a new service to a new customer group

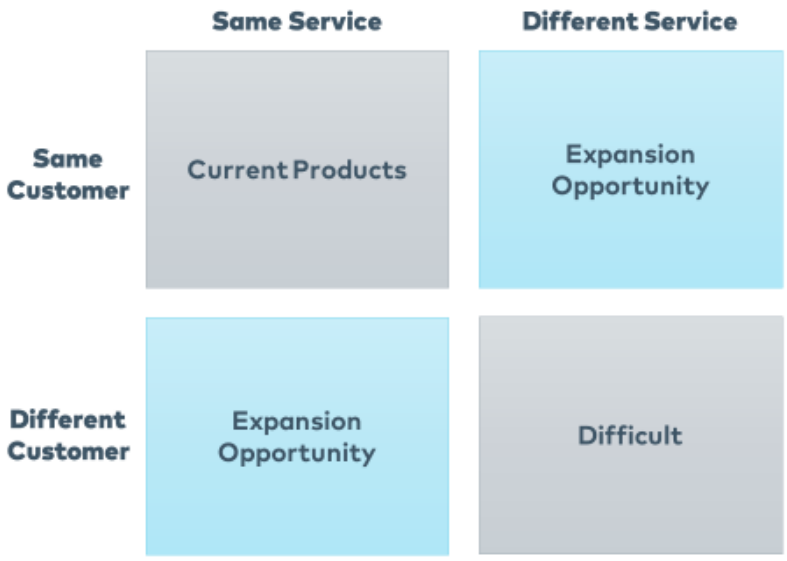
In order of ease of implementation, offering the same service to a new customer group will be the easiest, followed by offering a different service to the same customer group. Efforts to provide a new service to a new group of customers will be the most difficult, especially for smaller organizations that have limited capital or management time available to launch a new business line and market that line to a new group of customers.

Market Expansion Example

In July of 1996, Amazon.com launched as an online retailer selling only one product – books. As of January 2018, Amazon sells 100s of millions of products that range from eBooks, to cloud web storage, to their very own movie studio and streaming services. In their growth from small online start-up to one of the largest companies in the world, Amazon did what many companies do in pursuit of growth, they diversified their revenue streams.

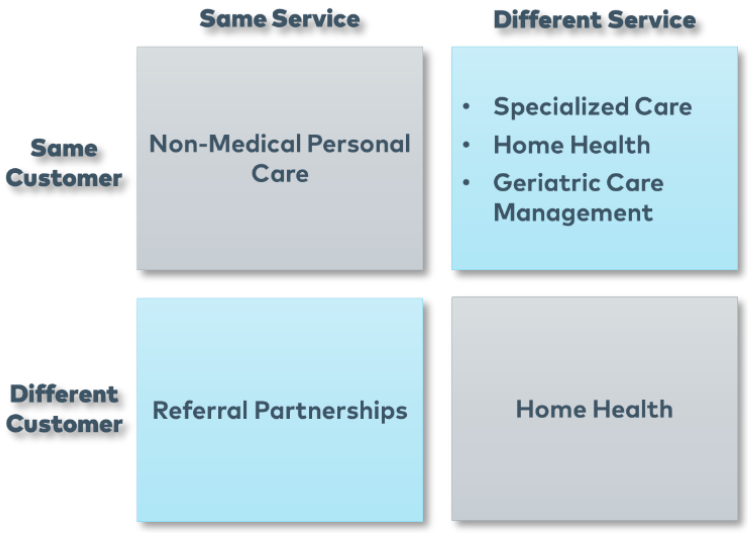
As a nascent start-up, the key to Amazon's success wasn't a diverse stream of revenues, but a relentless focus on developing a clear competitive advantage in one market. So, what was the key to Amazon's success: intense focus or diversification?

The answer, of course, is both. As a small cash strapped start-up, focus on one service or product is vital to entering the market and building a strong business. But as the organization matures and has more resources, it is often wise to expand into new markets, products, and services.



Summary of Primary Market Expansion Options:

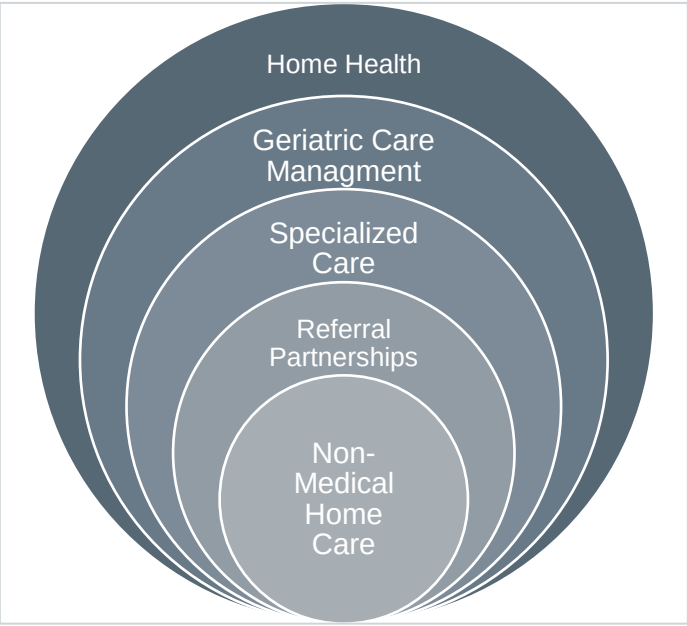
Utilizing the above framework, the ICA Group identified four primary strategies for revenue growth and diversification that show the most potential in terms of Demand, Payers, Capabilities, Financial Feasibility, and Barriers to Entry for existing home care cooperatives. These strategies are **Referral Partnerships** with a focus on hospice and assisted living facilities, **Specialized Care** with a focus on dementia care**, Geriatric Care Management**, and **Home Health**. In total, the ICA Group analyzed thirteen potential growth and diversification options. Several additional strategies are worthy of consideration depending on an agency's size or location but were not found to be broadly applicable. These include respite care, Dual Eligibles and Home Services (see pages 36-46 for a summary assessment of all evaluated options). The four selected primary options encompass different approaches to either provide the same service to new clients or increase the number of services offered to current clients.



The table below presents a summarized analysis of the four primary market expansion strategies. More in depth analysis of each strategy can be found in individual reports dedicated to each expansion strategy.

	Referral Partnerships	Geriatric Care Management (GCM)	Specialized Care - Dementia	Home Health
Opportunity	• **Primary:** Small and large private pay co-ops and public pay co-ops for expansion of public pay or growth into private pay	• **Primary:** Small and large private pay co-ops • **Secondary:** Public pay co-ops for growth into private pay	• **Primary:** Small and large private pay co-ops • **Secondary:** Public pay co-ops pursuing a pay for success model	**Primary:** Large public pay cooperatives
Demand	• Increasing demand for home care • Untapped potential for referral partnerships with Hospice and ALFs	Minimum of 400,000 potential clients, with growing awareness of GCM services	33% of all home care clients have dementia	$90 billion in revenue today, estimated growth to $170 billion by 2026
Payers	Primarily a private pay opportunity	Private pay opportunity	Private pay opportunity	Public pay through Medicaid & Medicare reimbursement
Operational Capabilities	• Already a core service • Plays into cooperative advantage • Key need is strong marketing materials and partnership development capabilities	• Need a Geriatric Care Management Specialist • Expanded marketing and admin support for scheduling and billing	• Already serving many of these clients • Caregivers will need additional training in specialized services • Expanded marketing of services	• Nurse supervision and Home Health Aides needed • State licensing
Financial Feasibility	• Low cost with few barriers to entry • Opportunity to grow private or public pay revenue streams	• Low cost with few barriers to entry • Opportunity to grow private pay revenue streams	• Low cost with few barriers to entry • Opportunity to grow private pay revenue streams	Feasible only for the largest cooperatives that are already operating in the public pay space.
Barriers to Entry	• No regulatory or other barriers to entry	• Attracting and hiring qualified GCM staff and covering upfront employment costs before new client revenue	• Limited barriers to entry with only a few states requiring additional training for dementia care	• Complex licensing • High upfront costs • Stiff competition particularly by large players

Ranked from most to least feasible, the four primary opportunities are:



1. **Referral Partnerships** are the most feasible opportunity for home care cooperatives to grow their revenue. While many cooperatives already utilize referral partnerships, as is true in the broader home care sector, this is an underutilized market expansion strategy. It is crucial that *all* cooperatives invest staff time and money in developing and growing referral partnerships.
2. **Specialized Care** services are an important method for cooperatives to differentiate themselves in the market. As many, if not all, cooperatives are already serving specialized customer segments (such as dementia care clients), differentiation through better training and marketing is feasible and will be advantageous.
3. **Geriatric Care Management** services are another method of providing more value to new and existing customers. This service requires hiring a Geriatric Care Manager. While barriers to entry are low, it is not as feasible as specialized care or referral partnerships given the upfront costs of employing a GCM and marketing a new service.
4. **Home Health** is the next stage in the continuum of care up from non-medical personal care. Adding home health requires new state licensing and more expensive medical staff required for supervision. This is the next logical step for large cooperatives.

Moving from Analysis to Process

When considering an opportunity to expand service offerings, a cooperatives' leadership should make an assessment that asks:

- Have we maximized delivery of our current services within our current customer market?
- Is there significant demand for the new service?
- Is there a population or payer group that can pay for it?
- Are we capable of providing the service?
- Does this service make financial sense?
- What are the risks and opportunity costs inherent in pursuing the strategy?

Given that the home care industry is rapidly evolving and subject to substantial shifts in national policy and market driven change, the best options for revenue growth and diversification may look different in five to ten years but the process of assessing new opportunities will remain the same. We hope that this report will give the reader not only a stronger understanding of new revenue opportunities available in the home care industry, but also a process for making organizational decisions about revenue growth and diversification and specific strategies worthy of consideration.

Referral Partnerships

Expanding Personal Care Services to New Customer Segments

Opportunity Snapshot

Opportunity	• To expand personal care services to a new customer segment. • Appropriate strategy for small or large private pay co-ops or public pay co-ops looking to expand private pay business.
Demand	• Strong and growing national demand for home-based personal care services. • Limited provision and/or public pay cost coverage of personal care services under hospice care and Assisted Living Facility programs and benefits.
Payers	• Primarily a private pay opportunity.
Operational Capabilities	• ***Staffing Needs:*** No new staff needed, but capacity for outreach and building partnerships is critical. • ***Marketing Needs:*** Ability to market to existing clients and referral partners, online presence and SEO.
Financial Feasibility	• ***Revenue*****:** Standard private pay (or public pay) rates. • ***Costs*****:** Comparable to general client acquisition costs (national median is $540 per client).
Barriers to Entry	• No regulatory or other barriers to entry.

Introduction

Within the personal care industry there are three key ways to acquire new clients: 1) direct to client marketing, 2) client referrals, and 3) referrals from partner organizations[3]. Referrals from partner organizations are an important and not fully realized opportunity for client growth within the home care sector. With lower turnover and longer caregiver tenure, better quality training and higher quality care, home care cooperatives have a marketing advantage that can and should be leveraged to secure and maintain strong referral partnerships. While there are numerous possible targets for referral partnership development, the ICA Group's research has identified hospice care agencies and Assisted Living Facilities (ALFs) as primary targets. Interestingly, an increasing number of hospice care recipients reside in ALFs, presenting a dual outreach and marketing opportunity for home care cooperatives to explore.

[3] Home Care Pulse 2018 Benchmarking Survey

Demand

Demand for home care services is at an all-time high and is rapidly increasing. By 2030, seniors aged 65 and over will represent 20% of the U.S population (an estimated 71.5 million people) and over 19 million seniors are estimated to need home care services to age at home. For home care cooperative agencies looking to grow private pay (or public pay) personal care, referral partnerships represent an underutilized business growth opportunity. Specifically, partnerships with hospice care agencies and assisted living facilities stand out as strong opportunities for home care cooperatives.

Hospice

Hospice care is end of life care that provides holistic and individualized care to patients facing a life-limiting illness or injury, and support to the families and other individuals who support them. As the National Hospice and Palliative Care Organization explains, hospice is "caring not curing"[4]. Palliative care, or pain and symptom management and relief, is a key component of hospice.

Hospice care is nearly 100% covered under Medicare (through the Medicare Hospice Benefit), Medicaid, many private insurance plans, HMOs and MCOs. Personal care is a vital component of both home-based hospice care and facility-based hospice care, but cost coverage for personal care is very limited under hospice care plans, with Medicare, Medicaid, and most insurance plans typically covering only one hour of non-medical personal care services per day. Establishing hospice care as a line of business inside of a home care agency is difficult. There is, however, a strong and untapped opportunity for cooperative home care agencies to partner with existing hospice agencies to offer personal care aide services to individuals and families that need more support for activities of daily living, companionship, or other personal care needs in addition to their hospice care.

2017 data suggests that there are 4,400 hospice care agencies in operation across the nation, with two-thirds representing for-profit agencies[5]. Despite the recent trend towards consolidation and acquisition of hospice care providers (primarily by large home health care providers), the majority of hospice care agencies remain small, serving 50 clients or fewer per day. The largest agencies serve 500 or more clients per day and represent less than 10% of the agencies in the market.[6] Currently, only 6% of home care agencies rate hospices as one of their top two revenue generating referral sources (representing 15% of their annual revenue).

Hospice Care Recipient Profile	
Age	**64%** of Medicare hospice patients are **80** or older
Percentage of Hospice Care by Location[7]	• Home: **55%** • Nursing Facility or SNF: **25%** • Assisted Living Facility: **13%**
Length of Service	• Average **71** days • Median **24** days • **54%** enrolled for less than **30** days
Assisted Living Facility	**64%** growth in hospice beneficiaries from 2010 to 2016

[4] National Hospice and Palliative Care Organization, https://www.nhpco.org
[5] Baxter, Amy. July 4, 2018. 2017 Hospice and Home Health Medicare Utilization Trends. Accessed Online: https://homehealthcarenews.com/2018/06/2017-hospice-and-home-health-medicare-utilization-trends/
[6] Facts and Figures: Hospice Care in America (2017) National Hospice and Palliative Care Organization. Accessed Online: https://www.nhpco.org/sites/default/files/public/Statistics_Research/2017_Facts_Figures.pdf
[7] Chiedi, Joanne, M. July 2018. Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio. U.S Department of Health and Human Services, Office of Inspector General. Accessed online: https://oig.hhs.gov/oei/reports/oei-02-16-00570.asp

Assisted Living Facilities

According to the National Center for Assisted Living (NCAL), there are currently over 30,200 assisted living communities in the U.S—56 percent chain affiliated, and 44 percent independently owned—serving more than 835,000 seniors. While the lack of federal regulations and standards on assisted living means wide variation in service provision and costs between states and facilities, a study by the Centers for Disease Control found that on average, residents of ALF's receive approximately twelve minutes of nursing care and two hours of personal care per day as part of their assisted living services package[8]. Many ALF residents, however, need additional care.

Large home care companies including Honor and CareLinx have been capitalizing on this need, seeing strong potential in growing partnerships with Assisted Living Providers[9]. That said, only 8.8% of home care agencies rate Assisted Living Facilities as one of their top two revenue generating referral sources (representing 22% annual revenue), demonstrating significant untapped potential for referral partnership development. For large assisted living chains, partnerships with large national home care companies will likely be most attractive, but smaller independent assisted living facilities may be more open to partnering with other local or independent providers.

Assisted Living Facility Resident Profile	
Age	**53%** of ALF residents are **85** or older
Gender	70% female
Median Length of Residency	22 months
Residents with Chronic Conditions	• Cardiovascular Disease: 46% • Alzheimer's or Dementia: >40% • Depression: 23% • Diabetes: 17%

Payers

While strong relationships with referral partners such as managed care organizations and other referring entities for public pay supported home care is critical, the focus of this report is on growing private pay revenue given the low rates of reimbursement across the industry. The process and needs are however very similar. While hospice care and Assisted Living Facility care plans do provide some cost coverage for personal care services, this care is very limited. Additional personal care support must be covered by out-of-pocket, private pay.

Operational Capabilities

Staffing Needs

The core staffing needs necessary to support referral partnership development are knowledgeable, passionate, and articulate cooperative representatives to do outreach and partnership development, and sufficient caregiving staff to meet the needs of referred clients. Because caregiving staff will be providing routine home-based personal care supports to referral partner clients, a home care cooperative's existing staff can perform this work. Depending on the target referral partners, identification of existing caregivers with specialized training or experience on staff may be necessary. Alternatively, agencies can invest in relevant training on

[8] Rome, Vincent and Harris-Kojetin, Lauren. National Health Statistics Reports: Variation in Residential Care Community Nurse and Aide Staffing Levels: United States, 2014 https://www.cdc.gov/nchs/data/nhsr/nhsr091.pdf

[9] Mullaney, Tim, July 23, 2017. Honor Sees Senior Living Partnerships as Route to New Markets https://homehealthcarenews.com/2017/07/honor-sees-senior-living-partnerships-as-route-to-new-markets/

specialized client populations or needs for caregivers to meet this need. Specialized training and experience will better position the cooperative to build successful referral partnerships.

Marketing Needs

Expanding home-based personal care supports for referral partnership clients is essentially a marketing strategy. Direct outreach and partnership development with referrals in the home care cooperative's service area forms the basis of this strategy. Strong marketing materials that highlight why a home care cooperative is a better partner than another traditional home care agency will be important and, outreach should be regular and recurring. Once a partnership or referral relationship is established, agencies should not assume that referrals will continue to flow without regular check-ins and reminders.

Key Cooperative Differentiators:

- Strong agency communication and accountability
- Lower turnover rates
- Greater consistency of caregivers
- Better trained caregivers
- Better caregiver supports to manage daily work challenges
- Agency reliability
  caregiver flexibility (if providing primary caregiver respite care)
- Experience with specific client pools (hospice, dementia, etc.)

Financial Feasibility

Costs

Because referral partnership development is effectively a marketing strategy, costs are generally comparable to client acquisition costs. Client acquisition costs vary regionally from a high of $675 per client in the Northeast Region to a low of $405 per client in the Great Lakes Region, with the national median at $540 per client (based on 2017 data)[10]. Given the nature of referral partnership development, the upfront costs of establishing a strong partnership will be higher, but the longer-term costs of maintaining that relationship and acquiring new clients will be lower.

An additional cost consideration for both hospice agency and Assisted Living Facility partners is length of service. Given length of service data, agencies can only safely assume revenue from hospice care patients for a period of 30 days. As such, it is important for agencies to consider the costs associated with onboarding new hospice clients and the need to more regularly fill caregiver schedules. The median length of stay in an ALF is 22 months[11], so client turnover will be less of a concern with this partner type.

Revenue

Home care cooperative agencies can elect to charge standard private pay rates for personal care service or charge higher rates where specialized types of care are being provided—such as to hospice care recipients or to ALF residents with conditions such as dementia care. To charge higher rates, however, the agency must also have specialized training, relevant experience, or advanced services to warrant the increase.

Barriers to Entry

There are no regulatory barriers to pursuing a referral partnership opportunity or to providing personal care services to hospice care recipients or Assisted Living Facility residents. Of

[10] Home Care Pulse 2018 Benchmarking Survey
[11] National Center for Assisted Living (NCAL), Fast Facts & Figures https://www.ahcancal.org/ncal/facts/Pages/Communities.aspx

course, an agency must adhere to the general rules and regulations governing the delivery of personal care services in their state.

Implementation & Entry Points

An agency interested in pursuing referral-partnerships as a growth strategy should follow these key steps:

1. Confirm that your agency has adequate staff capacity to respond to referrals, both in terms of office staff and caregivers to service clients[12].
2. Survey your market area to determine potential partners—locally owned or national chain hospice care agencies or Assisted Living Facilities. Prioritize the list based on partnership fit and identify specific contacts for outreach.
3. Research and develop a strong marketing pitch and associated materials that speak to both the referral partners and the clients that your partners would refer.
4. If your agency is not already engaged in partnership outreach and development, identify appropriate staff to conduct this work. Strong communication skills and responsiveness are critical to partnership success.
5. If serving a specialized population base, such as hospice recipients or ALF residents with a high percentage of dementia care, determine whether existing knowledge and experience exists on staff or whether additional training is needed.
6. Begin outreach. Check-in with partners to remind them you have capacity to help and to keep your agency top of mind.

Key Determinants of Success:

- Capacity to develop strong partnerships
- Staff capacity (both administrators and caregivers) to quickly respond to referrals
- Specialized caregiver training and experience
- Commitment to long-term partnerships

Risks & Challenges

Relative to other client growth strategies, there are very few risks and challenges to expanding through referral partnerships. Hospice support does warrant special consideration given the high rate of client turnover and the emotional distress that may follow. Ensuring caregivers have appropriate support systems in place to manage grief is an important factor to consider and may prevent caregiver turnover.

[12] In a recent article published in Home Care News, Assisted Living Providers highlighted two key attributes of successful home care partners: 1) strong communication and responsiveness, and 2) specialized training for caregivers, particularly in dementia care (an interesting tie in to the dementia care strategy discussed elsewhere in this diversification strategies report).

Geriatric Care Management

Growing Revenue Through Value-Added Support Services

Opportunity Snapshot

Opportunity	• To provide a new value-added service to the same customer segment to grow agency revenue. • Appropriate strategy for small or large private pay co-ops or public pay co-ops looking to expand private pay business.
Demand	• Primary population utilizing GCM services is elderly individuals aged 81-90 and their families. Estimated client pool of 400,000. • Continued growth of demand likely as population ages, ability of families to coordinate and manage care continues to decline, and awareness of geriatric care management grows.
Payers	• Private pay opportunity. Public pay case management requires significant scale to be financially sustainable.
Operational Capabilities	• *Staffing Needs:* Trained Geriatric Care Management (GCM) Specialist, added administrative capacity to support scheduling and client billing. • *Marketing Needs:* Ability to market to existing clients and referral partners. Online presence and SEO.
Financial Feasibility	• *Revenue*: Average hourly rate of $175 per hour in 2017. • *Costs*: Primary cost is GCM personnel. Client acquisition costs range from $86-193 per client.
Barriers to Entry	• No regulatory barriers to entry. • Primary barrier will be attracting and hiring qualified GCM staff and covering upfront employment costs before new client revenue accrues.

Introduction

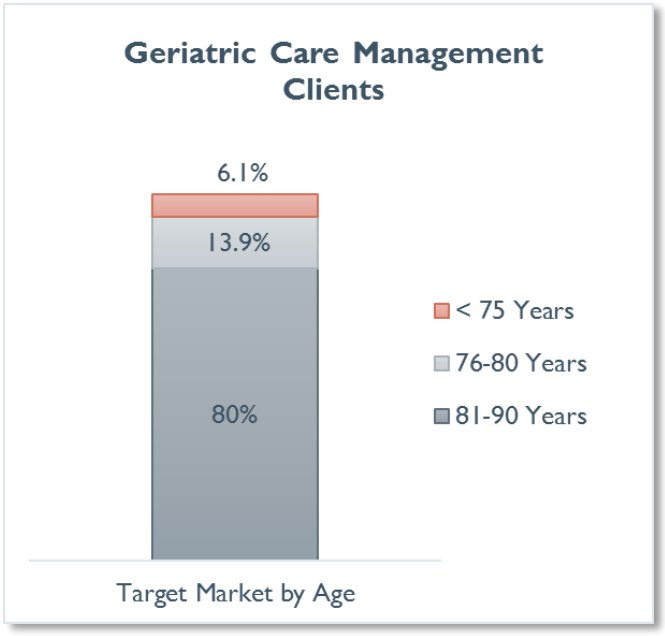
Geriatric care management (GCM) is a growing sub-specialty within the field of case management. While focused on a specific population—the elderly[13]—services provided by geriatric care managers are generally in line with case management. Geriatric care managers assess client needs, develop and coordinate care plans, monitor and regularly evaluate care quality and client outcomes, and advocate for services and supports on behalf of clients.

In addition to supporting clients in need of care, geriatric care managers are becoming increasingly important to client families with limited capacity and/or geographic barriers to caring for aging family members. A recent study conducted by the Aging Life Care Association found that 73% of “Responsible Parties” (individuals that authorize and pay for services) that engaged a GCM, did so because the family “lives far away”[14]. As America’s population ages, and the number of family caregivers available to manage family members care decreases, demand for GCM services is expected to increase.

[13] Despite their title, Geriatric Care Managers can and do also assist other client groups including the disabled.
[14] Horne, Mary Anne. Journal of Aging Life Care, How Responsible Parties Value Aging Life Care Professionals’ Services. Volume 27, Special Issue, March 2017.

Demand

By 2030, seniors aged 65 and over, will represent 20% of the U.S population (an estimated 71.5 million people) and over 19 million seniors are estimated to need home care services to age at home. Specific data on the demand for private pay geriatric care management services is not available, however, with a focus on private pay GCM services, we can assume that the market is represented by a subset of the out-of-pocket home-based personal care population. If we assume 25% of private pay home care clients will need to access GCM services, the potential pool of clients would be 400,000 at the low end. While this represents a smaller market than other assessed opportunities, the market is likely to grow rapidly, and there are likely people who can benefit from GCM that are not currently receiving service. Further, for an agency that is successful at launching and running a practice, profit margins are high for private pay GCM.



The primary population utilizing GCM services is elderly individuals aged 81-90 and their families, representing nearly 80% of clients. Of the remaining GCM client population, 13.9% of clients range in age from 76-80. Finally, 93.3% of GCM clients are Caucasian[15], though this could change over time.

Payers

While care management is a common service covered by public pay dollars, reimbursement rates are extremely low. Due to these low rates, agencies operating in the public pay case management space must operate at a very large scale to be financially sustainable or must offset the cost of care management services with other higher cost services. On the other hand, rates for private pay care management, specifically geriatric care management, are high and steadily increasing. As such, geriatric care management has been identified by the ICA Group as an opportunity for home care cooperatives to diversify and grow private pay revenue.

Operational Capabilities

Staffing Needs

On average, agencies earning less than $200,000 from GCM services employ one (1) dedicated care manager and one part-time (.5) administrative staffer. In the case of a cooperative home care agency, administrators would already be in place, but the capacity of the administrative staff to take on new care management associated tasks including scheduling and billing would need to be assessed. For GCM agencies earning between $200,000-$499,999 in annual revenues, no additional administrative capacity is needed, however agencies of this size

[15] Home Care Pulse, 2014 Care Management Benchmarking Study.

typically employ three (3) care managers. For providers earning $500,000 and above on GCM services, significant additional capacity is typically added including managerial level staffing.[16]

Geriatric Care Manager Job Profile	
Median Wage	$35 per hour or $48,000 per year
Benefits	• Paid Vacation • Sick Leave • Health Coverage
Other	Performance Bonuses
Qualifications	• Trained Social Worker or Nurse • Advanced Degree • Professional Certification

Most care managers are paid on an hourly basis (51.3%), and most receive benefits including paid vacation (86.2%), sick leave (69.2%), and major health coverage (63.1%). Being able to provide benefits to care managers may present a barrier to home care cooperatives looking to hire outside experienced care managers.[17] Starting hourly wages for geriatric care managers range from approximately $17 to $110, with the median hourly wage at $35. Similarly, annual salaries range from approximately $21,000 to $90,000 with a median salary of $48,000. Regional and rural versus urban variations, as well as agency size, are the primary factors driving differences in hourly wages and annual salaries. Many large agencies also offer monthly bonuses for client acquisition.[18]

There are currently no federal or state requirements for training or certification of GCMs. Training and certification are however, important indicators of quality, and well-trained care managers have higher client acquisition rates, provide better quality service, and demonstrate better client outcomes. Over 80% of GCMs are trained social workers or Registered Nurses and a majority hold advanced degrees (64.5% Masters' and 23.5% 4-year degree) as well as an industry certification[19]. Like the home care workforce, the GCM workforce is predominantly female and predominantly older with the median age for a GCM at 57 years old[20], presenting an opportunity for younger career professionals to enter the market. Unlike the home care workforce, however, the GCM workforce is predominantly Caucasian.

All GCM certifications require prior completion of an advanced degree (Associates, Bachelors, Masters', or PhD in a related field), supervised care management experience, and in some cases, direct client contact. As such, it may be very difficult for a cooperative to promote a GCM from within existing membership. While there are agencies and individuals without formal credentials operating in the field, this is recognized as a problem by professional associations who do not look favorably upon uncredentialled individuals. Launching a practice utilizing staff that are not credentialed could be a risk to the agency's reputation and should be considered carefully.

Marketing Needs

A strong marketing plan will ensure direct outreach to clients and client families, referral partners, and the community, while also investing in online marketing. As is true of personal care services, referrals from existing and past clients and referral partners are the strongest and

[16] Home Care Pulse, 2014 Care Management Benchmarking Study
[17] Home Care Pulse, 2014 Care Management Benchmarking Study
[18] Home Care Pulse, 2014 Care Management Benchmarking Study
[19] There are currently four certifications broadly recognized by the field: 1) Care Manager Certified (CMC)—administered by the National Academy of Certified Care Managers (NACCM), 2) Certified Case Manager (CCM)—administered by the National Commission for Certifying Agencies (NCCA), the accrediting body of the Institute for Credentialing Excellence (ICE), 3) Certified Advanced Social Work Case Manager (C-ASWCM), and/or 4) Certified Social Work Case Manager (C-SWCM)—credited by the National Association of Social Workers
[20] Home Care Pulse, 2014 Care Management Benchmarking Study

best source of new business. Home care and home health agencies that also offer GCM services often market their services as complimentary and often as an additional value-add to a suite of services including specialized care, respite care, and more[21].

There is currently no central source for identifying home care agencies offering GCM services[22], and online searches for GCM services return few and scattered results. As such, having a strong online presence would be beneficial. Home care cooperatives wishing to build their business from online searches will need to invest in website modifications *and* search engine optimization (SEO) to see strong results.

Financial Feasibility

Costs

Like home care generally, the primary cost in GCM is personnel, with care manager wages accounting for 51.6% of direct expenses on average and all personnel related expenses (care manager benefits, payroll taxes, etc.) accounting for 57.25% of expenses on average. As would be expected, direct expenses are higher for smaller agencies than for larger agencies. In contrast, indirect expenses including marketing, rent, and software are lower for smaller agencies. It is worth noting that a cooperative home care agency that adds GCM services will have lower overhead than a standalone GCM practice as rent, software, and other costs will already be paid for by the cooperative. Client acquisition costs range from $86-193 per client, with smaller providers spending less to acquire new clients than larger providers.[23]

Revenue

GCM services are typically billed at an hourly rate, with rates ranging from a low of $75 per hour to a high of $250 per hour depending on experience, geography, and other factors. Available data shows that rates are on the rise with an average rate of $175 per hour in 2017[24]. Many GCMs also offer flat rate fee options for initial assessment and development of a care plan. According to the 2014 Care Management Benchmarking Study, the median rate for initial care management consultation in 2013 was $350 per hour. Some long-term insurance plans will cover the one-time cost of a care assessment or care plan development.

A single full-time GCM services an average of 17 clients per month[25] at roughly two billable hours per client per week[26]. On average, agencies receive 56 inquiries per year and 21 of those inquiries become active clients, meaning the median close rate is 48%[27]. According to a 2002 study by AARP, 45% of client contracts lasted one year or less, 21% of client contracts lasted between one and two years, and the remaining 33% for longer[28]. Taking length of service, fee differentials, client acquisition costs, and other factors into account, client average lifetime values range from a low of $2,000 for small providers to a high of $8,297 for large providers[29]. We estimate that a home care cooperative would need to have ten ongoing GCM clients to cover additional expenses from launching a Geriatric Care Management service.

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[21] Examples of agencies offering GCM along with home care, home health and other support services include: Best of Care, Angels of Mercy Macon, Elder Care Home Care

[22] Associations representing the GCM field including the Aging Life Care Association and National Academy of Certified Care Managers (NACCM) do not list agencies (home care or otherwise) offering GCM services, rather they list certified member practitioners.

[23] Home Care Pulse, 2014 Care Management Benchmarking Study.

[24] Average rates in 2000 were $74 per hour and in 2013 $110 per hour[24].

[25] Stone, Reinhard, Machemer, and Rudin. November 2002. AARP, Geriatric Care Managers: A Profile of an Emerging Profession.

[26] Home Care Pulse, 2014 Care Management Benchmarking Study

[27] Home Care Pulse, 2014 Care Management Benchmarking Study

[28] Stone, Reinhard, Machemer, and Rudin. November 2002. AARP, Geriatric Care Managers: A Profile of an Emerging Profession

[29] Home Care Pulse, 2014 Care Management Benchmarking Study

Break-Even Estimate

At a conservative rate of $100 per hour assuming two client hours per week, at a median salary of $60,000 plus benefits, an agency would only need to acquire and service 14 clients per year (accounting for client turnover) to break even. While studies have shown that client acquisition is typically slow in year one, most agencies are able to build a base of clients and a reputation to continue to grow the GCM business by year two. As such, acquisition of 14 clients in year one does not seem unreasonable for an agency motivated to introduce a GCM service. Experienced GCMs will likely come to the agency with experience growing referral partnerships, and agencies can be careful to hire practitioners with this experience to assist with initial program growth.

Estimated Revenues and Expenses of GCM

Revenue		
Clients per Month		17
Weekly Billable Hours		2
Yearly Hours		1,768
Hourly Rate	$	100
Weekly Revenue		3,400
Monthly		14,722
Yearly	$	176,664
Additional Expenses		
Median Salary		60,000
Payroll & Benefits (30%)		18,000
Marketing		3,698
Admin Time (.5 FTE)		18,720
Total Expenses	$	100,418
Net Income	$	76,247
Yearly Break-even		
Hours Needed		*1,004*
Clients Needed		*9.7*
Clients Needed + Client Turnover		*14.0*
Inquiries Needed		*37.3*

Barriers to Entry

There are currently no federal or state regulations covering the Geriatric Care Management sector. Primary barriers to entry are the cost of hiring a trained professional and marketing GCM services to potential clientele. Notably, these expenses would need to be incurred prior to earning revenue from providing GCM services. Therefore, the cooperative would need to be financially stable and must fund the new program out of home care revenues or through a loan or line of credit. As a private pay business, potential clients in a cooperative agency's area must have the ability to pay for services. Understanding the appropriate rate to charge for services to both ensure affordability for potential clients and financial sustainability and profitability for the home care agency will be critical.

Implementation & Entry Points

The critical steps for an agency interested in pursuing Geriatric Care Management as a growth strategy are:

1. Assessing local competition and confirming sufficient unmet demand in the agency's service area.
2. Attracting and hiring a qualified Geriatric Care Manager.
3. Development of a strong outreach and marketing plan including outreach to clients and referral partners and development of an online presence and SEO.
4. Quickly securing clients and developing a strong client pipeline.

Offering Geriatric Care Management in-house creates an internal client referral feedback loop that can be leveraged. Prospective clients (individuals or their families) who inquire about home care services but are not ready to commit, or need assistance in assessing options before committing, can be referred to the agency's internal GCM for support. While a client (or client's family) may determine that they are not ready for home care services, they may need some level of assistance, such as developing a care plan. The agency can charge a fee for care plan development, while also keeping the potential client notified of potential future home care services. In cases where family members are geographically separated, clients may elect for both home care services and GCM services as an added support.

Risks & Challenges

While launching a GCM service presents fewer risks and challenges than other diversification strategies, they are still present as they are with any new business venture. Primary business risks and challenges include:

- Upfront cost of hiring a trained GCM before client load can cover costs
- Potential that client acquisition will be slower than anticipated
- Client demand is not sufficient to cover GCM staffing costs or too much competition
- Difficulty hiring a trained GCM that may be used to receiving benefits (if not offered at the agency)

Additionally, as GCMs frequently work with client families, many of whom live out of state, it is important to remain focused on what is best for the client, rather than convenient for the client family. This has become a criticism of the GCM field, and a good GCM will be adept at managing both what is best for the client and what is desired by the client's family.

Specialized Care

Growing revenue through specialized care services: A focus on dementia care

Opportunity Snapshot

Opportunity	• The primary opportunity for specialized care appears to be for private pay home care cooperatives. • A secondary opportunity exists for public pay home care cooperatives that are working to grow their private pay services and revenue and/or are pursuing pay for success models. • While there are numerous types of specialized care, dementia care stands out as the largest and most universal opportunity for home care cooperatives.
Demand	• The potential pool of dementia care clients is estimated to be 33% of all home care clients and it will continue to grow over the next decade.
Payers	• Dementia care services are paid through both public payers (as personal care services) and private payers, but the primary market opportunity will be through marketing to private pay clients.
Operational Capabilities	• ***Staffing Needs:*** Caregivers trained and certified in dementia care (or other specialized care fields). Administrative staff time for marketing specialized services. • ***Marketing Needs:*** Ability to market to existing clients and referral partners. Online marketing of specialized service capabilities and SEO.
Financial Feasibility	• ***Costs:*** Specialized caregiver training in dementia care as needed and additional marketing investments to promote and sell specialized services. • ***Revenue:*** If a cooperative can acquire two to four more clients per year, it will begin to earn additional profit with this strategy.
Barriers to Entry	• Limited barriers to entry with only a few states requiring additional training for dementia care.

Introduction

Specialized home care services are typically provided by specially trained caregivers for populations including individuals with dementia, autism, and chronic diseases. Many home care businesses already serve these populations. For example, one in three home care agency clients have been diagnosed with some form of dementia. There is potential for agencies that provide specialized training for their caregivers to better serve these populations leading to an advantage in the marketplace.

The ICA Group's research has identified dementia care as the best opportunity in specialized care for home care cooperatives to pursue. This does not preclude strategies in other specialized care markets, but these markets are either quite small (pediatric) or involve a shift towards home health care (chronic disease) that may be too expensive for many cooperatives. A dementia care strategy, on the other hand, is relatively inexpensive to launch, targets a large and growing market, and builds on skills and experience already developed within the home

care cooperative community. As such, home-based dementia care has been identified by the ICA Group as an opportunity for home care cooperatives to diversify and grow revenue.

Demand

The term dementia is used to describe a group of symptoms that are associated with several diseases including Alzheimer's, Lew Body, and Parkinson's[30]. Dementia is already a common condition among the nation's elderly, with 33% of home care agency clients diagnosed with some form of dementia nationally. As the population ages, the number of people living with some form of dementia is expected to grow. As preferences for aging at home also grows, the demand for home focused dementia care will also continue to increase.

Market for Dementia Care	
Populations	2017: 5.3 million → 2025: 7.1 million
Spending	$259 billion per year $186 billion from public payers
Individual Cost	$341,840 per individual with dementia
Out-of-pocket spending	70% of dementia care costs are out-of-pocket $61,522 over five years

Given this large and growing base of clients, there is significant market opportunity to improve care for current clients and to bring in new clients through the marketing and provision of specialized dementia care services. Outside of clients already working with home care agencies, it is estimated that friends and family members provide 18.4 billion hours of unpaid caregiving hours each year for loved ones with dementia.[31] Providing relief and support for these family caregivers is another opportunity to bring new clients into a home care business, with the potential for hours to grow as conditions worsen or family capacity changes.

Payers

There are two payers through which a home care agency may choose to bring on new dementia care clients: public sources such as Medicaid or private pay sources. Currently, public programs supporting home care clients do not differentiate and pay service premiums for dementia care clients under their purview. As such, the primary benefit to marketing and offering specialized dementia care services to public payers (such as Managed Care Organizations) is the potential for increased referrals. On the other hand, given the large and growing number of families caring for loved ones with dementia, it seems that private pay sources – either out-of-pocket or through long-term care insurance – could be a strong market. Further, families seeking support services for their loved ones suffering from dementia will in many cases prefer (and in some cases pay a premium for) caregivers experienced and trained in dementia care.

[30] Alzheimer's Disease and Dementia. (2019). *Alzheimer's and Dementia*. [online] Available at: https://www.alz.org/alzheimer_s_dementia [Accessed 3 Sep. 2019].
[31] Alzheimer's Disease and Dementia. (2019). *Facts and Figures*. [online] Available at: https://www.alz.org/alzheimers-dementia/facts-figures [Accessed 3 Jan. 2019].

Operational Capabilities

Staffing Needs

Most existing home care co-ops already take care of clients with dementia and some caregivers will have considerable practical experience providing dementia care. Despite this experience, for a co-op to deliver the highest quality care to its clients with dementia and market this advantage effectively, the cooperative needs to clearly demonstrate that all, or a subset of caregivers are officially trained in treating clients with dementia. Certifications or other official and reportable forms of training will significantly strengthen that advantage.

When it comes to treating dementia or other chronic diseases, retaining a customer is just as important as acquiring a customer. The progression of dementia can take up to 10 years through many distinct stages and care needs. A cooperative must be able to provide quality home care across most stages of dementia from initial support up until the client needs facility-based care. This creates a long-term relationship between client and caregiver leading to better quality care and more satisfied clients and caregivers. Ultimately, these relationships drive business success by reducing expenses on sales, marketing, and client and caregiver retention.

Marketing Needs

While it is always the goal of a home care cooperative to provide the best care possible, a cooperative must also leverage its high-quality care to bring in new clients[32]. A home care cooperative interested in pursuing a specialized dementia care growth strategy will need to increase marketing spending to attract new clients. This should include at minimum, an update to the agency's website describing and highlighting its dementia care service and a corresponding investment in search engine optimization, an update to other marketing and sales materials including printed brochures and print advertisements, and a planned effort to reach out to current and past clients and referral partners to highlight the agency's capabilities.

Financial Feasibility

Revenue

Home care agencies typically do not charge more for clients with dementia[33], but could charge more if expanded services are offered. Given this constraint, acquiring new clients with dementia is necessary to diversify revenue sources. In other words, this is primarily a marketing and volume strategy and not a margin strategy.

Costs

To implement this strategy, a home care business must 1) develop a clear competitive advantage in caring for clients with dementia, and 2) be able to communicate that advantage to the marketplace. A home care cooperative looking to pursue this strategy must invest in additional training for caregivers and additional marketing of services.

Training Expenses: In order to estimate the additional cost of specialized care, The ICA Group looked at the CARES training program, which is designed to prepare caregivers for the Alzheimer's Association's Essential ALZ exam. This program is a dementia care training program and is not limited to Alzheimer's care. This training program provides comprehensive training for

[32] Bildandco.com. (2019). *4 Ways to Market Memory Care on Your Website - Bild & Company*. [online] Available at: https://www.bildandco.com/2017/02/21/4-ways-to-market-memory-care-on-your-website/ [Accessed 3 Sep. 2018].
[33] Alzheimer's Disease and Dementia. (2019). *In-home Care*. [online] Available at: https://www.alz.org/help-support/caregiving/care-options/in-home-care [Accessed 8 Aug. 2018].

the exam using an online platform. To access the complete catalog of CARES training programs it cost $2,500 per year[34] for a single site with an unlimited number of user licenses. This analysis also factors in the cost of paying caregivers for the time spent completing the training. The full CARES program takes 32 hours to complete. Assuming a $15 per hour[35] fully loaded cost, it costs about $480 per caregiver to complete the training. This estimate is conservative and likely represents the higher end of training expenses.

Specialized Care Costs	
Training Program	$2,500 (High Estimate)
Training Time	$480/caregiver
Additional Marketing	$2,500 initial and $1,200 ongoing

Marketing Expenses: According to the 2018 home care pulse survey, the median cost of acquiring a new home care client is $590. The cooperative will likely also have additional expenses to add a new dementia focused page to its website, engage new referral partners or re-engage existing referral partners on dementia care, and to develop other new marketing materials such as fliers and online advertisements that the co-op deems necessary. It is safe to estimate that the cooperative will need to spend an additional $2,500 in year one and an ongoing additional expense of $1,200 per year.

Break Even Estimate

For a client acquisition and volume strategy to be viable, we need to know how many additional clients are needed to cover the new marketing and training expenses. The 2018 *Home Care Pulse* survey found that the median rate for a private duty agency was $23 per hour. Assuming a gross margin of 35%, each new billable client hour contributes $8.05 to cover overhead expenses. Using these assumptions and the cost estimates developed, we can determine how many new client hours are needed for this strategy to break even and start generating new income for a cooperative.

Using a hypothetical cooperative with 25 full-time caregivers on staff and a yearly caregiving staff turnover of 30%, the year one expense for training for all 25 caregivers is $14,500 and $6,500 each year thereafter. These expenses would be lower for a cooperative that chooses to train only a portion of their caregivers, say those that are members and have over one year of experience with the cooperative.

	Year 1	Year 2	Year 3
Gross Margin	$8.05	$8.05	$8.05
Expenses			
Training License	2,500	2,500	2,500
Caregiving Time	12,000	4,000	4,000
Marketing	2,500	1,200	1,200
Total New Costs	$17,000	$7,700	$7,700
Additional Clients Hours	2,112	957	957
40 Hours/Week Client	1.0	0.5	0.5
20 Hours/Week Client	2.0	0.9	0.9
10 Hours/Week Client	4.1	1.8	1.8

In this scenario, for the cooperative to break even in the first year it would need to add just over 2,000 more caregiving hours. In the following years the cooperative would need just

[34] Hcinteractive.com. (2018). *Pricing at a Glance | HealthCare Interactive*. [online] Available at: http://www.hcinteractive.com/pricing [Accessed 16 Aug. 2019].
[35] Rate will vary by geographic location.

under 1,000 additional caregiving hours. The cooperative could also recoup its costs over a longer time frame and add 1,340 hours per year over three years to break-even.

Clients with dementia have a range of care needs based on their family situation and the progression of their dementia. This can be as little as a few hours per week for respite care to 24/7 care in the later stages of the disease. Because of this complexity, it is difficult to estimate exactly how many new clients are needed for a dementia care strategy to be financially feasible. As can be seen in the above chart, if the typical dementia care client needs 10 hours per week, the cooperative will need to add four new clients in year one to break-even. If the typical new client needs 40 hours per week the cooperative will only need to bring on one additional client for financial feasibility. These estimates will, of course, vary based on the size and location of a home care cooperative, but those factors do not change the overall conclusions.

Based on this analysis, a focus on dementia care as a strategy for increasing revenue is financially feasible. Additional new costs are not significant, and a cooperative would only need the strategy to bring on a handful of new clients to cover expenses and start bringing in new income. For a cooperative working in the private pay market, emphasizing dementia care can be a financially viable strategy.

Barriers to Entry

Presently there are no additional licensing requirements for home care agencies taking on clients with dementia. Only 13 states have additional requirements for caregivers working with clients with dementia. As outlined in the financial feasibility section, there are some additional expenses needed to develop a quality dementia care program. While these costs are relatively low, a cooperative with limited credit or cash on hand may have difficulty launching such a program as operational needs will be more pressing. A cooperative could mitigate these barriers by only training a smaller subset of caregivers in dementia care. In general, this strategy is a low-cost method of diversifying revenue streams with few structural barriers to entering the market.

State[1]	Training Requirements
Illinois	24 hours of initial training and 12 hours per year ongoing
Massachusetts	Aides provided through HCBA waivers must be certified as a Home Health Aide or CAN and have additional training from the Alzheimer's Association of MA
Rhode Island	20 hours initial training and 5 hours of practical experience
Minnesota **Missouri** **Delaware** **Florida**	No hourly requirements. Training is needed on 4 or 5 of 7 requirements specified in each individual state's laws
Arkansas **Colorado** **Connecticut** **Washington** **New York** **West Virginia**	Other

Implementation & Entry Points

Successfully pursing a dementia care strategy hinges on execution and differentiation. To bring in new customers a cooperative must have a marketing strategy that differentiates them from local competitors. This is clearly a competitive space, and a "build it and they will come" strategy will not be effective in bringing in new customers. To effectively enter this market a home care cooperative needs to:

1. Provide high quality training in dementia care to some or all of its caregivers.
2. Have messaging and branding that stands out and differentiates the co-op from the competition. Pairing specialized training and care marketing with strong marketing about the cooperative difference (emphasizing lower turnover, a greater consistency of care, more committed caregivers, and better-quality care), could provide a competitive edge.

Examples of home-based dementia care marketing materials include website pages for major home care agencies such as:

- Bayada
- Home Instead
- Right at Home

as well as smaller, independent agencies such as:

- Best of Care
- Gentle Home Services

Risks & Challenges

- **Competition:** Dementia care is a competitive market, and most major home care franchises and agencies have some marketing materials focused on dementia care.
- **Quality and Training:** Quality dementia care is not the result of a one-time investment, but rather an ongoing commitment to recruiting, training, and retaining the best caregivers and ensuring caregivers serving dementia care clients receive ongoing and updated training. If a cooperative fails to provide high quality dementia care services, the organization could have a damaged reputation and lose clients.
- **Marketing:** If clients do not know about a cooperative's dementia care expertise and services, a cooperative will not be able to effectively execute this strategy. A long-term commitment to marketing to clients, families, and referral partners is needed to be heard in a crowded marketplace.

Additional Specialized Care Opportunities

	Chronic Disease	Pediatric Care	Autism Care
Demand	•75% of all health care spending •90% of Americans over 65 have a chronic condition	•500,000 children need home care •$6.7 billion in pediatric home care spending	•$236 billion in yearly spending on autism care •$50,000- $90,000 in yearly spending for individuals with autism
Operational Feasibility	• Home health care services are needed • Relationships with large health systems for referrals is beneficial	• Specialized training is needed	• Specialized training is needed • Substantially different population than current home care co-op clientele
Opportunity	• For large certified home health cooperatives	• Feasible in local markets, but not broadly	• Respite care

Home Health Care

Moving up the Continuum of Care

Opportunity Snapshot

Opportunity	• The primary opportunity to expand into home health lies with large public pay cooperatives that have efficient hiring practices, strong referral sources, and efficient back-office and administrative practices. • Providing both personal care and home health services for a client is a significant benefit for both home care agencies and clients. Agencies increase client values and clients can work with one trusted agency for their diverse care needs.
Demand	• $90 billion in industry revenue, growth to $170 billion expected by 2026 • 4.5 million clients
Payers	• Primarily public pay opportunity through Medicaid and Medicare. • Smaller but not insignificant private pay market (estimated at $8 billion).
Operational Capabilities	• ***Staffing Needs:*** Nurse supervision and certified Home Health Aides are needed. • ***Marketing Needs:*** Ability to market to existing clients and referral partners. Online presence and SEO, updated marketing materials. • ***Other:*** Experience and success providing personal care services to a public pay market.
Financial Feasibility	• ***Costs:*** Additional personnel costs for nurse supervision and home heath staff. Licensing costs both initial and for ongoing compliance. • ***Revenue:*** $5-$6 per hour higher than non-medical home care.
Barriers to Entry	• Complex licensing and ongoing maintenance of licenses and certifications. • Upfront costs of licensing and hiring before new home health revenue generated. • Stiff competition in the home health space, particularly by large players.

Introduction

Home health care encompasses a wide variety of in-home services ranging from a Home Health Aide reading vital signs to a Registered Nurse (RN) administering medication through a syringe, or even a physician providing significantly more intensive medical services. Home health care is usually less expensive, more convenient, and just as effective as care provided in a hospital or skilled nursing facility. Home health services include therapy and skilled nursing, administration of medication, medical tests, monitoring of health status, and wound care. Home health agencies are regulated by state and federal laws. Since home health involves medical care, it is covered by Medicaid, Medicare, and private insurance. Home health agencies employ a number of certified professionals from Home Health Aides (HHA) to Certified Nursing Assistants (CNA) to Physical Therapists.

For both clients and caregivers, adding home health services to a non-medical agency provides noteworthy benefits. By offering non-medical personal care and home health care, a cooperative can provide services for the same client across a broader spectrum of the care continuum leading to increased customer value. This strategy requires a cooperative to be large enough to recruit, hire, train, and retain HHAs, CNAs and possibly RNs to meet the needs of clients. For the client, this allows them to work with the same agency and possibly the same caregiver for a longer period. This leads to stronger relationships and a lower administrative burden both for the agency and for the client. For an agency, a longer-term relationship increases the total revenue earned per client, reduces per client marketing expenses, and decreases the administrative time spent onboarding new clients. Additionally, in an industry beset with high turnover, providing career pathways can increase caregiver retention. This can reduce hiring expenses and retain valuable expertise within a cooperative.

Demand

Home health is one of the nation's fastest growing health care sectors, with over 12,000 home health agencies serving approximately 4.5 million Medicare and Medicaid patients annually. This makes it a highly competitive industry with some big-name businesses dominating the market, namely Addus, LHC Group, and Amedysis. Generally, the trend in the home care space has been towards revenue diversification with both personal care and home health providers finding it profitable to expand their services to cover the broader continuum of care. Some home health-focused businesses like Amedisys have successfully added personal care services. Others like Almost Family struggled to keep up with rising wage rates for home care workers. The key takeaway is that while expanding services to cover the broader continuum of care is a logical business growth strategy, it does not guarantee success.

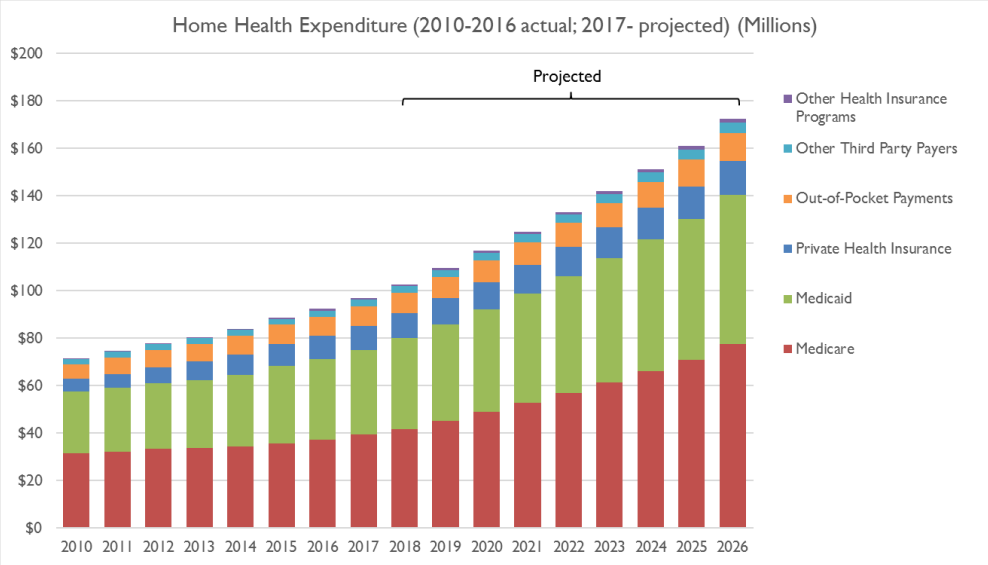
Customer Segment Highlight: Dual Eligible Population	
Who?	Individuals who are covered by both Medicare and Medicaid: • Older adults • Younger adults living with disabilities
Size of Market	$9 million
Market Opportunity	• High cost: average individual spending of $135,343 per year • 57% of high cost dual eligibles live in the community
Cooperative Opportunity	• For large public pay cooperatives certified to provide home health services • Ongoing partnerships with local hospitals, health systems, and nursing homes

Payers

National Health Expenditure data gathered by CMS estimates that 2016 spending on home health care totaled $92.4 billion. 77% of home health care spending was from public payers with $37.4 billion from Medicare and $34 billion from Medicaid. Of the remaining spending, $9.6 billion was from private insurance, $8.1 billion was out-of-pocket (private pay), and the remaining $3.4 billion was from other third-party payers[36]. By 2026, CMS projects that home health care spending will increase to $172.6 billion and a rapid increase in Medicare spending

[36] Cms.gov. (2018). *Projected - Centers for Medicare & Medicaid Services*. [online] Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html [Accessed 11 Aug. 2018].

as a large number of seniors continue to age into the program. The home health care market is projected to grow faster than all other health care services over the next ten years.



Operational Capability

The most viable opportunity for home care cooperatives to expand into the home health market will be through Medicaid payment for low level home health care delivered by HHAs and CNAs. Providing in-home care that must be directly performed by an RN is outside the core competency of home care cooperatives and would not be a viable strategy at this time. Home health care that can be delivered by an HHA and overseen by an on-staff RN, however, is a viable path to entry for home care cooperatives already operating in the public pay market. As such, experience providing non-medical personal care services in the Medicaid market is a critical operational capability that must be established and proven before expansion into home health care can be considered.

Staffing Needs

To meet licensing requirements and provide home health services, a cooperative agency will need to hire certified Home Health Aides and a supervising RN at minimum. CNAs can also be engaged for higher level care but are not necessary to launch a home health program. Like personal care, recruitment and retention of HHAs and CNAs is an ongoing challenge in the market. Shifting into the home health space from the personal care space may lead to additional challenges in recruiting and retaining a quality direct care workforce as there are more training requirements for HHAs and CNAs. A home health agency must either recruit from an already trained workforce or have access to enhanced training opportunities for their current workforce.

Marketing Needs

To drive new home health business, home care cooperatives need to focus on either expanding services to current clients, acquiring new customers through new referral sources, or both. At a minimum, administrative and sales staff would need to have both the ability and capacity to connect with new partners at medical facilities to inform them of the co-op's new service, and to reconnect with clients currently receiving non-medical care that could potentially benefit from home health care. Other key needs include website updates and revision and reprinting of updated marketing materials. This could be done in-house or by an outside professional depending on the capabilities and existing practices of administrative staff.

Financial Feasibility

Costs

Personnel

POSITION	PER HOUR RATE
PCA	$10.40
HHA	$11.46
CNA	$13.72

The primary cost of pursing a home heath diversification strategy is the cost of hiring home health personnel and state required supervision of that personnel. Home Health Aides (HHAs) earn about $1.00 per hour more than Personal Care Aides, and Certified Nursing Assistants (CNAs) earn $2.00 an hour more than Home Health Aides. These rates vary from state to state. The Bureau of Labor Statistics (BLS) survey provides state level rates that offer a more accurate estimate of local rates. Co-ops interested in pursuing a home health strategy should look at the BLS survey, and research the local competition. Based on the number of additional client hours that need to be covered, a cooperative would need to hire a minimum of five new caregivers (HHAs or CNAs). We estimate it would cost approximately $3,600 to hire new caregivers and about $1,200 per year afterwards to account for staff turnover. More detail on these calculations can be found in the break-even analysis in the Appendix.

In addition to direct caregiver expenses, home health regulations require a supervisory nurse or physician for all medical home care[37]. This adds a significant overhead expense that must be considered before launching an expansion of services into home health care. The national average yearly salary for a Registered Nurse is about $70,000. Assuming the supervisory nurse also receives benefits, the additional overhead expense for a full-time RN position is about $90,000 per year. This is a conservative assumption, as a slower rollout of a home health program may start with a part-time supervisory nurse.

Licensing

Home health agencies need to be licensed in the state they are working in. This can be a time-intensive process that will delay the launch of a home health business line and will also require ongoing compliance. There is a licensing fee, but the cost of ongoing compliance will be the largest new expense. A California state report estimated that for the average home health agency in the state 3.5% of administrative time was dedicated to compliance activities.

Revenue

Home health care services are primarily paid through public payers such as Medicaid or Medicare. Nationally, reimbursement rates from public payers for Home Health Aide services are about $5-6 dollars per hour higher than they are for non-medical personal care services[38], resulting in higher gross margins (44% vs. 34%). Rates do vary from state to state and any individual home health revenue strategy should be modified to match a cooperative's local market reimbursement rates. Additionally, some state's reimbursement rates are calculated per visit and not by hour, meaning average hourly rates would be calculated based on the average length of a client visit. While out-of-pocket payments represent a much smaller portion of the home health care market and gross margins for private pay services are comparable to personal care, it would be wise for a cooperative to consider diversification of payers as well as

[37] Law Firm | Health Care Law Firm in the USA | Hall Render. (n.d.). *CMS Finalizes New Conditions of Participation for Home Health: Part 3 | Hall Render*. [online] Available at: https://www.hallrender.com/2017/01/26/cms-finalizes-new-conditions-participation-home-health-part-3/ [Accessed 5 Sep. 2018].

[38] O'Malley Watts, M., & Musumeci, M. (2018). *Medicaid Home and Community-Based Services: Results From a 50-State Survey of Enrollment, Spending, and Program Policies* [Ebook]. Kaiser Family Foundation. Retrieved from http://files.kff.org/attachment/Report-Medicaid-Home-and-Community-Based-Services

services. This would allow cooperatives that are already accepting private pay clients for personal care to add additional services for that pool of clients.

RATES	PRIVATE	PUBLIC
HOME HEALTH	$24.50	$24.50
PERSONAL CARE	$23.50	$19.00

Break-Even Estimate

Based on rate estimates and the typical pay differences between Personal Care Aides and Home Health Aides, public pay home health care services show higher gross margins than public pay personal care services (44% vs. 34%). Meanwhile, gross margins for private pay services are comparable between personal care and home health.

Assuming a larger home care cooperative is looking to expand into Home Health Aide services in the public pay market, ICA estimates that the cooperative will need to take on an additional 9,500 billable home health client hours to cover additional expenses from new supervision, licensing, and compliance. Given that client needs can vary significantly depending on the level of care needed, ICA also estimated the number of new clients needed based on different levels of care.

At an average of 20 hours per week per client, a cooperative would need to bring on an additional nine or ten ongoing clients to cover expenses generated from launching a home health business. Assuming there is some client turnover the cooperative will need to acquire more than ten clients per year.

Given that it will take time to acquire ten new clients, a cooperative must have the financial ability to fund the upfront expenses associated with launching a home health line of business. Assuming a linear growth rate of one new client per month, a cooperative would need approximately $45,000 to fund this strategy before enough clients have been acquired to fund ongoing expenses. While an agency can certainly reduce upfront costs by launching an HHA service with only a part-time supervisory nurse and fewer HHA staff, some additional working capital will be needed to fund a home health start-up strategy regardless of scale.

	Year 1	Year 2	Year 3
Gross Margin	$ 10.75	$ 10.75	$ 10.75
Expenses			
Supervision	70,000	70,000	70,000
Benefits & Fringe	21,000	21,000	21,000
Licensing	2,500	-	-
New Hires	3,640	1,092	1,092
Compliance	4,284	4,284	4,284
Total New Costs	$ 101,424	$ 96,376	$ 96,376

Additional Clients Hours	9,437	8,967	8,967
New Clients Needed			
At 40 hours/client/week	4.5	4.3	4.3
At 20 hours/client/week	9.1	8.6	8.6
At 10 hours/client/week	18.1	17.2	17.2

Barriers to Entry

While stronger margins can make the home health market look like an attractive prospect, entering the market is a complex process that takes significant time and has substantial up-front costs. Depending on the state, a home health agency must meet certain requirements to be licensed as a home health provider.

Home health agencies must also meet state and federal requirements for Home Health Aide training. If a cooperative's caregivers are not trained and certified as Home Health Aides, the cooperative will either need to hire new caregivers who do meet state training requirements or provide training for caregivers to become certified HHAs.

Home Health Aide Training Requirements	
Federal	Minimum 75 hours
State*	• No additional training requirements: **33 states** • 75-120 hours: **17 states** • 120+ hours: **6 states**
**PHI has conducted a survey of all state Home Health Aide training requirements that can be found here.*	

Developing and implementing a training program in-house or investing in an outsourced training platform is not insignificant. Finally, as outlined in the financial feasibility analysis, the fixed costs of operating a home health agency are greater than the fixed costs associated with operating a non-medical personal care agency. More specifically, hiring a supervisory nurse adds significant ongoing personnel costs that would be burdensome for a smaller cooperative. This is also a cost that must be incurred prior to bringing on new home health services and receiving new revenue. Therefore, a cooperative that moves towards home health care must have cash reserves or access to a line of credit that can cover additional costs until new revenue can cover these costs.

Implementation & Entry Points

Key Determinants of Success	
Licensing & Regulation	• Ability to successfully navigate the home health licensing process. • Ability to attract trained caregivers or train caregivers to meet state requirements.
Client Acquisition	• Capital cushion needed to cover additional expenses prior to acquisition of new clients.
Policy	• Organizational ability to anticipate and navigate upcoming policy changes including the expected shift towards value-based care and Patient-Driven Groupings Model (PDGM).

The key steps for an agency interested in pursuing home health care as a revenue growth strategy are:

1. For a private pay, personal care cooperative interested in home health care, the cooperative must first enter the public pay market as a personal care services provider before attempting to take on home health. The cooperative should maximize and fine-tune its public pay personal care service line before expanding into home health.
2. For a public pay cooperative that is already successfully operating in the public pay personal care space, the first step is for a cooperative to conduct a thorough feasibility

assessment including a market assessment to confirm demand, research the home health licensing process, and confirm available working capital to cover both licensing and new personnel expenses including any needed training.

3. Assuming the feasibility assessment returns positive results, the cooperative must then begin the licensing and hiring process. The cooperative should also begin work on marketing materials and the development of a marketing and outreach plan, focusing on the identification of key referral partners, and outreach to existing and past clients who may benefit from home health services.

Risks & Challenges

There are several risks in pursuing expansion into home health care. First, if client acquisition is much slower than expected, this could cause the cooperative to increase costs without adding additional revenue. Second, if a cooperative cannot meet state and federal regulatory requirements, it could lose its home health license or close altogether. Third, in any highly regulated industry there will always be a risk that policy changes will cause significant changes to that market. CMS has recently proposed changes to the Prospective Payment System called the Patient-Driven Groupings Model (PDGM)[39]. The trend is a long-term shift from the current payment system towards value-based care. All home health providers, especially those that are reimbursed through public payers, need to pay attention to and be prepared for upcoming changes in regulations and reimbursements. Finally, a risk that is not unique to home health, but must be noted, is that cooperative management will have to oversee two lines of business as opposed to one. Anytime an organization brings on a new business line there is a risk that focus on the new business line will lead to a loss in quality or revenue in the agency's core business. Any cooperative considering pursuit of a home health care diversification strategy will need to carefully weigh these risks against potential gains.

[39] Holly, R. (2018). NEWS [Updated] CMS Proposes Home Health Groupings Model, $400 Million Medicare Payment Boost. *Home Health Care News*. Retrieved from https://homehealthcarenews.com/2018/07/cms-proposes-home-health-groupings-model-400-million-medicare-payment-boost/

Summary of Non-Selected Reviewed Diversification Opportunities

Introduction

The following nine reviewed diversification opportunities that were not selected for a full-scale analysis are presented here in the following order:

1. Feasible for the right home care cooperative
    a. Respite Care
    b. Dual Eligibles
2. Feasible but small opportunity
    a. Home services—Home Modifications and Domestic Work
    b. Community Health Worker (at this time)
3. Unlikely given complexity/capital needed
    a. Financial Management Services (FMS)
    b. TeleMedicine/TeleHealth
    c. Durable Medical Equipment (DME)
4. Opportunity unknown/undetermined
    a. Opioid Recovery Support
    b. Home Dialysis

Many of these strategies may prove to be feasible and financially viable in the near term as regulations and funding change such as Community Health Workers, and/or may become feasible in specific locations as programming takes shape such as Opioid Recovery Supports. At this time however, these are not seen as broadly feasible, beneficial or likely for the majority of cooperatives, at this time. It is worth noting that a handful of additional opportunities were assessed above and beyond those presented here but were quickly dismissed because they did not meet any of our core criteria.

Respite Care

Overview

Respite care is a supportive service that offers a break for caregivers by providing temporary caregiving for a client (whether it is a child or an adult).[40] Respite care can be offered for a few hours or a few days depending on the caregiver's needs. Respite care is especially valuable for family caregivers to prohibit burnout and allow them time off to tend to errands or self-care. Respite care is partially covered by Medicaid through waiver programs, and waiver eligibility criteria varies by state. Medicare does not offer coverage for respite, unless it is for hospice care, nor do private insurance plans. Respite care is also paid for out-of-pocket for those not eligible for public benefits.

There are a two primary forms of respite care:

- **In-home respite:** an ideal choice for most people who want someone to come into their home and give the primary caregiver a break. In this instance, the respite caregiver

[40] Generally, this population includes children or adolescents who are developmentally disabled, and adults who are either frail, aging, disabled, and/or have chronic diseases.

drives to the care recipient's home and performs necessary services ranging from activities of daily living to companion care.

- **Out-of-home respite:** an ideal choice for care recipients who want to be outside of the home, whether it is to prepare for transitional living or for recreational purposes. In this instance, the care recipient would need to be transported to a care center or facility for respite services. This includes:
    - Family care homes
    - Respite centers
    - Adult day care centers
    - Respite in foster or group homes
    - Residential facilities
    - Parent/Family caregiver cooperative model
    - Hotels offering respite
    - Hospital-based respite
    - Camps[41]

Opportunities for Home Care Cooperatives

Respite care is a difficult standalone service to offer though one that can be added to existing services offered by home care agencies. A successful respite line of business requires access to a large pool of caregivers that can be tapped into quickly. There are two different business opportunities available with respite care:

- Adding in-home respite care to the current roster of services that a home care and/or home health agency offers to private pay clients, or
- Developing a respite-only pool of caregivers that any agency can access

While these are potentially interesting opportunities to explore for the right agency, the low and unpredictable number of hours typically required by clients make building a respite care business line quite challenging. The variable nature of respite care makes administrative work difficult for agencies who must coordinate scheduling, and ensure caregivers are able to get full-time hours without an undue burden. For larger agencies that have access to a large number of caregivers, can potentially absorb the added effort to manage respite care scheduling, and can utilize respite care clients to round out caregiver hours, respite care could be a worthwhile opportunity to pursue.

Additional Resources for Agencies Interested in Exploring Respite Care

- ARCH National Respite Network and Resource Center, *The ABCs of Respite*: https://archrespite.org/consumer-information
- National Association of States United for Aging and Disability (NASUAD), *National Respite Network Guidelines*: http://www.nasuad.org
- ClearCare, *Adding Respite to Agency Services*: https://www.clearcareonline.com/blog/adding-respite-care-to-your-services
- AARP, *Research Report: Family Caregivers and Managed Long-Term Services and Supports*: https://www.aarp.org
- AARP, *Insight on the Issues: Valuing the Invaluable, 2015 Update*: https://www.aarp.org

[41] ARCH National Respite Network and Resource Center, The ABC's of Respite, https://archrespite.org/consumer-information

Dual Eligibles

Overview

Dual eligible are individuals who are covered by both Medicare and Medicaid. There are currently 9 million people in the US that are considered “Dual Eligible”. Dual eligibles are a high cost population that needs both complex medical services and in-home long-term care supports and services. Care coordination between medical services and long-term care is critical for both meeting client medical needs and for reducing costs to the medical system. Unfortunately, there are significant structural barriers that make coordinated care difficult to achieve. Since medical services are paid and administered through Medicare and long-term care services are paid and administered through Medicaid coordination across providers, payers, and administrators is exceedingly difficult. For home care cooperatives it is better to think of dual eligibles as a potential new client base in which home care agencies may be able to develop products or services that can better meet the needs of this unique population leading to increased revenue and margins.

Dual eligibles can be split into two separate populations with distinct needs: 1) the older adult population, and 2) younger adults living with disabilities. Businesses that have chosen to target the dual eligible population typically focus their services towards one of the specific subsets of that population and not the entirety of dual eligibles.

In an industry struggling with low margins, dual eligibles provide a significant revenue opportunity. In 2010, high-cost dual eligible beneficiaries spent an average of $135,343 per year with 53% of that cost coming from Medicare and 47% from Medicaid. Most of the Medicaid spending on dual eligibles is directed towards the population of younger adults living with disabilities, but the higher per-capita spending rate is on adults over age 65. Long-term, younger dual eligibles are far more likely to remain high cost for a longer period of time than those over age 65. Finally, 57% of high-cost dual eligibles live in the community and not nursing homes.

Opportunities for Home Care Cooperatives

For home care cooperatives there seems to be a possible opportunity for larger cooperatives with home health capacity to meet the needs of dual eligibles who fall into the subset of younger adults living with disabilities. This population receives the larger share of Medicaid dual eligible spending, are more likely to live in the community, and are more likely to be long-term clients. A business that pursues this route would have to be effective at coordinating with medical facilities as this population typically goes in and out of facility-based care. An alternative route would be for cooperatives to seek out higher margins with older adults that spend more per capita but are a smaller population that will likely be shorter term clients.

There are two overlapping problems facing the dual eligible community that will require creative business and policy solutions; complex medical needs and complex administrative needs. Cooperative home care agencies that are either affiliated with or partner with hospitals can provide better care coordination while reducing the administrative burden of moving between hospital and home.

To be able to execute on this strategy would require 1) that an agency be Medicaid and/or Medicare Certified, 2) that an agency have an experienced administrator that can maintain strong relationships with large health care systems while also being knowledge in both Medicare and Medicaid, and 3) that the agency be large enough scale to successfully pursue partnerships with hospitals and health systems, which preference large, national companies that offer a diversity of services in the continuum of care. Examples of home care companies participating in the dual eligible field are: Hometeam and the LA Care Pilot Program

Additional Resources for Agencies Interested in Exploring Dual Eligibles

- Henry J Kaiser Family Foundation: Dual Eligible: https://www.kff.org/tag/dual-eligible/
- Centers for Medicare and Medicaid Services, *Booklet: Dual Eligible Beneficiaries Under Medicaid and Medicare:* https://www.cms.gov/
- National Institutes of Health, *Journal Article: High-Cost Dual-Eligibles' Service Use Demonstrates Need for Supportive and Palliative Models of Care* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5633373/

Home Services

Overview

As the preference to age in place grows, changes in the home need to be made to ensure a senior can have successful daily living. The two biggest components of this outside of personal care are home modifications and domestic work.

Home Modifications

Home modifications include any physical changes to the home that allow a senior or disabled person greater accessibility and independence based on their changing needs. It can be as small as adding grab bars in the shower to larger renovations such as a chair lift.

Seniors who qualify for Medicaid and are at risk of nursing home placement do have access to waivers for home modifications. For those that do not qualify for Medicaid, most expenses for home renovations are paid for out of pocket. Medicare or private insurance may cover the cost of medical equipment that is installed in a home, but they generally do not pay for home remodel projects. Some seniors may qualify for a limited number of home improvement grants, based on their income and where they live. Modification and repair funds provided by the Older Americans Act are distributed by Area Agencies on Aging. Nonprofits are also available to assist low-income seniors.

Domestic Work

As people age, routine chores such as cooking, and cleaning become difficult to perform. Domestic workers can perform any housekeeping chores, from meal prep to laundry to grocery shopping, and assist an elder or disabled person. While personal care aides can perform a number of these tasks, if ADLs take up the bulk of their time, it is helpful to have domestic help. The cost of domestic help would need to be paid out-of-pocket.

Opportunities for Home Care Cooperatives

For agencies looking to add home services to their list of product and service offerings, there are a few opportunities:

- The most feasible option is to contract out these services to other area service providers and maintain lists and relationships that can be offered to clients via a customer service hotline or other means. This strategy would be primarily one of client satisfaction and retention, rather than of pure revenue generation. Agencies could potentially charge a referral fee for successful sales as one way to increase value from this effort.
- Adding domestic work to an agency's services is complicated as there is a fine line between domestic service and instrumental activities of daily living (IADLs). Likely, it is more viable for an agency to recruit, train, and retain caregivers who can perform IADLs rather than establish a domestic help line of business. However, if any agency is

interested in this sector, they would need to consider having clients outside of home care to make it financially viable. This would require that a market assessment is conducted to establish need, target clientele, pricing, etc.
- If an agency is considering becoming a DME supplier, they can offer DME and home renovation services as package deals for clients.

Additional Resources for Agencies Interested in Home Services

- Administration for Community Living. *Fact Sheet: Home Modifications:* https://eldercare.acl.gov/Public/Resources/Factsheets/Home_Modifications.aspx
- Paying for Senior Care, *Medicaid Programs that Pay for Home Modifications for Aging & Disabilities*: https://www.payingforseniorcare.com/home-modifications/medicaid-waivers.html

Community Health Worker

Overview

Community health workers (CHW) are members of a community that usually share socio-economic, language, ethnicity, and life experiences with the community in which they work. They provide supportive health services including health education, outreach, care coordination, and medication adherence support. Until recently, CHW's were in a relatively informal role with few training requirements. The Bureau of Labor Statistics (BLS) only started gathering statistics on CHWs in 2009. They have recently come to prominence following the passage of the Affordable Care Act (ACA) as there is language in the law that authorizes the government to provide funding for community health support roles that include CHWs. Given these recent policy changes and the recent increased professionalization of the workforce, the number of CHWs in the country is expected to increase 18% by 2026.

There are currently several different models in which CHWs are utilized in the field:

- Lay Health Worker Model: The more traditional model of a CHW in which CHWs share social, cultural, linguistic, and economic characteristics with individuals who they work with as a patient advocate, educator and mentor.
- Member of Multi-Disciplinary Team: In this model CHWs collaborate with medical professionals to deliver frontline medical services such as blood pressure screening, first aid, and medication counseling.
- Care Coordination/Care Manager: In this model CHWs act as a "patient navigator" assisting individuals as they navigate multiple systems of care to ensure that individuals receive the medical services they need.
- Health Educator: CHWs work with individuals to educate them on health topics including: chronic disease prevention and healthy living choices. This model is frequently paired with outreach and assessment work.
- Community Organizer/Capacity Builder Model: In this model CHWs play a role in assessing social determinants of health. This could include conducting a needs assessment, raising awareness for a specific topic, and community organizing.

These models are not mutually exclusive and more than likely any one CHW will wear multiple hats during a day. Additionally, some of these job functions could be performed by a frontline health worker such as a home care worker during personal care or home health visits. Examples of companies employing Community Health Worker roles include: Molina Healthcare of New Mexico, University of Pennsylvania Health System, New York-Presbyterian Hospital in NYC, and Hennepin Health in MN.

Opportunities for Home Care Cooperatives

There is strong evidence that CHWs provide significant cost savings to the health system and improved health outcomes. Despite this there are significant barriers to implementing a financially sustainable CHW business model. As a field, CHW programs have mostly been implemented as pilot projects and most projects are unable to find ongoing funding after the end of the initial pilot. Given the distributed nature of the American health care system, programs that save money for the broader health care system are often not rewarded in the marketplace. With so many payers and misaligned incentives it will be difficult for a CHW focused program to develop a value proposition and business case that will lead to sustainable revenue streams for a cooperative agency.

On the other hand, any home care strategy involving diversified payers will need a role that can coordinate across different service lines – a role that CHWs fit well. In the operations world a CHW would be known as a "boundary spanner"; a person whose job spans multiple job functions and touches multiple departments. In a business model where the home care cooperative is working with dual-eligibles a CHW would be integral in working with the client to coordinate care across caregivers, medical professionals, and disparate administrative barriers. Additionally, in a cooperative that primarily serves the Medicaid population, having CHWs available to work with vulnerable populations could lead to significant improvements in quality of care. Across the range of home care services there seems to be a role for a CHW, however, currently there does not appear to be a clear business opportunity to pursue.

Additional Resources for Agencies Interested in Exploring Community Health Workers

- International Journal for Service Learning in Engineering*, A Typology of Revenue Models for Community Health Worker Programs*, Vol. 9, No. 2, pp. 93-105, Fall 2014, available online. https://ojs.library.queensu.ca/
- Bureau of Labor Statistics, *Health Educators and Community Health Workers, Job Outlook*: https://www.bls.gov
- Urban Institute, *Opportunities for Community Health Workers in the Era of Health Reform*: https://www.urban.org
- Community Health Worker Network of New York City, *Report: Making the Connection--The Role of Community Health Workers in Health Homes*: http://www.chwnetwork.org/

Opioid Recovery Support

Overview

Opioid addiction is a modern day public health care crisis, affecting every demographic. Key statistics of relevance:

- According to the CDC, opioids killed more than 42,000 people in 2016. 40% of all opioid overdose deaths involved a prescription opioid[42]
- "While opioid use disorders are more common in younger patients, prevalence among the elderly is growing, and misuse poses unique risks in the geriatric population. From 1996 through 2010, the number of opioid prescriptions provided to older patients increased 9-fold. More alarming, 35% of patients older 50 years with chronic pain reported misuse of their opioid prescriptions in the past 30 days. The hospitalization rate for geriatric misuse of opioids has quintupled in the past 20 years" [43].

[42] Centers for Disease Control: Drug Overdose: https://www.cdc.gov/drugoverdose/
[43] Psychiatric Times. Opioid Use in Elderly Rises. http://www.psychiatrictimes.com/special-reports/opioid-use-elderly

- In 2006, opioid overdoses in rural areas surpassed urban areas and has continued to rise[44].

It is likely that home care aides are actively providing support to recovering opioid addicts that have returned to their homes, however no public research on this topic has been done to date. There appears to be a potential opportunity for home care workers to become involved in this growing and important space. Specific post-withdrawal support roles for home care workers could include:

- Transportation to and from treatment and recovery-oriented activities
- Emotional support/companionship
- First line of defense to spot relapse or behaviors that might indicate potential relapse
- Medication monitoring
- And for home health aides, medication management

Home care aides would need specialized training to be properly equipped to play a role in an individual's recovery.

Opportunity for Home Care Cooperatives

While home care agencies do not appear to be actively marketing support for home care clients recovering from opioid or other drug addictions, this could be an area of "specialized care" to consider, particularly in rural, or other areas that have been hard hit by the opioid epidemic. It would be wise to consult with local organizations specializing in drug recovery about both this idea and the best way to seek training for caregivers before pursuing a strategy. Beyond marketing for drug recovery support through specialized care, there is likely an opportunity for home care cooperative agencies to become involved in community level projects as well, including grant funded community pilot projects on recovery care. For example, USDA is funding multiple projects. Managed Care Organizations may also run recovery related programs and be interested in contracting with agencies that have trained to offer specialized care in this area.

Because the role of home care providers in supporting opioid recovery is new and untested (or at least unresearched and undocumented), it is a challenging area to assess both regarding positive impact to clients and revenue generation for home care agencies. This is an opportunity that can be explored on the local community level however and should be watched and further researched on the national level.

As a related example of this in practice, Cooperative Care in rural Wautoma, Wisconsin was contracted in the past by Waushara County to provide "mom services" to people recovering from a mental health hospitalization. There is one employee of Cooperative Care that provides these services – medication reminders, grocery shopping, transportation, socializing, etc. This service was offered at a higher rate than regular home care services contracted by the county.

Additional Resources for Agencies Interested in Exploring Opioid Recovery Support

- Center for Disease Control and Prevention, *Opioid Overdose:* https://www.cdc.gov/drugoverdose/
- Relias, *Blog: How the Opioid Crisis Stretches into Post-Acute Care:* https://www.relias.com/blog/how-the-opioid-crisis-stretches-into-post-acute-care
- U.S. Department of Agriculture, *Topics: Opioid Misuse in Rural America:* https://www.usda.gov/topics/opioids

[44] Centers for Disease Control, CDC Reports Rising Rates of Drug Overdose Deaths in Rural Areas https://www.cdc.gov/media/releases/2017/p1019-rural-overdose-deaths.html

Home Dialysis (Renal Care) Support

Overview

According to The US Renal Data System there are an estimated 30 million American adults suffering from Chronic Kidney Disease (CKD) and over 500,000 individuals on dialysis treatment (both traditional facility-based dialysis and home-based dialysis) in the U.S. Annually, care for individuals suffering from CKD is over $100 billion (2015 Medicare expenditures)[45]. While a greater proportion of dialysis patients still receive care in a facility-based setting, home-based dialysis is quickly growing in popularity. It is less disruptive to patients' lives and generally results in better patient outcomes, and it is also less expensive. Typically, patients who elect to pursue home-based dialysis work with a medical team—either at a hospital, clinic, or a private company to access equipment (which often requires home modifications) and get trained on how to perform the procedure. Some treatments can be done without assistance, while others require assistance. Assistance is typically provided by a family member who is also trained on the use of the systems or a contracted RN. RN's typically conduct the training (5-6 weeks in the U.S) and provide overall client supervision through remote/check-ins or onsite support. Typically, other support services such as nutrition supports are wrapped into a clients' care plan to ensure overall health and wellbeing of the patient. Home dialysis is covered by private insurances for the first 30 months and then typically by Medicare.

The dialysis and home dialysis markets are highly consolidated with Fresenius Medical Care and DaVita Kidney Care controlling over 80 percent of the of the market and are continuing to experience year over year growth.[46] Interestingly, CMS is encouraging more small dialysis organizations to enter the market.

Opportunity for Home Care Cooperatives

An initial assessment does not support home care cooperative agencies directly entering the home dialysis market. This would require specialized training, equipment purchase, RN contracting, the addition of patient training programs and more. There does seem to be an interesting potential opportunity however, for home care providers to act as patient supports in the home as part of a suite of specialized care offerings. In the study linked below (Keeping Home Dialysis Patients at Home), patient and caregiver burnout were mentioned as reasons for patients dropping out of home-based care, and home care providers could potentially step into this service with additional training. There is, however, no available information that we are aware of personal care aide or home health aide involvement in home dialysis care. This would likely be best piloted as a contract-based service in partnership with existing large providers like Fresenius or community-based hospitals, in the agency's local area. This requires more research, including contacting renal dialysis centers to explore interest. It is worth noting that translating pilot projects into ongoing business is very challenging, and this must be considered as well when pursuing a home dialysis or other pilot effort.

Additional Resources for Agencies Interested in Exploring Home Dialysis Supports

- United States Renal Data System, https://www.usrds.org/
- American Journal of Kidney Disease, *Article: Keeping Home Dialysis Patients at Home*: https://www.ajkd.org

[45] United States Renal Data System, 2017 Annual Data Report https://www.usrds.org/adrhighlights.aspx

[46] Helio, Nephrology News & Issues, July 16, 2017. The largest dialysis providers in 2017: More jump on integrated care bandwagon, https://www.healio.com/nephrology/practice-management/news/online/%7Bd894132b-b577-435e-8dec-401cd89d1b1e%7D/the-largest-dialysis-providers-in-2017-more-jump-on-integrated-care-bandwagon

- National Kidney Foundation, *A to Z Health Guide: Home Hemodialysis*: https://www.kidney.org
- Medical Education Center, *Home Dialysis Central, Home Dialysis Basics*: https://www.homedialysis.org/home-dialysis-basics

Financial Management Services (FMS)

Overview

Providers of Financial Management Services (FMS) manage and direct the distribution of funds for participants in publicly funded home and community-based services programs. In general, these services. facilitate the employment of individual providers for participants through processing payroll, withholding and filing federal, state, and local taxes, making tax payments, and performing fiscal accounting and making expenditure reports to the participant and state authorities. Participants are Medicaid eligible home care clients looking to self-direct their services, and Independent Providers are family caregivers or independent personal care workers that are not employed by an agency.

There are two models of FMS services. The first is known as Fiscal/Employer Agent (F/EA) and the other is known as Agency with Choice (AwC). These two models are separated primarily by the FMS provider's role in the employment relationship.

1. **Agency with Choice (AwC):** AwC is a model of participant directed FMS. The home care client or participant will engage an agency, a private entity, to act as a joint employer of the home care or home health aide worker. The participant has ability to choose their caregivers, set their caregiving schedule, and dismiss their caregiver from their home, if needed. The AwC provider is the legal employer of the caregiver and provides payroll processing state-directed funds and other back office functions. As the AwC provider is the legal employer, the participant does not have the authority formally hire and fire a caregiver beyond the services provided in the participant's home.

2. **Fiscal Employer Agent (F/EA):** A model of FMS that differs from AwC in the following ways: The client directly hires their own worker and is the sole employer, the participant has the legal authority to hire, train, schedule, manage, and fire the worker. The F/EA supports the participant by: assuming liability for reporting and paying taxes, performing all tax, labor, and workers comp policy responsibilities.

In general F/EA models charge a flat monthly fee for services and AwC services charge a percentage of the caregivers' hourly rate. This depends on the specific contract however.

Opportunities for Home Care Cooperatives

As states continue to move towards large networks of independent providers (for public pay home care and home health), gaining a foothold in the FMS space would give home care cooperatives a competitive advantage, and ensure continued relevance as agencies begin to play a smaller role in the sector. Large, diversified national companies like Consumer Direct started out as direct care providers and then moved into FMS over time as they grew, so there is precedent for this model. Building FSM into a diversified revenue model is a logical growth model. That said, the fixed costs and time needed to develop robust FMS are quite high and can only be handled by a well-resourced organization. Therefore, it seems most viable for more mature companies to develop FMS and seems challenging for smaller home care agencies to develop quality FMS services. While the majority of existing home care cooperatives don't have the scale or resources needed to develop their own FMS line of business, it would be wise for

cooperative home care agencies and the home care cooperative sector as a whole to develop a long-range strategy to meet this coming challenge head on.

Additional Resources for Agencies Interested in Exploring FMS

- National Association of States United for Aging and Disability, National Resource Center for Participant Directed Services, *Fiscal Management Services 101: An Introduction to Financial Management Services (FMS) for Participant Self-Directed Programs,* http://www.nasuad.org
- National Association of States United for Aging and Disability, National Resource Center for Participant Directed Services, *Agency with Choice Primer: http://www.nasuad.org*

Telemedicine/Telehealth

Overview

Telemedicine or Telehealth initially developed as a method for primary care practitioners to reach out to patients in rural communities. It has now expanded across the spectrum of medical care and clients. More recently, telehealth models have been used to expand home and community-based services to more clients with barriers to accessing care in facilities. There are a variety of different modes through which telehealth services are delivered including.

- **Live Video:** In these "virtual visits" primary care providers can conduct medical appointments with individuals with mobility limitations via video conferencing platforms.
- **Remote Patient Monitoring (RPM):** Using mobile medical device technology clients have certain vital signs monitored and transmitted to their primary care physician. This includes: weight measurements, blood pressure readings, heart rate monitors, and blood glucose monitoring. RPM is most often used for individuals with chronic conditions, so health problems can be detected before critical care is needed.
- **Messaging Tools:** Messaging is often integrated in with RPM to help individuals with chronic conditions learn self-management skills, so they can diagnose and monitor their health at home.
- **Activity Monitoring:** Using passive technologies such as cameras, sensors, or other devices to monitor an individual if a caregiver is not in the home. This can include sensors such as home-leaving sensors, water leak sensors, and bed sensors.

There is growing public funding for telehealth type services from the VA, Medicaid, and Medicare. The Veterans' Administration has the largest and most successful publicly funded telehealth program in the country with 116,000 participants. The program called Care Coordination/Home Telehealth (CCHT) provides routine non-institutional care and targeted care management, and case management services to veterans with certain chronic conditions.

Almost half of all Medicaid state programs provide some form of home telehealth. Twenty-two states provide reimbursements for RPM & six for live home video visits. In general, the size and scope of these programs depends on the specific state in which a program is operating. Individuals who are eligible for telehealth through Medicaid are usually those already receiving home health or other home and community-based services. While there is some funding for telehealth under Medicare, an individual's home is not an approved originating site. Examples of telehealth in practice include FirstHealth of the Carolinas.

There is mixed evidence on the efficacy of telehealth services. A review of the VA's CCHT program showed 41,483 participants were able to live independently in their home instead of having to live in a facility. On the other hand, reports and research completed by well-regarded

institutions such as the Mayo Clinic found no evidence for improved outcomes through telehealth. Overall, the best evidence for positive health outcomes is through RPM in conjunction with ongoing in-person care.

Opportunities for Home Care Cooperatives

The effective implementation of Telehealth can be challenging and faces significant barriers. First, telehealth can only be effective if patients can understand and use the technology. In some pilot projects patient adherence in a 12-week program was only 55%. Second, growing telehealth from pilot projects to large scale interventions requires significant investment to ensure that the technology and systems can function at scale. Finally, the fragmented policy environment leads to a wide variation in programs and reimbursements across states.

There doesn't seem to be a one-size fits all solution to integrating telehealth into a home care diversification strategy. Additional research would have to be conducted to identify states with the most generous reimbursements and broadest requirements for eligibility for public pay telehealth. There is also a competitive market for private pay telehealth services that may be worth looking into. Finally, integrating telehealth into home care will require a significant capital investment into purchasing hardware, writing software, integrating data systems, and additional caregiver training. Given these barriers, it seems unlikely that telehealth will be part of revenue diversification strategies in the short-term and will only be viable in the long-term with a significant and ongoing funding source.

Additional Resources for Agencies Interested in Exploring TeleMedicine/TeleHealth

- Evisit.com, *The Ultimate Telemedicine Guide: What is Telemedicine:* https://evisit.com/resources/what-is-telemedicine/#1
- AARP, *Insight on the Issues: Using Telehealth to Improve Home-Based Care for Older Adults and Family Caregivers:* https://www.aarp.org
- Center for Connected Health Policy, *State Telehealth Laws and Reimbursement Policies Report*: https://www.cchpca.org
- Medicaid.gov, *TeleMedicine:* https://www.medicaid.gov/

Durable Medical Equipment

Overview

Durable Medical Equipment (DME) is defined as any medically necessary equipment that can:

- Withstand repeated use
- Used for a medical reason
- Not usually useful to someone who isn't
- Not usually useful to someone who isn't sick or injured
- Used in your home
- Has an expected lifetime of at least 3 years[47]

Generally, DME is covered by Medicaid, Medicare, and some private insurance. Many families will also pay for DME out-of-pocket especially with the easy availability of equipment on platforms like Amazon.

[47] Medicare.gov, Durable Medical Equipment (DME) Coverage, https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage

The U.S. DME market size was valued at $41.9 billion in 2016 and is expected to grow at 6% over the next 4 years.[48] With the growing preference for home-based recovery and aging, DME plays a huge role in post-surgery recovery and elder care in the U.S.

Monitoring and therapeutic devices held lucrative share of around 85% in 2016.[49] This segment is inclusive of a wide range of devices used for long-term care for numerous disorders such as cardiovascular & neurological diseases and cancer. Monitoring and therapeutic devices include blood sugar monitors, Continuous Passive Motion (CPM), infusion pumps, nebulizer, oxygen equipment, Continuous Positive Airway Pressure (CPAP), suction pumps, traction equipment, and others. However, the other segments, including wound care products, cardiology devices, vital sign monitors, and neuromonitors, are expected to grow significantly and possible surpass monitoring and therapeutic devices given the growing demand for wireless monitoring devices and growing incidence of lifestyle-related diseases that require routine vital statistics analysis.

Opportunities for Home Care Cooperatives

For a cooperative home care agency looking to incorporate DME into its product and service offerings, a few options are available. One option is that the agency can be a DME referral source for clients and families. Ideally, the agency should have relationships with general DME and Medicare contract suppliers that they can direct clients to. The agency can collect a service fee per successful referral that leads to a sale.

The agency could offer to be an insurance intermediary that helps clients and families navigate reimbursements for products. While this might not be a line of business the agency could charge for, it would be a distinct competitive advantage, especially in the elder care space.

For the agency to be a DME supplier, the agency would need to purchase DME in bulk. This would require a large source of referrals and a warehouse space to store products. This is not a lucrative option for any coop agency.

While profit margins are high in the DME industry it is a difficult market to enter and participate in. Competition is high, and direct to consumer purchasing through Amazon and similar sites are increasing, thus, growing the competition. An agency interested in pursuing this market would be successful as an intermediary rather than as a direct provider of goods.

Additional Resources for Agencies Interested in Exploring DME

- Harris Williams Durable Medicaid Equipment Market Update, March 2016: https://www.harriswilliams.com
- Grand View Research, *U.S. Durable Medical Equipment Market Analysis Report By Product (Monitoring & Therapeutic Devices, Personal Mobility Devices, Bathroom Safety Devices & Medical Furniture), And Segment Forecasts, 2018 – 2025:* https://www.grandviewresearch.com
- Business Insider, *Durable Medical Equipment Market - Global Industry Analysis, Size, Share, Growth, Trends and Forecast 2017 – 2025,* https://markets.businessinsider.com
- Medicare.gov, Durable Medical Equipment (DME) Coverage, https://www.medicare.gov/

[48] Harris Williams Durable Medicaid Equipment Market Update, Accessed Online: https://www.harriswilliams.com/system/files/industry_update/dme_updated_us.pdf

[49] Grand View Research, *U.S. Durable Medical Equipment Market Analysis Report By Product (Monitoring & Therapeutic Devices, Personal Mobility Devices, Bathroom Safety Devices & Medical Furniture), And Segment Forecasts, 2018 – 2025:* https://www.grandviewresearch.com/industry-analysis/us-durable-medical-equipment-dme-market